Let's Make Healthy Change Happen.

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

Bruyère

6/29/2020

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

Bruyère is a multi-site academic healthcare organization that is maximizing quality of life and helping people stay and return home. They deliver a wide variety of services in aging and rehabilitation, medically complex, palliative, residential, and primary care. Their research leads to constant innovation in the services they provide with a focus on providing care that promotes independence.

The two inpatient hospital campuses, with a total of 450 beds, offer specialized care and rehabilitation for geriatric, palliative, medically complex, and stroke patients. The Academic Family Health Team is affiliated with the University of Ottawa and provides comprehensive primary health care to 17,000 patients from the Ottawa area at two locations. The two long-term care homes, with 269 beds, offer residents a caring environment with innovative, evidence-based programming that provide a sense of place and enhances quality of life.

Our Vision: TOGETHER. Making each life better.

Priorities Identified for 2020-21 include:

Hospital:
•Patient experience: Would you recommend this hospital to family or friends if they needed this type of care?
•Documented assessment of needs for palliative care patients: Percent of physicians who have completed Serious Illness Conversation Training.
•Falls (per 1000 patient days).
•Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.

Family Health Team
•Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.
•Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment?
•Proportion of primary care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.
•Percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by any provider in the health care system within a 6-month reporting period.
•Percent of patients with social determinants of health (SDH) included in the EMR.

Long Term Care
•Percentage of LTC home residents who had a fall in the last 30 days recorded on their target Resident Assessment Instrument.
•Percentage of long-term care (LTC) home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment.
•Percentage of residents responding positively to: "Staff ask how to meet my needs."
•Documented assessment of needs for palliative care patients: Percentage of LTC physicians and identified staff who have completed the training/education on the use of the serious illness conversation guide

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

As a multi sector organization, we have chosen to highlight significant Quality Improvement achievements across our various programs.

In order to support learning, education and quality, Bruyère staff and physicians regularly attend the University of Ottawa Telfer School of Management Quality Improvement and Patient Safety Leadership program. This year, as part of the program, participants developed and implemented projects to enhance quality and/or patient safety.

1) Inpatient Stroke Rehabilitation: Stroke Rehab Intensity Matters:
We were able to increase the number of rehabilitation therapy hours for stroke patients through the use of a customized and flexible patient therapy schedule and now hold efficient team meetings to discuss challenges and solutions. This project resulted in better functional outcomes for patients (walking, dressing, speaking and thinking). It also allowed for better outcomes for Bruyère performance, such as improved rehabilitation efficiency, reduced length of stay and reduced costs.

2) Complex Continuing Care: Including The Patient and Family in Pressure Injury Prevention and Education:
A new education module was developed in collaboration with our patients and families and approved by the Patient and Family Advisory Committee (PFAC). The project demonstrated a number of positive outcomes related to pressure injuries including:

- A 35% increase in patients/families knowledge of what is a pressure injury
- A 55% increase in knowing how pressure injuries develop
- A 35% increase in the ability to identify pressure injury risk factors
- A 78% increase in education provided related to pressure injuries.

Long-term Care (LTC):

Bruyère's LTC homes participated in the Canadian Foundation for Healthcare Improvement Appropriate Usage of Antipsychotic (CHFI AUA). As part of the CFHI AUA Collaborative, at Saint-Louis Residence (SLR) we were able to decrease or eliminate our use of inappropriate anti psychotics by 66% in the cohort population (n= 17). Additional outcomes included a decrease in the use of other psychotropic drugs with no significant changes in behaviours, falls or restraint use. We have now created our own 'Process for Anti psychotic Reduction' to ensure ongoing improvements and sustainability at SLR and enabled us to spread this initiative to our smaller home, Résidence Élisabeth Bruyère.

Bruyère's Family Health Teams (FHT):

Mental health remains our top diagnosed chronic disease at 24% of our patient population. Our FHT has focused on a team based approach to mental health care delivery model to address the complex needs of our patients. We have expanded the use of our multi-disciplinary team which resulted in:

- 69 referrals to the kinesiologist for behavioural activation.
- 31 referrals to the dietitian for nutrition in treating mental health.
- Training of all reception staff on suicide protocol and de-escalation strategies.
- Further implementation of the stepped care approach to mental health services delivery including:
    - A targeted series of mental health training to all nurses (RNs).
    - We have trained four RNs in Cognitive Behavioural Therapy (CBT). An RN dyad delivers four week CBT education

sessions to referred and self-referred patients who are diagnosed with mild to moderate depression or anxiety.

Although this is in early stages, groups have served 14 patients with average 87.5% functional improvement

(WSAS score) and average 90% patient satisfaction scores.

This multi-pronged approach has had the following impacts: improved interdisciplinary collaboration, greater provider confidence in managing the complex needs of this population, and early improved patient experience and outcomes.

Collaboration and integration

Ottawa Health Team

Vision
People are healthy, well and supported to live in the community.

