Let's Make Healthy Change Happen.

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

espanola
regional hospital and health centre
hôpital régional et centre de santé
d'espanola

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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

The Espanola Regional Hospital and Health Centre (ERHHC)is a leading example of integrated care and programs. Our health campus offers a variety of health care services and patient initiatives to promote the health and well-being of our community across the continuum of care. Our services include an 11 bed Emergency Department, 15 bed Medical Unit with Hospice Suite, Family Health Team (FHT), Long-term Care Home, Assisted Living Units and Seniors Apartments, Visiting Specialist Clinics, Sleep Lab with Pulmonary Function Testing, In/Out-patient Physiotherapy, In/Out-patient Lab Services, Diagnostic Imaging to include cardiac testing (ECHO, Holter and Stress Testing) and Vascular Studies.

The Rural Health Hub project, although in its infancy has further promoted relationships and opportunities to improve access to care and programing within our community. New partners have joined our Community Health Network Committee and dialogue with all partners across the acute, primary and community sectors has been exceptional. Conversations and approaches to ways we can collectively improve access and equity of care have brought forward ideas and initiatives to assist us all in tackling challenges and barriers to care. The past year has brought many great initiatives to fruition and these opportunities were possible due to the dedication and engagement of providers. The success of bridging gaps in health care services and our ability to provide seamless and comprehensive patient care relies heavily on the engagement and participation of all providers within our community. The Espanola and Area FHT is the central meeting ground where providers from all sectors meet to review, discuss, plan and evaluate quality of patient experience and access to care. Our community is extremely fortunate for the inclusion and participation of these community agencies, as improved access has resulted in the enhancement or development of programs and services that address the needs of the patient throughout the continuum of care.

ERHHC continues to pursue excellence in patient/ resident care and incorporate our "Patients First" philosophy in all aspects of patient care. Quality improvement initiatives, patient engagement strategies, cultural sensitivity training, integration of technology and staff education have been key objectives of our QIP in order to develop a strong cohesive team to deliver programs and services. We have accomplished much in a quickly changing environment and continually strive to improve our services and provide patients with the care they require, when and where they need it.

QI Achievements From the Past Year

The Espanola Regional Hospital, Espanola Nursing Home and Espanola & Area Family Health Team have an integrated Quality Improvement Plan (QIP) which highlights the collaboration and integration of programs and services that streamline and enhance the patient/resident care experience. Our Quality Improvement Plan achievements and outcomes illustrate how we have worked towards meeting key objectives relevant to our patients needs and strategic goals of our organization. Investments to improve access to care are aligned with our strategic priorities and the Excellent Care for All Act. Providing patients with access to the right care, in the right place, at the right time, is our driving priority.

The patient/resident voice has been instrumental in helping guide us to improve care delivery and implement new programs. Through patient and family feedback we have identified opportunities to create programs, revise processes and reach out to community providers to lessen gaps between acute, primary care and community services in order to ensure more positive patient outcomes. We have bolstered our patient/ resident surveys to include questions that quantify their health care experience and those results are key drivers for care delivery improvements. A hospital Patient Advisory Committee is being introduced to our community and our patient relations process has been restructured to provide a safe forum for patients, residents and families to provide feedback and become part of positive change. Staff engagement and networking opportunities across the sectors have strengthened our ability to collaborate and integrate services by allowing providers to share information, resources and best practices.

Collaboration between the Acute, LTC and Primary Care teams within our QIP has made it possible to streamline workflow, integrate processes across the sectors and assist patients to better navigate transition points in care. Staff education and engagement have been instrumental in implementing our quality improvement methods and measuring patient outcomes. Key initiatives have improved care for the at risk elderly, those with mental illness and addictions, those needing palliative and end-of-life support, the geriatric population requiring behavioural support, cardiac health and chronic disease management.

Engagement and patient care planning with community providers such as CCAC, HSN Community Mental Health, Behavioural Support Ontario, Sagamok Anishnawbek, Mamaweswen North Shore Tribal Council, Public Health Unit, Espanola Child and Family Centre, Espanola EMS, Espanola Regional Police and OPP, have offered many opportunities to enhance coordination of services and improve patient access to quality care.

