Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

March 31, 2017

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.
Overview

When people receive hospital, community or home care services in the Central West region, they expect safe, quality care.

This Quality Improvement Plan is an example of how the Central West Community Care Access Centre, Headwaters Health Care Centre, and William Osler Health System (Brampton Civic Hospital, Etobicoke General Hospital, Peel Memorial Centre for Integrated Health and Wellness) are working together to improve the quality and safety of patient care in our community. It is one element of our broader quality program.

Patients and families are partners in helping to drive quality and safety in our organizations, and this plan showcases how their input is playing a key role in how we design and deliver care in the Central West region.

What it means to deliver safe, quality care

Quality patient care means:

- Patients have the information they need to make decisions about their health so that they remain healthy and can better manage their conditions at home and in the community.
- Patients receive timely care that respects their beliefs and values, and they move effortlessly between emergency services and hospitals, hospital departments, hospitals in the region, and hospital and home/community care.
- The health professionals who deliver care are using the most up-to-date information to help them make informed decisions about patient care to support the best health outcomes.

Our 2017-18 Quality Improvement Plan (QIP) builds on previous quality improvement activities and introduces new ones that will help us continue to deliver safe, effective care that meets our patients’ needs and expectations.

We will be working together in many ways this year to continuously improve patient care. We will:

Deepen Patient and Family Involvement. To help us create a health system that supports patients and families, we will involve patients and family members in all aspects of care. We will invite them to share their experiences and ideas to help improve the patient experience, from lending their voices to the design and improvement of services, to sharing insights on how and where care is delivered.

Improve Patient Satisfaction. We will use a variety of ways to survey patients to better understand opportunities to improve the delivery of care across our organizations. Working as partners, we will identify and put solutions in place that make patient movement between services and organizations as smooth as possible.

Reduce Preventable Hospital Admissions. Being readmitted to hospital within 30 days of being discharged can be challenging for patients and families. We will work to reduce hospital readmissions for patients living with Chronic Obstructive Pulmonary Disease (COPD).

Improve Wait Times. The number of patients visiting our hospital Emergency Departments (EDs) has been steadily increasing. This impacts how long patients have to wait for care. We will continue our work to reduce readmissions, and improve access to services, with a special emphasis on patients with complex needs.
Reduce Falls. For seniors and those with disabilities, falls pose a major risk to safety and wellbeing and can lead to unexpected visits to the ED, hospitalization, and/or premature admissions to long-term care. By educating people who are vulnerable, we can help increase individual knowledge, confidence and independence while also reducing their risk of falling. We will work to reduce the risk of patient falls by identifying patients at risk for falls upon admission to hospital, upon return home, or when transferred to another health care facility or long-term care home.

Reduce Medication Errors. We will review a patient’s medication history both at admission to hospital and upon discharge to ensure health care providers have the right information to help make informed decisions about a patient’s care. We will also empower patients to care for themselves at home by helping to further educate them about their medications.

Organization-specific quality improvement plans
In addition to this joint Quality Improvement Plan narrative, our organizations have individual quality improvement plans that outline quality initiatives specific to our organizations. We regularly monitor our progress so that we can measure our performance to ensure we are meeting the needs of patients and families.

To view the detailed plans describing each organization’s quality goals, measures, targets and improvement initiatives, please visit:

Central West CCAC: [www.healthcareathome.ca/centralwest/en/Our-Performance](http://www.healthcareathome.ca/centralwest/en/Our-Performance)
Headwaters Health Care Centre: [www.headwatershealth.ca/qualityimprovementplan](http://www.headwatershealth.ca/qualityimprovementplan)

As we developed our joint Quality Improvement Plan narrative we considered the health care priorities of the Ministry of Health and Long-Term Care ([Patients First Action Plan for Health Care](https://www.health.gov.on.ca/en/ohdh/planforhealthcareprovincialactionplan/)) and the Central West Local Health Integration Network ([Integrated Health Service Plan 2016-2019](https://www.health.gov.on.ca/en/ohdh/planforhealthcareprovincialactionplan/)), as well as the individual strategic priorities and goals outlined in our respective Strategic Plans, joint Annual Business Plan, and other key planning documents, including our Clinical Priorities Plans, Patient Safety Plans and Operational Plans.

