Excellent Care For All.

2012/13 Quality Improvement Plan

(Short Form)

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

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.

Ontario

Part A:
Overview of Our Hospital's Quality Improvement Plan

Purpose of this section: Quality Improvement Plans (QIPs) are, as the name suggests, all about improvement. They are an opportunity for hospitals to focus on how and what to improve, in the name of better patient-focused care. As such, they will be unique documents, designed by, and for, each individual hospital. Overall, a QIP should be seen as a tool, providing a structured format and common language that focuses an organization on change. The QIP will drive change by formalizing a plan and facilitating shared dialogue to support continuous quality improvement processes. This introductory section should highlight the main points of your hospital's plan and describe how it aligns overall with other planning processes within your hospital and even more broadly with other initiatives underway in your hospital and across the province. In addition, this section provides you with an opportunity to describe your priorities and change plan for the next year.

Please refer to the QIP Guidance Document for more information on completing this section.

[In completing this overview section of your hospital's QIP, you may wish to consider including the following information:

- Provide a brief *overview* of your hospital's QIP.
- Describe the *objectives* of your hospital's QIP and how they will improve the quality of services and care in your hospital.
- Describe how your plan *aligns* with other planning processes in your organization.
- Describe how your plan takes into consideration *integration and continuity of care.*
- Describe any *challenges and risks* that your hospital has identified in the development of their plan.]

PURPOSE OF THE CAMH QUALITY IMPROVEMENT PLAN

Our purpose statement is: At CAMH, we Care, Discover, Learn and Build to Transform Lives. At CAMH, we strive to find new and better ways to enhance patient-focused care, increase satisfaction and achieve even better clinical outcomes. In 2012, CAMH goes forward with a new strategic plan. Strategic directions will focus on enhancing access to integrated care and social support; earning a reputation for outstanding care and service, accountability and professional leadership; igniting discovery and innovation; and revolutionizing education and knowledge exchange. As an academic health sciences center, education and research are integral to our performance measures. However the CAMH Quality Improvement Plan (QIP) is focused on the goal of improving mental health and addictions care and priorities that include ready access to patient centered, safe, appropriate, efficient and integrated care and treatment. The principles that guide our decision making include: quality of patient care, staff safety and quality of worklife, promoting our academic mission of research and education, contributing to the health of our neighborhood and system leadership for mental health.

As a sector, mental health is challenged by a paucity of valid indicators for measuring quality. As part of our commitment to quality and enhanced accountability, CAMH has come together with the mental health care hospitals in Ontario and launched the Mental Health and Addictions Quality Initiative (MHAQI). Through this initiative, hospitals developed standardized performance indicators to measure key areas including client complexity, client outcomes, client access, staff safety, human resources, fiscal responsibility and client safety. The MHAQI was launched in the fall of 2011 and in the next year we expect to see an expansion in the number of partners in the initiative as well as increase in the number and robustness of the indicators to measure the various dimensions of quality.

OBJECTIVES OF THE CAMH QIP

Patient safety is the most foundational dimension of quality and as such, the majority of our identified objectives are in the safety domain. For the past three years CAMH has had a focused initiative on reducing restraint that has resulted in considerable decrease in the use of restraints. While we have achieved excellent results, we aim for continued improvements in this area. We are also promoting medication safety through ensuring that medication reconciliation on admission is implemented for all clients across the organization. We will measure the % of medication reconciliation and also the quality of the medication reconciliation system and processes through audits and analysis of the reported medication related incidents. Improving hand hygiene remains a priority for CAMH. Last year we participated in the handy-audit project through CAHO to standardize the methodology for hand hygiene audits and our stated goal was to do 1000 audits. This year we are shifting our focus to improving performance.