The Ottawa Health Team is comprised 11 convening partners which includes the Ottawa Community Health Centre (CHC) Collaborative (Carlington CHC, Centretown CHC, Pinecrest Queensway CHC, Sandy Hill CHC, Somerset West CHC and South East Ottawa CHC); Ottawa Inner City Health, Inc. (OICHI); Carefor Health & Community Services; The Ottawa Hospital (TOH); Ottawa Public Health (OPH); and Bruyère Continuing Care. In addition to the convening partners, there are 47 additional partners that cover the entire continuum of care. As part of the OHT, our shared mission is working to:

- ensure people have equitable access to high quality care and support when and where they need it
- ensure people have the best possible experience as they access and receive health care and supports
- improve the experience and work life of providers and staff striving to provide quality care and support
- establish the conditions that support health and create healthy communities

The Ottawa Health Team has identified potential quality indicators related to two identified priority populations for year 1:

- Adults with moderate to complex Mental Health and Addictions (MHA) not connected to primary care
  - Decrease avoidable hospital emergency department visits for people with MHA issues by providing timely access to primary care within a team-based care model that includes mental health and addictions services
  - Reduce the frequency of emergency department visits per year for people with mental health and addictions (i.e., 4 or more times per year)
- frail older adults (55+ years of age)
  - Reduce Alternative Level Care (ALC) rates
  - Reduce rate of hospitalization for ambulatory care sensitive conditions
  - Reduce avoidable emergency department visits (ED visit rate for conditions best managed elsewhere)
  - Decrease the number of patients receiving care in unconventional spaces or hallways.

Bruyère continues to work in collaboration / partnership with several organizations in order to improve patient flow and transitions of care (timely access):

- Partnering with TOH and the Champlain LHIN, to add 20 ALC beds at our two campuses to alleviate pressures in acute care, including hallway medicine.

Bruyère's Family Health Teams (FHT):

Currently in our community there are key populations not adequately connected to primary care where primary care services need to come to them. As a Patient Medical Home, we recognize our capacity to bridge this access gap. We have created formal outreach relationships with community partners including St. Mary's Home and Bethany Hope Centre (shelter and support services for young parents and their children), the Ottawa Mission (homeless shelter), Unitarian House (retirement residence) and this year we have added new initiatives: Cornerstone – Princeton Women's Housing and Options Bytown Supportive Housing. Although providers go to these sites to provide primary care services, these patients can also access the FHT services promoting health and managing chronic disease – including diabetes, smoking cessation, falls prevention, education and navigation of the system. Many of these patients also experience mental health and addictions issues that can make self-management and access to health care challenging.

We currently have a Nurse Practitioner providing care in a barrier free setting to 22 previously homeless women with moderate acuity needs as identified by the Housing First Ottawa initiatives. We have also allocated 0.5 FTE clerical support to help with systems navigational needs of the patients.

Options Bytown provides services for 256 tenants and report, in 2018, a combination of 30 hospital visits with no admittance, 25 paramedic visits, 46 hospital visits with admittance, and total of 629 nights in hospital. The majority of their health care utilization is from poorly managed chronic conditions including mental health and addictions, and severe wound infections resulting in ICU care and/or death. We anticipate that the FHT support provided will improve chronic disease management and reduce health system usage.

Patient/client/resident partnering and relations

Patients, residents and families play an important role in informing programs and strategic direction along with improving the patient experience for all programs at Bruyère.

Hospital Programs:

The mandate of the Patient and Family Advisory Committee (PFAC) is to enhance and improve the patient and family care experience by incorporating the voice and perspectives of patients and their families in the planning, delivery and evaluation of care and quality initiatives at Bruyère Continuing Care. For 2020-21, PFAC helped identify priority indicators for the Quality Improvement Plan and will be actively involved in helping us achieve success in meeting our performance targets for 2020-21 with a focus on improving the patient experience.

Patients and families were also engaged and involved in the redesign of a new delivery model in out-patient ambulatory stroke. They were interviewed to gather feedback regarding what components of the program work well and areas of improvement. In addition, an in-patient stroke and rehab orientation program was developed after a need for this was expressed by patients and families. Their feedback was sought in the review of the design and content.

Bruyère’s Family Health Teams (FHT):

In response to our desire to move toward co-design in our engagement activities, this year the FHT Patient Engagement Committee participated in a series of strategic planning meetings to develop an intentional and robust patient engagement plan moving patient engagement toward a partnership model. These activities were led by a newly named patient co-chair and involved patient engagement experts from across our region. Outcomes included: renaming of the committee to Patient Partner Committee, a new strategic plan and updated terms of reference.

The committee agenda now includes standing items for review of patient complaints, patient safety incidents, and also review of projects that impact patients. Central to these activities is an intentional culture shift toward patient involvement within the FHT with patient partners participating in FHT standing committees such as Communication to Patients, Mental Health Retreat, and Patient Safety Subcommittee. The strategic plan has also outlined patient partner recruitment strategies to better reflect the diversity and voices of the patient population we serve. Already there are change ideas that have arisen from this greater inclusion including the role for a patient advocate during case conferences and for patient education material about safety practices to expect from staff. Patient partners have also brought their unique interests to the table such as Social Prescribing and patient safety. FHT staff has already commented on the high value of this expanded patient partner engagement.