Quality Improvement Achievements in 2016-17
Our joint 2016-17 Quality Improvement Plan included a number of activities to help further improve the delivery of safe, quality patient care in our hospitals, in patients’ homes and in the community. The following are just some of the ways we were successful in meeting our quality improvement goals:

- **Accreditation.** In 2016, Accreditation Canada approved the first ever regional Accreditation Survey in Ontario as a pilot in partnership with Central West CCAC, Headwaters and Osler. We participate in the national accreditation program because Accreditation Canada’s rigorous standards are designed to help improve quality, safety and efficiency so that we can offer the best possible care and service. Our regional approach was commended by Accreditation Canada, reinforcing the strength of our local and regional commitment to the delivery of safe, high quality, patient-centred care. Both Headwaters and Osler were successfully accredited, with Headwaters attaining Accreditation with Exemplary Standing.

- **Hospital to Home (H2H) Program.** This innovative model of care evolved out of our collective efforts to support safe patient transitions between hospital and home. Patients played a key role in each step of the design and planning. In 2016-17 the program successfully reduced the average hospital length of
• **Hospital to Home (H2H) Program.** This innovative model of care evolved out of our collective efforts to support safe patient transitions between hospital and home. Patients played a key role in each step of the design and planning. In 2016-17 the program successfully reduced the average hospital length of stay by four days, and the average length of service in the community from 21 to 11 days for these patients. In 2016, the program was recognized with a place on the Honour Roll for the Minister’s Medal Honouring Excellence in Health Quality and Safety.

• **Health Links.** In 2016, the five Health Links in the Central West region were successful in completing the most coordinated care plans in Ontario for complex and vulnerable patients. Health Links help improve a patient’s journey through the health system while also helping to reduce visits to the Emergency Department and unnecessary hospital admissions, resulting in a better patient experience.

Other successes achieved as a result of our regional partnership in 2016-17 include:

• **Improved patient communication.** We are working together to implement a patient portal that over time will eventually be available through all three organizations. MyChart™ will make it possible for patients to access personal health information, share information with their health care providers to better support their care needs, and reduce duplicate testing, resulting in more coordinated care.

• **Reduced hospital readmissions.** Working together, we successfully reduced the percentage of patients being readmitted to hospital within 30 days of being discharged. The rate for hospital readmission of patients on CCAC services improved from 19.2 percent to 17.6 percent after staff received training aimed at reducing avoidable hospital readmission rates among home care patients.

**Population Health**

The better we understand the people we serve, the better prepared we will be to meet their individual health care needs.

We have created a series of population profiles for Dufferin County, Town of Caledon, and for the areas served by Etobicoke General Hospital and Brampton Civic Hospital using information from the 2011 Census. All three organizations will use this information in 2017-18 to better assess how we are meeting the needs of specific patient populations.

Some of our early population health activities focus on the risk of inequity faced by vulnerable patient populations with the goal of supporting smooth transitions between care providers, improving care coordination, and reducing unnecessary ED visits and hospital admissions.

**Health Links.** Our five regional Health Links focus on creating coordinated care plans for vulnerable populations including the frail elderly, mental health and addictions, and people who have palliative care needs.

**Hospital to Home (H2H).** Our regional H2H program currently focuses on patients with a diagnosis of Cellulitis or Urinary Tract Infections (UTIs) who need short-term nursing. In 2017-18, we will expand the model to include additional diagnoses and population groups.

The Central West CCAC further supports the needs of vulnerable populations by providing direct nursing care in a variety of care settings to students with mental health or addiction issues, frail seniors and adults, children with serious complex illnesses as well as people who need end-of-life care.
**Equity**

The Central West CCAC, Headwaters and Osler are committed to ensuring that all vulnerable and disadvantaged patient populations have equitable and barrier-free access to safe, quality care, and to creating inclusive working environments for everyone.

While we each have our own multi-year Health Equity Plans, we share common goals:

- Embedding health equity into each quality improvement plan to make sure it is implemented and monitored
- Creating inclusive work environments
- Supporting effective data and demographic collection
- Working to better understand our patient populations from a diversity lens
- Improving the health equity journey and promising practices.

We deploy a variety of initiatives across our region as part of our equity program including staff training, tools and resources, patient experience working groups, participation in regional diversity committees and more. We will continue to implement and monitor our Health Equity Plans, use data to inform and improve service delivery for patients, and explore how we can further benefit patients and families through equity initiatives.