The second important 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, hence patient flow and monitoring wait times are important indicators of how well we are serving our communities. By increasing efficiency in this process we can provide care to more patients and families. With increased awareness for the need for mental health services, in the past year we have seen significant increases the number of patients accessing our emergency department, and thus posing a risk for long waits. In addition to monitoring wait times in the ED we are also embarking on a patient flow initiative that will streamline intake and work with our system partners to ensure CAMH patients are discharged appropriately to services in the community. Therefore we have chosen an aim of reducing the number of ALC days in the integrated dimension of quality. The ALC issue is particularly complex for the mental health sector given the challenge of designation as well as identifying appropriate housing.

We are also focusing on enhancing patient-centred, family sensitive care. Surveys of consumers of mental health services can provide complementary insights into the quality of care. 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 whether they are being helped by their care at CAMH is our indicator of patient centeredness. This survey also provides critical and detailed information about the content of care and the manner in which it is delivered.

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.

HOW THE PLAN ALIGNS WITH OTHER PLANNING PROCESSES

The QIP is developed as a result of systematic and regular operational planning, consistent with organizational strategy. It is in alignment with our HSAA commitments.

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 epidemiologic research, providing education to health care professionals and scientists, and contributing to the healthcare system through our leadership role in the mental illness and addiction sector. Specifically, our BSC reflects our well developed Quality Improvement agenda and several measures in 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. Where possible we have chosen measures that can be compared across the mental health care hospitals in Ontario.

We have partnered with Accreditation Canada to develop a Client Experience Survey for the mental health an addictions sector. The nature of our population makes it particularly challenging to get patient feedback, however we have worked with Accreditation Canada to develop, pilot, and refine a Client Experience Survey. The tool was administered at CAMH for the second time in February to March, 2012 and plans are in place to implement the survey on an annual basis in the future. This instrument will be used to report on patient centeredness for the 2012-13 QIP at which time several sets of data will be available to help us to understand our performance.

HOW WILL CAMH USE THE QIP?

CAMH has developed a formal internal quality structure of improvement groups that span the organization both vertically and horizontally, including the Board of Trustees who oversee the QIP. This structure is necessary to execute improvement activities effectively, especially in its provision of leadership to set priorities, actively manage activities, designate internal champions and foster accountability.

With the QIP, CAMH senior leaders formally establish and/or reinforce an organizational quality improvement agenda. As a next step, serial reports of results will be disseminated to the service level and to inpatient clinicians. Improvement groups will use targets to ascertain whether results across programs and services represent high quality care or, alternatively, present opportunities for quality improvement. When performance is deemed to be unsatisfactory, we develop strategies for improvement to implement at the service level and, again, assess performance against the QIP standards. Reports of progress and barriers will be made to appropriate committees with participation and coordination among necessary departments and diverse stakeholders. In 2012, CAMH will launch its new strategic plan and a key initiative will be the realignment of our clinical programs and services.

This realignment provides us with an opportunity to review and realign our quality structures and processes for increased focus and accountability for quality. We are embarking on systematic implementation of best practice guidelines that focus on safety, client /family centeredness, and fostering a healthy work environment. The implementation of best practice guidelines and evaluation with respect to client and staff outcomes will be monitored through our quality structures.

CHALLENGES AND RISKS IN THE DEVELOPMENT OF THE QIP

There are a number of identified areas of challenge and risk 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/benchmark data and the significant transformation agenda heralded by a new strategic plan.

- CAMH is embarking on a transformation agenda that will involve construction (including construction in the ED), physical relocation of existing services, and establishment of a new inpatient unit and a new clinical population (youth with concurrent disorders).

- We are implementing a new Clinical Information System. Our Information System is in its infancy with an expected lag till the system allows for comprehensive data collection and quick analysis of data. In this context, additional issues include: the interpretation of data element definitions, documentation, and limited resources for data collection.

- We are embarking on a significant realignment of our clinical programs - how clinical care services are clustered and aligned. While the ultimate aim is to improve quality through increased access and efficiency, transition can be challenging and quality threatened until new processes are well-established.