Patient and resident satisfaction for acute, primary care and LTC services are extremely positive. Frontline staff in all areas are educated on the QIP and how the work they do impacts our ability to provide quality care and reach our goals. It is the dedication and enthusiasm of the entire team that has allowed us to be so successful in our efforts, whether it is within the organization or includes our community partners. Key aspects of the Rural Health Hub Model are already anchored in the partnerships and efforts that ERHHC and community agencies have put forward. As we continue to strengthen those relationships and break down barriers to care, patients of our community will undoubtedly see seamless care and access to services regardless of where they enter the health care system.

Population Health

ERHHC serves a population of about 13,500 within a catchment area that include the Town of Espanola and Townships of Nairn & Hyman, Sables-Spanish Rivers, Baldwin, Sagamok Anishnawbek and Whitefish River Frist Nations . Like many northern communities, our catchment area is aging rapidly. One in five of our residents is now over the age of 65 and this proportion of seniors is expected to grow significantly.

In terms of the health status of our catchment population, compared to the provincial average, we have:

* a higher population of seniors and aboriginals,
* higher rates of unemployment, smoking, obesity and binge drinking
* lower levels of education and income
* higher rate of single parent families
* higher death rates due to injuries, poisonings and suicide

* higher rate of teenage pregnancy and lower birth weight
* higher morbidity and mortality (with reduced years of life from various cancers, respiratory illnesses, cardiovascular disease, accidents and suicides).

These health status factors lead to higher rates of Emergency Department use and higher acuity patients in our ED. The hospital's 24 hour Emergency Department has a volume of approximately 13,000 visits each year which is considered high for a rural area.

Equity

Equity of care is essential to positive health outcomes of all members of our community. Lack of equity in care can lead to health disparities that affect mortality, increase the rate of chronic disease, mental health issues, substance abuse and result in poor health outcomes. With equity being a new indicator it has offered us the opportunity to take a more in-depth look at how we see inequity in local care provision and work with providers to incite change and improve access. Our goal is to look at equity of care in current practices and with any new change ideas to ensure we are meeting the needs of all patients in our community.

As a first step, Cultural Competency training was assigned to all staff through our Learning Management System. We met our target for this indicator by achieving 85 % completion. This training highlighted that differences in health status and access to care can occur in populations defined by specific characteristics such as, socio-economic status, race, ethnicity, gender and geographic location. Our staff's role in ensuring equity of care and providing an environment where trust and open communication can occur to improve patient-provider relationship was a key aspect of this training. Four members of the Management Team have also participated in indigenous cultural safety training provided through the NELHIN.

Our organization has been working with the Sagamok Anishnawbek Community over this past year to enhance services and patient experience when accessing care at ERHHC. Access to hospital and primary care services, building a relationship of trust, fostering traditional practices into hospital services, and cultural education were key priorities and components of community conversations held in Sagamok Anishnawbek. From those conversations, the ERHHC management team took part in a 2 day cultural sensitivity training session with members of the Sagamok Wellness Unit and Community Elders. Sagamok Anishnawbek and ERHHC have worked together with a facilitator to develop a Collaborative Protocol. The purpose of this protocol is to outline how ERHHC and the Sagamok Anishnawbek Community Wellness Department can work in partnership to ensure that Sagamok community members receive a positive and quality care experience when accessing hospital and primary care services. A joint working group has been established with the shared responsibility of addressing these key priorities and implementing solutions that are grounded in trust, mutual respect and cooperation.

ERHHC is an active member of the Espanola Health and Community Services Planning Network, as well as the Mental Health Sub-Committee of the Planning Network. The committee looks at initiatives with our community partners to ensure equity of service to all populations. Equity of access to quality health care in the acute, primary, and community sectors is a fundamental priority of this working group.

