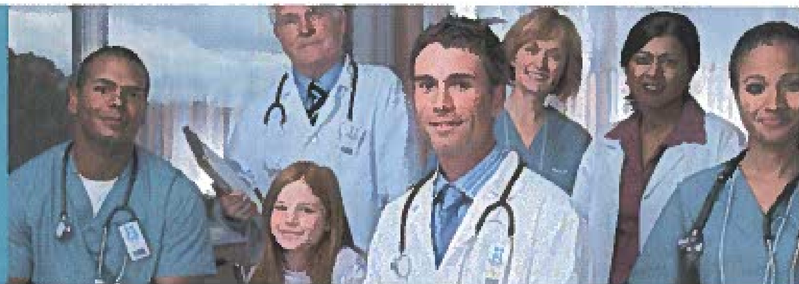
Let's Make Healthy Change Happen.



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

ST. JOSEPH'S CARE GROUP

03/19/2019

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

St. Joseph's Care Group (SJCG) combines tradition and innovation in responding to the unmet needs of the people of Northwestern Ontario since 1884. We are here for our clients, offering a broad range of programs and services in Addictions & Mental Health, Rehabilitative Care, and Seniors' Health across multiple sites in the City of Thunder Bay.

The past few years have been one of our largest periods of growth since the Sisters of St. Joseph of Sault Ste. Marie first opened St. Joseph's Hospital in 1884. Our construction projects are certainly the most visible of our changes with the recent completion of our new Mental Health Rehabilitation East Wing at St. Joseph's Hospital (2018).

More importantly we are evolving our models of client-centred care. We are continuing to advance a self-management approach to care, and we are involving our clients more closely in their own care decisions to achieve the health outcomes that are important to them. To bring care closer to the people we serve, we are using technology to help overcome challenges with accessing healthcare services due to our vast service area.

SJCG is pleased to submit one Quality Improvement Plan (QIP) for 2019-2020 for St. Joseph's Hospital and our two long-term care homes: Bethammi Nursing Home and Hogarth Riverview Manor.

The priorities in this integrated quality improvement plan (QIP) align with our strategic directions: *Here for Our Clients*, *Here for Our Partners*, *Here for Our People* and *Here for Our Future* through a lens of quality, safety and risk.

Our QIP also aligns with provincial priorities and planning processes related to Service Accountability Agreements (SAA) Planning, Health System Funding Reform (HSFR) and Accreditation Canada Required Organizational Practices (ROPs).

For 2019-2020 we will be focused on the following improvement themes. Planned improvement initiatives are outlined in the detailed 2019-20 QIP work plans for St. Joseph's Hospital, Bethammi Nursing Home and Hogarth Riverview Manor.

1) Timely and Effective Transitions

- Reducing alternate level of care days in hospital (time clients spend waiting in hospital for another level of care such as long-term care or supportive housing)
- Reducing wait time in acute care for a rehabilitation care bed
- Reducing potentially avoidable emergency department visits from long-term care

2) Service Excellence

- Improving daily communication with our clients and residents

3) Safe and Effective Care

- Prevention of workplace violence to increase safety for our clients and staff
- Improving medication reconciliation on discharge from hospital
- Reducing antipsychotic drug and restraint use in long-term care
- Improve pressure ulcer prevention in long-term care

Describe your organization's greatest QI achievement from the past year

The following outlines St. Joseph's Care Group's greatest quality improvement achievements within each clinical service area: 1) Addictions & Mental Health 2) Rehabilitative Care and 3)Seniors' Health.

1) Providing a Continuum of Care in Addictions & Mental Health

Over the past year, St. Joseph's Care Group has realized a vision set in motion decades ago. Advances in psychiatric medicine and treatment saw the end of the institutional model, changing the environment from one of custodial care to rehabilitative care. It was a significant change not just in terms of treatment model, but also in public perceptions and beliefs about mental illness and the capabilities of people living with mental illness. For rehabilitation to be successful, there has to be a spectrum of services in place to help people live well in the community. For many years, St. Joseph's Care Group has been developing new services, expanding existing services, and cultivating key partnerships to meet the needs of clients and to identify and remove barriers to accessing care. The continuum of mental health care reached its symbolic culmination with the closure of the Lakehead Psychiatric Hospital, and the opening of the new inpatient Mental Health Rehabilitation wing of St. Joseph's Hospital.