Long-term Care (LTC):

Both homes have very active Resident and Family councils which help set priorities and develop action plans for dealing with their concerns and issues throughout each of the homes. On January 18, 2018, Saint-Louis Residence held the kick-off to a beautiful transformation journey! More than 70 people came together for the Shared Aspirations in Long-Term Care workshop, which included residents, family members, nurses, auxiliary services and food services staff, physicians, researchers, managers, partners and board members. This workshop launched our five-year transformation journey with four key themes:

•Resident- and family-centered care;
•Meaningful activities and reducing isolation;
•Employee recognition and development; and
•Safe and secure environment.

We assembled a transformation advisory team who meets quarterly and guides our work plan (now in Year 2). We are exploring some dimensions of various 'models' for culture change, such as the Butterfly model and Eden.

Workplace Violence Prevention

As part of our commitment to the prevention of workplace violence, Bruyère Continuing Care has implemented a number of initiatives including:

• Implemented an on-line incident reporting and investigation system in December, 2018, to make it easier for staff to report all incidents including violence. System includes violence specific investigation tool for managers. Monitoring, coaching and training continued throughout 2019. This will continue throughout 2020-21.
• Portable and stationary panic alarms in place in several areas including Code blue alarm boxes in parking lots to summon assistance.

• Restricted access to building entrances and elevators from 9pm to 6:50am, requires employee badge access.
• Flagging system to communicate risk of patients with a history of violence to staff including individual client risk assessments conducted on patients flagged for violence.
• Implementation of violence flagging program within Bruyère's Long-Term Care facilities.
• Recruitment of a behavioural therapist.

All polices & procedures related to staff safety including workplace violence are reviewed annually by health & safety committee. For 2020-21, workplace violence statistics will be reported to senior management and the Board of Directors through the quarterly dashboard report.

Virtual care

Hospital Programs:

This is an area for identified future development. A few years ago the hospital implemented a research project called Telepalliative Care Project: Leveraging technology to improve access to palliative care consultation. This project was in partnership with the LHIN. Funding ended at the completion of the project.

We are in conversation with the Virtual Care program at The Ottawa Hospital to explore the possibility of collaborating with TOH consultants (ex: vascular program) in completing virtual appointments for our patients.

Bruyère is making rehabilitation more accessible by testing the use of non-immersive virtual reality (VR) to motivate patients to do more exercise in the home. Home-based VR removes common barriers for older adults to participate in rehabilitation and exercise, such as a lack of transportation, prohibitive costs, or bad weather. This simple innovation helps improve health outcomes and keeps older adults active. With huge potential to scale, Bruyère is now partnering with a number of sites to deliver VR rehabilitation in assisted living residences, rehabilitation hospitals, and in the homes of Canadians in British Columbia, Northern Ontario, and New Brunswick.

Bruyère’s Family Heath Teams (FHT):

The FHT makes use of virtual care opportunities to streamline patient care to minimize transition points, the need for office visits, avoid unnecessary visits to the emergency department and expedite information flow. The most pervasive of which is our use of telephone communication through the implementation of a business process which results in patients with acute issues, having access to either a nurse or an on-call physician 24 hours per day and seven days per week. In addition, the organization makes use of a patient portal system which provides asynchronous, secure communication between patients and their providers. This eliminates the need for multiple telephone calls and in many cases office visits as well.

One of the most significant virtual care that we have implemented is use of eConsult. This provides the ability to obtain consultation from a wide variety of specialists on complex patient problems in a much more rapid timeframe without needing to physically send the patient to the specialist. Through novel workflow that we have implemented facilitated by our referrals clerks, the provider team has been able to fully integrate the eConsult service into their daily practice. This has resulted in more timely treatment and a reduction in the need for conventional

consultation. We continue to explore additional virtual care opportunities that balance convenience and patient privacy such as online booking and virtual visits.

Executive Compensation

Our executives' compensation, including the percentage of base salary and targets that the executive team is accountable for achieving, is linked to performance in the following way:

- President and Chief Executive Officer: 5% of annual base salary is linked to successful completion of the QIP performance goals.
- Senior Leadership Team*: 4% of annual base salary is linked to successful completion of the QIP performance goals.

(*Includes: Vice President Human Resources and Organizational Development, Senior Vice President Clinical Programs & Chief Nursing Officer and Allied Health, Senior Vice President Corporate Services and Chief Financial Officer, Vice President Medical Affairs, and Chief of Staff)

The pay for performance envelope is spread across the four QIP priority indicators for all members of the executive subject to pay for performance. Partial achievement of objectives will result in partial payout, as determined by the Board of Directors.

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 _____ (signature)
Board Quality Committee Chair _____ (signature)
Chief Executive Officer _____ (signature)
Other leadership as appropriate _____ (signature)