Integration and Continuity of Care

The Quality Improvement Plan Committee has invested much time and effort into care integration strategies between health care providers of the ERHHC health campus to enhance services and programs affecting health promotion and prevention. Community providers have also been engaged during this process when initiatives are linked to transitions of care in the community sector. The collective work of providers across the care continuum has been instrumental in streamlining workflow processes and initiatives between the acute care, long-term care, primary care and the community sector. Opportunities for the hospital to collaborate on initiatives with Long-term care and the Family Health Team have linked providers to offer improved care options and deliver more comprehensive programs. These opportunities have allowed members of different teams to come together and share their experience and expertise in programming and service delivery. The process of joining forces, breaking down silos and removing barriers to access has been not only rewarding from the patient service delivery perspective, but also from the provider perspective. Initiatives have offered an opportunity for relationship building, as well as dialogue that has led to a greater understanding of the service providers themselves, their mandates for patient care and their challenges with care delivery. Working together on initiatives has incited unique opportunities for sharing human resources, improving the flow of patient information, and educating providers on where resources are within the health care system. This has further resulted in patient care initiatives that have had positive impacts on our patients' health and well-being. Continuity of patient care at transition points and hand-off between providers have been a key area of focus for the ERHHC team. Those initiatives having the biggest impact on our patient population have addressed issues regarding mental health, palliative care, chronic disease management and the frail elderly population. As we look to improve continuity of care and work to remove barriers when accessing care, we are truly demonstrating the objective of a rural health hub model.

ERHHC and the Espanola Health and Community Services Planning Network have made great strides in terms of collaborative initiatives that have resulted in improved access to patient care services. This group is an example of unlimited opportunities to collaborate on many fronts to improve and enhance patient care. Discussions have included EMS out-reach programs, situation tables for at risk members of the community, presentations by 211, March of Dimes, Public Health, identification of service gaps and each provider's role in ensuring access to quality care. This health provider network has branched off into sub-committees that address care gaps in mental health and addictions, as well as access to palliative care services. This committee has also been a great source of provider education on the mandates and services that our community partners have to offer.

ERHHC and the Family Health Team are working closely with Mental Health and Addictions, Family and Child Services providers, DSSAB, EMS, Espanola High School, Public Health Unit and both Regional and Provincial Police departments to develop strategies and options for patients presenting with mental health concerns regardless of their age and where they enter the system. These key players continue to work on strategies to provide vulnerable patients access to mental health services. The central intake form developed to stream patients from the primary care and acute care sector has worked well in ensuring access to timely intake. With the inclusion of the police at this table and their exposure to the vulnerable populations, direct referrals to mental health services are occurring when suitable. The Family Health Team along with Child and Family services and Public Health are working with the area schools to provide programs and education on coping strategies at the primary and secondary school level, as many children are facing stressors that impact their mental health. Opportunities to make a difference in the mental health and well-being of all age groups have been a focal point of this working group.

Espanola Regional Hospital is working with Health Sciences North Mental Health program providers to look at ways to support patients awaiting psychiatry beds. Challenges with bed availability have led to delays in access to psychiatric assessments and mental health services. These delays in access have initiated conversations to improve and lessen that gap, as well as explore opportunities for psychiatry assessment via OTN. Access to mental health services while awaiting transfer and possible integration of mental health providers at the hospital and primary care level are also potential opportunities. Small communities must look at options for collaboration and integration of services that allow providers to straddle acute, primary and community care, in order to create a system that supports the patient and advocates for their care. Building capacity and aligning care across the sectors to support and manage mental health needs close to home, will have a positive impact on equity of mental health services in our small rural community. The MOHLTC Rural Health Hub pilot project and Health Link initiatives are key supports for our community to enhance patient access to service and create a strong supportive health network for all levels of care.

ERHHC is working closely with our Aboriginal partners at the Sagamok Wellness Unit to improve access to care and services in the acute and primary care sectors. Health disparities and barriers to care have been identified and ERHHC is working closely with Sagamok Anishnawbek First to improve access and patient experience. This partnership has provided an opportunity for service providers of both health agencies to have a better understanding of roles and accountability within the system and opportunities for collaboration. Clinical Managers from the Sagamok Wellness Unit, Espanola Regional Hospital and Espanola Family Health Team have started a working group that is focusing on priorities outlined within the protocol in order to improve relationships and service provision to our Aboriginal patients. Opportunities for bringing traditional healing practices into the hospital, communication strategies to improve the patient/ caregiver relationship, educational opportunities for frontline staff in regards to cultural competence and safety, are shared goals of this working group. Mamaweswen North Shore Tribal Council Health Community Supports Services Manager and Aboriginal Navigator are guests on this working group as they have a key role in providing in-home supportive services on the Sagamok Reserve. It is anticipated that this partnership will improve access to acute and primary health care services and positively impact the overall health status of the Sagamok Anishnawbek community.