Inpatient Mental Health Rehabilitation

The opening of the expansion to St. Joseph's Hospital in the summer of 2018 marks a new era in psychiatric care. Known as the East Wing, it is home to the Mental Health Rehabilitation program, providing 38 longer-term inpatient rehabilitation beds for people living with a severe, persistent, chronic and/or relapsing mental illness, along with other co-existing issues.

Utilizing a psychosocial model of rehabilitation, clients will learn to manage and live with mental illness in a purpose-built environment that promotes dignity, and respects cultures, traditions and beliefs. With our support, clients lead their own care journey and identify their own personal wellness goals.

St. Joseph's Hospital is truly a rehabilitative care hospital: clients coming through the front door will turn left for physical rehabilitation, and right for mental health rehabilitation. A testament to the need and to the success of the unit, at the time that this plan is being developed, two more mental health rehabilitation beds are being added to the East Wing.

Supports in the Community

St. Joseph's Health Centre (the Health Centre) opened in 2007 to provide outpatient programs previously located at the Lakehead Psychiatric Hospital, as well as additional services. The Health Centre is a far cry from the stigma of past visits to a psychiatric institution. Located inside a shopping centre, it is on a bus route, easily accessible, and part of a vibrant community where clients can shop, bank and access social services.

In 2018, the Health Centre was expanded. Known as Health Centre South, the expansion is home to additional programs including employment services and peer counseling that support people living with addictions and mental illness who live in the community. Also located at this site is the Getting Appropriate Personal and Professional Support (GAPPS) program which, in partnership with the NorWest Community Health Centres and Canadian Mental Health Association Thunder Bay, provides street outreach services, meeting people where they are at and connecting them with the right medical and social supports.

Housing

For people living with addictions and/or mental illness, housing can be both difficult to attain and sustain. In the fall 2018, Amethyst House opened its doors, providing 12 units of high-support housing. This represented an increase of 6 high-support housing units, and allowed SJCG to close an existing home that was not meeting the needs of clients living with severe and/or persistent mental illness.

SJCG has recently purchased another property that would allow for 30 units of transitional housing for people living with addictions and/or mental illness who are trying to make positive change. For SJCG's Balmoral Withdrawal Management Centre, it would provide clients who have completed withdrawal transitional housing with appropriate supports.

Increasing Access to Care and Increasing Capacity

Primary care providers want to help people stay in or as close to their home as possible, but sometimes the specialized supports needed are not immediately available. Project ECHO (Extension for Community Healthcare Outcomes) focuses on moving knowledge, not people. The heart of the *ECHO model™* is its hub-and-spoke knowledge-sharing networks, led by expert interprofessional teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care providers learn to provide excellent specialty care to patients in their own communities.

Primary care providers receive the professional supports needed in caring for people with complex needs. Northwestern Ontario is a vast region. Imagine the difference this makes to a client in Red Lake, who would have to drive for 7 hours each way to see a specialist in Thunder Bay. Currently focusing on Chronic Pain, Project ECHO will be expanded to offer supports in other specialized clinical service areas.

Expanding Care through Partnerships- Rapid Access to Addiction Medicine

In response to the growing demand for timely access to addiction medicine that supports the whole person, five community partners St Joseph's Care Group, NorWest Community Health Centres, Thunder Bay Counselling, Dilico Anishinabek Family Care, and People Advocating for Change Through Empowerment collaborated to develop and implement a Rapid Access Addiction Medicine (RAAM) clinic in early 2018. The primary goal of the RAAM Clinic is to offer specialized primary care for individuals living with complex health issues that include substance use and mental health concerns. Thunder Bay Regional Health Sciences Centre, Alpha Court Addiction and Mental Health Services and the Thunder Bay Drug Strategy supported this initiative through in kind contributions.