- There are no valid and reliable tools for measuring patient centeredness in mental health and addictions care and treatment. In the past, we have relied on in-house satisfaction surveys but we are now moving towards a more consistent tool with Accreditation Canada. The nature of the patient population leads to special challenges in collecting patient/family satisfaction data and challenges exist in the capacity of our clients to provide information when they are most ill.

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

Part B:
Our Improvement Targets and Initiatives

Purpose of this section: Please complete the "Part B - Improvement Targets and Initiatives" spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to HQO (QIP@HQOntario.ca), and to include a link to this material on your hospital's website.

[Please see the QIP Guidance Document for more information on completing this section.]

Please see spreadsheet

PART B: Improvement Targets and Initiatives:

Centre for Addiction & Mental Health, 1001 Queen Street West, Toronto

AIM		MEASURE				CHANGE				
Quality Dimension	**Objective**	**Outcome Measure/Indicator**	**Current Performance**	**Performance Goal 2012/13**	**Priority**	**Improvement Initiative**	**Methods and Results Tracking**	**Target for 2012/13**	**Target Justification**	**Comments**
Safety	Improve provider hand hygiene compliance	% staff hand hygiene compliance pre and post client contact	74% pre client contact, 90% post client contact	75% Pre client contact	2	In 2011_12 CAMH was part of the Handy Audit Project which was designed to develop more reliable methodology for hand hygiene. Although the tool gives standardized measures we want to review our process to ensure that there is no bias in the process and the results are accurate.	Review of audit process. Monthly review of audit results.	75% Pre client contact	Best Practice benchmarks	We want to review the process to validate our current results.
	Reduce medication errors	% of clients who have medication reconciliation completed on admission	Q2 2011-12: 94.6%	96%	1	Refine and implement the process for medication reconciliation on admission.	Random chart audits	96%	Best Practice and Internal Targetting exercise Given that current performance is strong, we are anticipating a modest improvement	While we have implemented a process for ensuring med reconciliation on admission for all patients, our tracking system is being refined. We are striving towards 100% target, but do not have the system to ensure 100% data accuracy.
						Development of indicators to assess the quality of the direct admission medication reconciliations.	Random chart audits			
	Reduce use of mechanical Restraints	Prevalence of physical restraint use – percentage of patients whose RAI - MH admission assessment indicates use of physical restraints.	Q2 2011-12 2.8%	3.5%	1	We have a comprehensive initiative aimed at restraint reduction focusing on staff education, policy revision, staff and client debriefing to learn from incidents, and development of alternatives to restraints. Focused review of restraint practices in ED as the high use area	Each aspect of the strategy has tracking methods built in.		Our target is a more accurate reflection of the nature of client population and disposition on admission. The ability for further reduction is compromised by increased volumes and over-crowding in ED. The target of 3.5% is based on trend analysis and planned rennovation in ED which will add to space and environmental pressures.	This continues to be a priority initiative The nature of our population and indicator of restraints on admission is less sensitive to interventions since clients often come to us in restraints or in an extreme state of agitation requiring restraints for safety. We continue to focus on and monitor other indicators such as reducing time in restraints.
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 2010/11, OHRS	2010-11: 2.3%	Above 0	3	Continued monitoring				