Investments and improvements to our palliative care initiatives have been the direct result of collaboration with the NELHIN, Espanola Family Health Team, CCAC, Mamaweswen North Shore Tribal Council, and ERHHC Hospital Auxiliary. With new NELHIN funding the Hospital has created a one bed hospice suite and space for patients and their family. Nursing staff and physicians have attended palliative care training and the hospital has teamed with the Family Health Team to create a program that supports patients to the end of their health journey. The FHT RN and NP are both trained to provide in-home assessments and accept referrals from CCAC and primary care providers. They collaborate with CCAC to ensure patients are supported in the home while they await placement. We have set up joint palliative care rounds to ensure providers are aware of community patient needs and assist them to transition to the Hospice. The Acute Care Manager at ERHHC works closely with the FHT team to manage the waitlist. The provision of palliative care is based on the physical, mental and spiritual needs of the patients and their family. All members of the team work towards providing a positive end of life experience and supports to the patients and their families throughout their journey. The ERHHC social worker and FHT RN have teamed up on two initiatives that have enhanced the quality of life for both patients and care givers. The development a Palliative Care Resource Guide for families has provided them with valuable information as

they care for their loved one at home and prepare for the end of life. Information is provided regarding caring for their loved one's physical, emotional and spiritual needs, resources for equipment, financial assistance, funeral planning and space for daily journaling to monitor their loved one's pain and medications. A Grief Support Group has been created to assist families and caregivers cope with the loss of their loved one. These two initiatives address transition points in care where patients, families and caregivers can be very overwhelmed. The information and education provided eases fears and allows them to feel empowered to navigate this difficult journey. Our First Nations partners are utilizing the Palliative Care Resource Guide in their palliative care model and members of their community are able to participate in the grief support group offered out of the FHT.

Lastly, we have a spent a good portion of the year creating a Cardiac Care/Rehab program with collaborators being the visiting cardiologist, the cardio-diagnostic department, the FHT RN, physiotherapy department, FHT dietician. Referral comes from the HSN cardiac rehab program, primary care providers, ERHHC emergency department and in-patient referrals. The premise of this program is to capture patients at any point in their care where a cardiac diagnosis has been made or they have been identified as having cardiac risk factors. The FHT RN has become the primary nurse working with the cardiologist to screen, manage, and ensure appropriate testing is scheduled to achieve positive health outcomes. This model facilitates care for those patients and ensures they are receiving comprehensive testing, education, treatments and therapies to maintain good cardiac health. Programming is offered at the FHT (heart health, smoking cessation, blood pressure management, healthy eating, stress management) and physiotherapy and cardiac testing/monitoring are done through the hospital. We are in the beginning stages of developing the same type of out-patient program for our respiratory/COPD patients. Initiatives such as these, and partnerships between organizations and providers, help to reduce readmission rates, ensure appropriate follow-up care on discharge, and highlight health prevention and promotion. Educating and informing patients of the opportunity to take an active role in leading healthier lives is key to changing health outcomes and strain on the health care system.

Integration and collaboration amongst providers is instrumental to the success of organizational goals and our mandate to provide quality service. Initiatives that link primary, acute, long-term and community care in supporting patient well-being are highly utilized by physicians and health care providers in our community. Their engagement and perspective is sought after as we continually look for further opportunities to improve access to care. The Espanola Hospital, Long-term Care Unit and Family Health Team are extremely committed to working together to provide the highest standard of care to patients and residents of all ages.