Rapid Access Addiction Medicine (RAAM) clinics provide broad spectrum addiction care and have been shown to improve access to addiction services, divert individuals away from the Emergency Department, and serve as a referral source for primary care providers who have individuals that may be struggling with opiate dependency, poly-substance use and complex mental health and medical issues.

The Thunder Bay RAAM Clinic provides evidence-based treatment delivered within a trauma informed and harm reduction framework that is responsive to client-centred goals. The clinic establishes a care plan designed to meet the health care goals of the individual while also ensuring access to the appropriate level of treatment that is informed by assessed level of need. The goals of the RAAM clinics are to provide timely access to specialized supports, support and stabilize medical conditions and facilitate access to a broad range of services and supports that address their personal goals.

The services are low barrier and open to any individual interested in accessing support, including people who are currently using opiate replacement therapy. Treatment is person-centred, based on each individual's identified needs and includes an outreach component to effectively engage with vulnerable individuals in our community.

Since the opening in March of 2018, the RAAM Clinic has served over 1,095 distinct individuals, resulting in over 2,515 appointments. The RAAM team is closing a significant gap in service between acute care services, primary care and the community addiction and mental health service system. Offering these services at two locations, the RAAM clinics are currently operating at NorWest Community Health Centres at their Simpson Street location and at St Joseph's Care Group, Balmoral Withdrawal Management Centre.

2) Rehabilitative Care

St. Joseph's Hospital is a site of the St. Joseph's Care Group (SJCG) Corporation, providing rehabilitative care and services to the people of Northwestern Ontario. The rehabilitative services in-patient care is organized into care streams including medically complex care, geriatric assessment and rehabilitative care, palliative care and transitions and general and physical rehabilitative care. The out-patient services provided include specialized geriatric services, wound care, diabetes health, respiratory, general and physical rehabilitative care. Our teams work in close collaboration with Thunder Bay Regional Health Sciences Centre (TBRHSC), the community, and regional partners, to develop system-wide responses to the continued overcapacity challenges and Alternate Level of Care (ALC) pressures across the health care continuum.

To enhance efforts to reach the frail seniors population presenting to the emergency room, St. Joseph's Hospital partnered with TBRHSC to develop an enhanced seniors' pathway that aims to improve access to out-patient specialized geriatric services directly and avoid acute care admissions. The collaboration developed relationships, resources, standardized screening assessments, documentation and referral patterns. The uptake is progressing slowly since the November 2018 implementation and we continue to work toward meeting the referral targets and breaking down barriers to client access to specialized geriatric services.

To respond to overcapacity and ALC pressures across the continuum, the expansion to 20 from 7 Assessment Beds was developed and implemented in December, 2018. The Assessment Beds aimed to improve patient flow and wait times, client experience through provision of care in the most appropriate setting and mitigation of some of the persistent overcapacity challenges that TBRHSC anticipated for the fall. Clients deemed 'non-acute' move from TBRHSC to the Assessment Beds at St. Joseph's Hospital. The most appropriate course of post-acute care and treatment is determined by the rehabilitative team. Ideally, clients selected are those at risk for functional decline and deconditioning, and who will benefit the most from rehabilitative care. Expert case management and discharge planning from the interprofessional care team at St. Joseph's Hospital assist in increasing flow at TBRHSC and St. Joseph's Hospital. The 'assessment bed' initiative showed an increase in throughput for the same 6 week period in 2017-18 by 71 % in 2018-19. We will continue to focus on further quality improvements related to wait times and client experience in 2019-2020.

3) Seniors' Health

The Seniors' Health Service area is comprised of two long-term care homes, Bethammi Nursing Home and Hogarth Riverview Manor, each with adjacent apartments for seniors who can live independently with our without support. Within Hogarth Riverview Manor, the service area operates a 32-bed specialized behavioural support unit and behavioural supports out-reach team for the Northwest region.