**Integration and Continuity of Care**

We know that we can strengthen our local health care system and provide patients and families with an improved experience when we work together. Regional planning and joint investment opportunities are helping us to deliver a more integrated approach to care delivery, while also supporting safe, high quality care across the entire health system.

Working collaboratively leads to smoother transitions as patients move between health service providers for care. The following are some of the joint approaches we will continue to use to improve access to health care services for patients and families:

- **Regional Patient Experience Office.** This regional office works across all three organizations and has been instrumental in helping us better understand what is important to patients and how we can use that insight to help shape a patient-centred health care system that is easier for people to access, understand and navigate.

- **Regional Information Management and Information Technology.** By taking a regional approach to how we share information and data between our organizations, we can connect local health care providers with the information they need to support quality patient care.

- **Hospital to Home (H2H).** This program provides patients with a single point of contact for their care as they leave the Emergency Department (ED) and continue their care and treatment at home. This program uses virtual technology provided through the Ontario Telemedicine Network to help patients access the right care, when they need it and in the comfort and privacy of their own homes.

- **Health Links.** This Ministry of Health and Long-Term Care initiative, in partnership with the Central West LHIN, brings our partner organizations together with local health care providers to better and more quickly coordinate care for patients who have complex needs by creating joint care plans. With the support of the Ontario Telemedicine Network, we are able to connect virtually with one another and provide coordinated input into care planning to help patients achieve better health outcomes.
- **Integrated Care Coordinators.** This combined role of the Hospital Discharge Coordinator and the CCAC Care Coordinator meets the needs of patients in a more efficient manner by streamlining the process for patients as they are discharged from hospital and transition to home and community services.

- **Primary Care Integration.** The Central West CCAC is working to strengthen working relationships with primary care providers (e.g., Family Health Teams, Community Health Centres, primary care professionals) to connect patients who have complex needs with the supports they need following discharge from hospital.

- **Telehomecare.** Our partners at the Ontario Telemedicine Network are helping us increase access to programs, services and health care information for patients living with Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD). This partnership links patients to nurses who provide patients with remote monitoring and regular health coaching sessions.

**Access to the Right Level of Care - Addressing ALC Issues**

We work collaboratively to meet the unique needs of patients who no longer need hospital care, but can’t be discharged from hospital until the supports they need in the community or at home are available.

Our work in 2016-17 resulted in our region having the lowest Alternate Level of Care (ALC) rate in Ontario (ALC rate measures people waiting in a hospital bed to transition to another level of care like long-term care or care in the home). We did this by:

- **Proactively planning for patient discharge** throughout their hospital stay and proactively discussing discharge plans with patients and families.

- **Helping patients receive the care they need outside of a hospital setting through initiatives** like Health Links, Hospital to Home, Home First, and Telehomecare (connecting patients with care using technology).

- **Applying legal and ethical expertise** to support health care professionals in making informed decisions about patient care, in consultation with patients.

- **Partnering with staff, physicians and leaders** at the Central West CCAC, Headwaters and Osler, and with community care providers, to coordinate the best possible patient care and smooth transitions between care providers.

Caring for patients in the most appropriate setting improves the quality and safety of patient care and helps to ensure timely hospital care is available for patients who need to be admitted to hospital.
Engagement of Clinicians, Leadership & Staff

An emphasis on continuous quality improvement is deeply rooted in our organizations and everything we do is focused on patient needs.

- **Leadership Engagement.** We continue to engage leaders to learn and apply Evidence-Based Leadership practices that will advance our commitment to quality improvement and further enhance the care we provide to patients and families.

- **Employee Engagement.** We are committed to providing a positive, inclusive workplace where people are empowered to be their best. We know employee engagement is closely linked with patient satisfaction, and we regularly survey employees so we can actively continue to enhance the workplace experience.

- **Physician Engagement.** Understanding what is important to physicians in the workplace benefits patient care. Headwaters and Osler regularly survey physicians to help identify where improvements can be made to better support them in the care of patients.

- **Primary Care Engagement.** CCACs are working closely with primary care to ensure providers have the information they need to respond to the increasing needs of patient with complex conditions and their caregivers.

Our Quality Improvement Plan was developed with the involvement and commitment of our organizations’:
- Boards of Directors
- Respective quality committees
- Senior Leadership and Joint Senior Leadership
- Leadership teams
- Staff members care providers, clinicians, physicians and support staff who work at the point of care.
- Patients

To drive quality improvement and ensure success, we continuously measure and monitor quality across our organizations in a variety of ways including: team huddles, staff meetings, daily access reporting tools, Evidence-Based Leadership practices and the compensation of our senior leaders (see the section on Performance-Based Compensation).