Access to the Right Level of Care - Addressing ALC Issues

Alternate Level of Care challenges are evident in both large and rural centers. ERHHC is not immune to those challenges and puts every effort forward to move patients to the most appropriate discharge destination. Alignment with the NELHIN Patient Flow Strategy for Improving Care Coordination and Alternate Level of Care (ALC) Performance is important as ERHHC looks at strategies to improve ALC rates. Initiatives to identify "at risk" elderly patients early in their presentation to the health care system is an opportunity for change. Improvements to appropriately identifying individuals who require supports to maintain their quality of life in the community and collaboration with CCAC, VON, Mamaweswen North Shore Tribal Council and Behavioural Support Ontario have resulted in opportunities to enhance

patient experience. Accessing all the available resources and services in coordination with community providers has facilitated opportunities to maintain seniors' independence and quality of life. This approach is fundamental to enhancing patient experience and optimizing resources for those awaiting long-term care placement.

In order to mitigate ALC presentations, we will begin utilizing a Triage Risk Screening Tool in the Emergency Department for those aged 70 years or older in order to identify the at risk seniors population. This tool will assess cognitive impairment, difficulty ambulating or recent falls, emergency department use in previous 30 days, or hospitalization in previous 90 days, those patients living alone with or without a caregiver. In addition, if emergency department nursing staff have concerns regarding patient weight loss, failure to cope, incontinence, medication issues, depression /low mood or sensory deficits that are impacting the patient's ability to care for themselves, these issues will be flagged. Patients being identified with 2 or more risk factors will be referred to the social worker and follow-up will occur immediately or within 2 business days depending on the assessment of risk. It is expected that this strategy will identify needs early in decline and allow seniors to maintain quality of life in their own home with community supports. Coordinated and concerted efforts between the hospital and community partners to implement strategies will assist in strengthening partnerships and commitment to the management of ALC challenges.

Engagement of Clinicians, Leadership & Staff

Engagement of Clinicians, Leadership and Staff in the development, implementation and evaluation of the Quality Improvement Plan across all levels of the organization was a goal we set last year. Effective June 2016 our Continuous Quality Improvement (CQI) Manager developed a joint QIP Committee where managers from the Acute Care, Long-term Care and Primary Care (FHT) sector came together along with 2 members of their front-line staff to work on the organizational QIP. The involvement of front-line staff in the creation and implementation of initiatives has resulted in greater up-take of process measures and methods, engagement of staff in organizational quality improvement initiatives, as well as front-line solution based thinking. QIP targets are also discussed at staff meetings and with key clinicians who are involved in the direction of care. The inclusion of front-line staff has positively impacted the implementation and effectiveness of work plans, as well as patient and resident safety. There is a greater understanding of the organizations' quality targets, why performance is being measured, and how collaboration across transitions must occur for better continuity of care. The engagement of front-line providers in our QIP planning activities has played an essential role in implementing strategies that have enhanced patient experience, allowed us greater opportunity to hear the patient voice, and to reach our targets in providing high quality care.

At the Quality Assurance and Patient Safety (QAPS) Committee level, the addition of a Family Health Team board member has resulted in board level representation for each of the three health care sectors. The CQI Manger has also aligned our QAPS Dashboard to include the indicators on our QIP. The QIP priority indicators and progress of our process measures and methods are tracked and reported monthly at the QAPS meetings. Our QIP is closely monitored by the QAPS committee members and leaders within our organization to ensure the mandate set out in the QIP is monitored, managed and supported for success. We feel strongly that this inclusive environment will positively influence our ability to improve the quality of care and foster collaboration and team work at the organizational level which will inherently lead to the success of initiatives to improve patient outcomes.

Resident, Patient, Client Engagement

Our CQI Manager is leading several new initiatives to include the development of a Patient Advisory Council and has created a Patient Relations Brochure. Patients throughout the organization have access to written and visual material that highlights the importance of their voice in the care they receive. Patients, residents and caregivers are an essential part of quality improvement. Their insight, experiences and ideas for improvement have been key motivators to influence change in process and practice, as well as identify areas where efforts need to be focused in order to improve quality patient care. Patients are encouraged to provide feedback by way of surveys, the use of our "Happy or Not" survey tool, contacting the Patient Relations Officer or becoming a member of the Patient Advisory Committee. Feedback is sought on the care provided, their comfort while in our care, the level of respect and professionalism they experience from providers and the level of cleanliness of the facilities. Patient/family engagement opportunities are posted on our website and in our patient information booklets given out on admission. We also distribute an ERHHC newsletter to homes in the community bi-annually and distribute an ERHHC internal newsletter monthly to communicate initiatives and feedback to staff. Waiting areas throughout the hospital and FHT are fitted with information screens and these provide the patient with information and education to make them aware of ways they can provide feedback on the care they have received and be involved in change. Feedback is brought to the ERHHC team, as well as community agencies and collaborating partners. We are continually seeking opportunities for system improvements, streamlined services, and shared resources and programs for better patient outcomes and navigation through the system.