The most significant quality improvement initiatives in 2018-19 were focused in both long term care homes. Hogarth Riverview Manor, a 544-bed home and Bethammi Nursing Home, a 112-bed home, both focused their efforts on three areas: (1) establishing strong and stable management teams, (2) recruitment and retention of registered and personal care staff and (3) implementation of policies and procedures in programs such as: zero-tolerance for abuse and neglect, medication management, falls prevention and management, skin and wound care, continence care and pain management. Through new and expanded initiatives funded through the Ministry of Health and Long Term Care and with support of the North West Local Health Integration Network, the homes continued to develop their capacity in the management of responsive behaviours and in nursing and personal care. The quality improvement achieved through these focused efforts and the added capacity have set the foundation for continuous improvement in the quality indicators included in the 2019-20 QIP.

Client and Family Partnering and Relations

SJCG is committed to working with clients and families on initiatives that enhance the quality and safety of care and service. Client and family input guides the development and implementation of quality improvement initiatives.

In 2018, client & family volunteers assisted in administering a client survey to measure the therapeutic relationship between nursing and clients within hospital inpatient unit. The trained volunteers collected the survey information using iPads at the bedside. The survey data collected is helping to inform initiatives to improve client experience.

The Client-Centred Model of Care has been well integrated into the planning and delivery of projects and services at all levels within SJCG. In 2018, there were more than a dozen separate operational working groups and 52 Client & Family Partners who provided input in a "formal" way. The Accessibility Steering Committee designed and delivered an in-person and electronic survey focusing on the level of accessibility for SJCG's sites, publications, and services. The outcome of the survey was to both inform SJCG's next 5 year Accessibility Plan, and to assess perception of progress on SJCG's existing Accessibility Plan.

With the development of a training program for volunteers, SJCG incorporated Client & Family Partners on management interview panels including two new Vice Presidents.

Workplace Violence Prevention

Workplace violence prevention is a strategic priority for SJCG. SJCG Strategic Direction, "Here for Our People" includes actions to provide tools, skills and support to keep staff and volunteers safe and well.

SJCG recognizes the impact of workplace violence and harassment on staff and clients, as well as the challenges of managing violence safely in a complex health care environment. SJCG has an established Prevention of Workplace Violence and Harassment program.

Incidents of workplace violence are tracked, investigated and reported to the Board through a quarterly Quality, Safety, and Risk Report. Proactive workplace violence risk assessments are ongoing.

Executive Compensation

Our executive team's compensation includes 3% at risk based on the following indicators approved by the Board of Directors. These indicators have been chosen to reflect the highest improvement priorities.

Indicator	Percentage of Pay at Risk
"How often did staff listen carefully to you?" Increase Always response (Outcome Measure)	1%
Medication Reconciliation on Discharge – 85% (Outcome Measure)	1%
Workplace Violence Prevention– Percentage of code white evaluations completed – 85% (Process Measure)	1%

The performance indicators tied to the executive team's compensation will be directly linked to outcomes that are within the executive team's control or influence. The three indicators will be team-based, and not individually measured at this time.

Upon annual review (March 31, 2020), the Board and the President/CEO will determine whether the goal has been met, and whether the full 3% of at risk salary (or a portion thereof) will be paid out to each member of the executive team (including the Chief of Staff). The Board solely determines the compensation for the President & CEO.

Members of the executive team included in the at-risk compensation plan are:

President & CEO
Chief of Staff
Vice President, Rehabilitative Care
Vice President, Addictions and Mental Health
Vice President, Seniors' Health
Vice President, People, Mission and Values
Vice President, Infrastructure and Planning and Chief Financial Officer

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan:

Board Chair:	Maureen Brophy	[signature]
Quality Committee Chair:	Naomi Abotossaway	[signature]
Chief of Staff:	Dr. G. Davis	[signature]
President & CEO:	Tracy Buckler	[signature]