AIM		MEASURE				CHANGE				
Quality Dimension	Objective	Outcome Measure/Indicator	Current Performance	Performance Goal 2012/13	Priority	Improvement Initiative	Methods and Results Tracking	Target for 2012/13	Target Justification	Comments
Access	Reduce wait times in the ED	90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI [suggested indicator].	11/12 Q1 - 3.6 hrs; Q2 - 3.0 hrs	4.0 hrs	2	Patient flow initiative; Clinical programs realignment ; ALC initiative with focused attention to early discharge planning	Monthly audits	4 hrs	We continue to be well below other organizations. Increased target reflects the increased volumes in the ED and planned renovation that will temporarily decrease our capacity	MH & A has been an underserved area - as awareness of the need and service increases, so does the demand; however our capacity for discharge remains limited.
Patient Centred	Improve Patient Satisfaction	% of patients who answered "yes" to the following question on annual survey. "Overall how would you rate the services you are receiving?"	64 - 68% inpatients, 86-87% inpatients		2	The survey tool is still under development. We will continue to validate the tool and re-implement annually and act on identified areas for improvement. We utilize client surveyors to distribute the surveys leading to increased response rate.	Annual survey supplemented by other mechanisms of getting more timely feedback		Establish benchmarks based on comparators across other mental health facilties	There are no benchmarks for mental health and addictions on this. We are collaborating with other like organizations to develop benchmarks. Many of our clients do not come voluntary. As well, many of our clients have severe and persistent mental illness and are treatment refractory.
Integration	Reduce ALC days	Reduce % of Long stay clients (greater than 1 year)	Dec 31, 2011 - 172 long stay clients [107 forensic and 65 non forensic]	Reduce non-forensic by 10%	2	Clarify organizational criteria for declaration of ALC. We are focusing on a reduction of long term (>1 year) non-forensic clients. ALC initiative to review clients across all clinical programs will be implemented. Initiative with community housing partners to support discharges.	Organizational audit	Non-forensic long stay clients 59 or less (10% reduction)	There are no benchmarks for mental health and addictions on this. Discharge options in the community are limited for mental health and addictions clients, particularly for forensic clients. Therefore our focus will be on working with community partners on non-forensic partners.	We are not reporting % ALC days as the current organizational processes do not capture all ALC clients. This year we will embark on an initiative to understand the magnitude of ALC by clarifying the criteria and strengthening our processes for ALC declaration and undertaking a systematic review across all clinical programs.

Part C:
The Link to Performance-based Compensation of Our Executives

The purpose of performance-based compensation related to ECFAA is to drive accountability for the delivery of quality improvement plans (QIPs). By linking achievement of targets to compensation, organizations can increase the motivation to achieve both long and short term goals. Performance-based compensation will enable organizations to ensure consistency in the application of performance incentives and drive transparency in the performance incentive process.

Please refer to Appendix E in the QIP Guidance Document for more information on completing this section of the QIP Short Form. The guidance provided for executive compensation is also available on the ministry website.

Manner in and extent to which compensation of our executives is tied to achievement of targets

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.

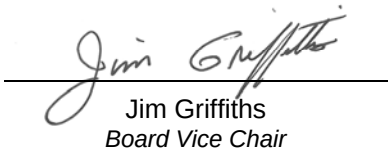
Quality Dimension	Objective	Weighting	CEO Compensation	ELT Compensation
Safety	Improve provider hand hygiene compliance Reduce use of mechanical restraints Improve Medication Safety	20%	1.25	0.75
Effectiveness	Improve organization financial health	20%	1.25	0.75
Access	Reduce wait times in ED	20%	1.25	0.75
Patient-centred	Overall Patient Satisfaction	20%	1.25	0.75
Integrated	% ALC days	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

Part D:
Accountability Sign-off

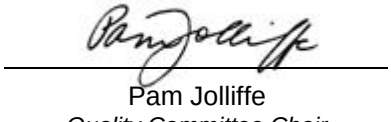
[Please see the QIP Guidance Document for more information on completing this section.]

I have reviewed and approved our hospital's Quality Improvement Plan and attest that our organization fulfills the requirements of the *Excellent Care for All Act*. In particular, our hospital's Quality Improvement Plan:

1. Was developed with consideration of data from the patient relations process, patient and employee/service provider surveys, and aggregated critical incident data
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in and extent to which, executive compensation is tied to achievement of QIP targets; and
4. Was reviewed as part of the planning submission process and is aligned with the organization's operational planning processes and considers other organizational and provincial priorities *(refer to the guidance document for more information)*.



Jim Griffiths
Board Vice Chair



Pam Jolliffe
Quality Committee Chair

Dr. Catherine Zahn
Chief Executive Officer