Resident, Patient, Client Engagement

Across the Central West region, patients and families are actively involved as partners in driving quality and safety in all aspects of the patient experience. As individual organizations and as partners, we involve patients and our communities in informing decisions made about their care and experiences through:

- Patient satisfaction surveys at various touch points in the health care journey
- Phone calls to patients after they have left the hospital to ask about their total care experience from hospital to home through the first-of-its kind regional call centre
- Patient, Family and Community Advisory Councils who provide input and advice so we can design care that works for patients and families
- Social media, online polling questions and feedback forms
- Information from compliments or complaints received
Under the leadership of our Regional Patient Experience Office, we are working closer than ever with patients and families so we can design programs, policies and models of care to help improve health outcomes across the local health care system.

**Staff Safety & Workplace Violence**

The Central West CCAC, Headwaters and Osler are committed to providing safe, inclusive workplaces free of workplace violence and harassment. We work to ensure that all staff and physicians are familiar with and understand their roles and responsibilities in contributing to a safe, positive work environment.

To support this we:
- Assessed each organization for workplace risks related to workplace violence and harassment.
- Ensured all policies reflect relevant health and safety legislation and are aligned with best-in-class practices.
- Developed action plans to close gaps and eliminate or minimize workplace risks.
- Formed a joint working group to review staff engagement survey results.
- Hosted a joint Workplace Investigation Techniques and Report Writing Workshop.
- Are rolling out standardized Management of Aggressive Behaviour (MOAB) training for staff in ED, Security and Mental Health and Addictions at Osler and Headwaters.

From an occupational health and safety perspective we have:
- Used technology to track and monitor occupational health and safety issues (e.g., injuries, immunization and medical information, mask fit testing) to help improve staff safety across our three organizations.
- Jointly leveraged a Canadian Board Certified occupational health physician to support safe and timely employee recovery and return to work planning.

**Performance Based Compensation**

It is mandatory under the Excellent Care for All Act (ECFAA) to link compensation for the Chief Executive Officers (CEOs) and other executives reporting to the CEOs to the achievement of performance targets in our individual organizations’ Quality Improvement Plans (QIPs). The purpose of performance-based compensation is to:
- Drive performance and quality of care
- Establish clear performance expectations and expected outcomes
- Ensure consistency in the application of the performance incentive, accountability and transparency
- Enable teamwork and a shared purpose.

Performance-based executive compensation is linked to achieving the specific QIP targets, as well as achieving other individual performance targets. The amount of compensation that is performance-based for each executive team is determined as a percentage of that member’s base salary.
Headwaters’ Executive Team Composition and Portion of Compensation Linked to Performance

The performance-based percentages for the 2017-18 fiscal year are:

- President & Chief Executive Officer: 3.6%
- Chief of Staff & VP Medical Affairs: 1.42%
- VP Patient Services and Chief Nursing Executive: 1.79%
- VP Corporate Services: 1.79%

To be eligible to receive the Performance-Based Compensation, the Executive Team Member (Member) is required to have been in the Executive Position for a minimum of 4 months. If the Member joins or leaves the organization mid-year, his or her Performance-Based Compensation will be pro-rated based on the portion of the year in the Executive Position.

Headwaters’ Application of Improvement Targets to Individual Executives

To enhance our accountability and ability to achieve success, the targets identified in the 2017/18 QIP form the basis for several performance goals for the leadership team, staff and physicians. Each Member listed above will have his or her Performance-Based Compensation tied to the achievement of three key targets in the board approved 2017/18 QIP. Specifically, Performance-Based Compensation will be based on achievement of the following indicators:

- Emergency Department satisfaction - Would you recommend this ED to your friends and family? (top box)
- Inpatient satisfaction - Would you recommend this hospital to your friends and family? (top box)
- Emergency Department length of stay - Emergency Department Wait Times for Complex patients (CTAS 1-3)

Sign-off

I have reviewed and approved Headwaters Health Care Centre’s Quality Improvement Plan.

[Signatures]

Louise Kindree
Board Chair

Saagi Kang-Gill
Quality Committee Chair

Stacey Daub
President and Chief Executive Officer