Long-term Care utilizes both Family and Resident Council as a forum for feedback and suggestions for all aspects of care and services in the LTC Home. Residents are surveyed annually and are involved in decision-making processes in regards to purchases that enhance the well-being and quality of life in their home.

It is our goal to integrate the perspective of patients, families and caregivers into solutions and processes that lead to improvements in patient experience and service provision. Inclusive and proactive approaches to care designed from patient/caregiver feedback are instrumental in putting the patient in the center of care. Improvement in coordination of care, integration of services and navigation through transition points will result in higher quality of care, improved efficiency, better use of resources and positive patient outcomes.

Staff Safety & Workplace Violence

Our CQI Manager is very involved in our emergency preparedness training program, our employee health and safety program and prevention of workplace violence. All employees are assigned emergency code procedures through our Learning Management System annually and mock codes are held routinely to ensure processes and responses from staff are appropriate. We have added a Code Silver (Threatening Weapon) in 2016 and have run two mock drills with our local police department. Being a small rural facility we have limited staff in the building on night shift and have installed panic buttons throughout the ED, Acute Medical Unit and LTC if immediate assistance from local police is required. Code White(aggressive patient)mock drills were done in the ED and LTC area to facilitate situational exposure and to evaluate staff response. Staff utilized their Non-Violent Crisis Intervention training and Gentle Persuasive Approach training throughout these scenarios. Workplace violence and harassment education is also provided annually and staff have mechanisms in place to seek assistance if they are having difficulties at work. The CQI manager also attends these meetings and provides

education on emergency preparedness activities and their role in understanding and responding to various codes. Managers are key members of the Emergency Preparedness Committee, Joint Health and Safety Committee and are able to provide employees direction when assistance through EAP as needed to ensure their health is priority of the Management Team.

Performance Based Compensation

Performance Improvement Targets drive accountability for the delivery of quality care and patient care services. Our executive compensation, including the percentage of salary at risk and QIP targets that the executive team is accountable for achieving is linked to performance in the following manner.

Senior Management Team:

Chief Executive Officer: 3% of annual base salary linked to achieving 100% of target
Chief Nursing Officer: 1% of annual base salary linked to achieving 100% of target
Chief Financial Officer: 1% of annual base salary linked to achieving 100% of target

Targets:

Quality Dimension	Indicator
Safety	Hand Hygiene Compliance: greater than 90%
Safety	Medication Reconciliation: greater than 91%
Patient-Centered	Patient Satisfaction: greater than 90%
Patient-Centered	Employee Satisfaction: less than 4 FTE vacancies for > 3 months

Terms:

1) The four indicators / outcome measures are equally weighted
2) Achievement of the target would result in 100% payout, partial achievement of targets will result in partial payout, as determined by the Board of Directors.

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Other

Espanola Regional Hospital and Health Centre, Espanola and Area Family Health Team and Espanola Nursing Home are continually seeking innovative and collaborative ways to streamline services, assist patients in navigating the health care system and providing smooth transitions of care. Integration and collaboration are key to the success of patient initiatives in our organization and in assisting patients to navigate a complex system. We continually look to find efficiencies, reduce redundancies, as well as costs and most of all to provide patients with a positive quality health care experience. Our integrated QIP highlights the commitment of all providers to collaborate on care strategies, share resources by developing initiatives to improve patient experience, population health outcomes and break down silos in care provision. We are collectively invested in the health of the community and pride ourselves on maintaining our vision of putting the "Patient First" in all we do.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

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

Board Chair Janet Whissell
Quality Committee Chair Dave Pope
Chief Executive Officer Nicloe Haley
Other leadership as appropriate Jane Battistelli