Let's Make Healthy Change Happen.

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

Sinai Health System

3/24/2017

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

At Sinai Health System (SHS), our vision is to be Canada's leading integrated health system, pushing the boundaries to realize the best health and care from healthy beginnings to healthy aging for people with specialized and complex care needs. Our mission is to deliver exceptional care in hospital, community and at home, focused on complex and high needs conditions with the greatest impact on the overall health of the population. Our focus as an organization is on discovering and translating scientific breakthroughs, developing practical health solutions, educating future clinical and scientific leaders, and leading efforts to eliminate health inequities for the patients we serve. Our four strategic priorities are clinical excellence, operational effectiveness, research & education and growth & investment. At the core of clinical excellence is delivering exceptional patient care with outstanding patient experience and ensuring the highest standards of quality and safety.

In 2016, the Board of Directors approved a set of High Level Quality Aims for SHS to align and focus the organization's efforts related to quality and set stretch improvement targets over a three year time horizon. These Aims were established through a systematic and consultative process that included: patient and family feedback, a comprehensive review of internal and external information, key stakeholder committee feedback and frontline staff and content experts. The Aims were identified as high priority areas for focus because:

- they are clinical issues that are widely understood to be highly challenging to address and require organizational coordination, innovation and alignment of resources, and
- they are cross-system issues and strategically aligned to our organizational priorities and are patient issues that commonly face the complex and specialty needs of the populations we serve.

Once the Aims were established, a series of expert content groups were established to identify the key drivers of quality related to each of the areas of focus and a program of work was defined to complete over several years. These Quality Aims therefore form the scaffolding to anchor our year-over-year Quality Improvement Plans including progressive improvement targets and 2017/18 marks the start of the second year of our efforts.

The Sinai Health System's Aims are as follows and a comprehensive list of sub-aims can be found at the end of the Narrative:

1. Make care safer by **eliminating preventable harm or death** caused in the delivery of care.
2. **Provide effective and reliable care** in the implementation of clinical processes to detect and manage both pain and behavioural and psychological symptoms of dementia for populations with complex and specialized care needs.

3. **Provide timely access** to acute, rehabilitative, complex continuing and community care for populations with complex and specialized care needs by being a top 10% operational and best practice performer in achieving length of stay and wait time targets for complex orthopedic and medicine populations.
4. Be a top 10% performer in **engaging and informing patients and their families** in the design and delivery of care and care transitions.

QI Achievements from the Past Year

In January 2015, Mount Sinai Hospital, Bridgepoint Active Health Care, and the Lunenfeld-Tanenbaum Research Institute, along with our home care partner Circle of Care, came together to form Sinai Health System. The quality improvement (QI) journey of SHS has reflected the efforts of building a newly formed system. Existing strengths were built upon and new opportunities were discovered collectively. Best practices in QI were applied systematically to evaluate the drivers of improvement within the Quality Aims. Driver diagrams and roadmaps for improvement were developed for each sub-aim. Control charts as applicable have been integrated into quality performance reports to better understand variation and support leadership decisions on the effectiveness of change ideas.

Emerging from our focused work within the Quality Aims, SHS had QI activities that were **foundational** as a newly formed integrated system such as forming a joint SHS Quality, Patient Safety and Clinical Risk Committee, while other activities continued on building reliability through **standardization and consistent application** of leading practices such as consistent use of pressure injury risk assessment. In some situations, SHS was able to capitalize on deep organizational learning and build towards **innovation**; for example, by implementing technology to support corporate bed management and patient flow.

In this past year, SHS's efforts to make care safer have led to important QI achievements. Two highlights are our work with preventing serious harm with patient falls, and the activity to support reaching a rate of zero nosocomial Clostridium-Difficile Infections (**CDI**). The aims are envisioned to be achieved over three years. Here we describe our progress through the first year.

In 2016/17, a SHS Falls Working Group was created combining the knowledge and expertise across the system. These efforts were **foundational** to the governance and oversight of this Quality Aim. Through their leadership, a direction was set to build and expand on existing falls programs to ensure SHS's compliance with Accreditation Canada's Required Organizational Practice to **consistently** apply falls risk assessments and create a falls plan of care for those at high risk. By year end, compliance with falls risk assessment was maintained at greater than 90% completion within the first 24hrs following admission for

rehabilitation and complex continuing care (CCC) patients and improved to 81% across acute areas. Through literature review and analysis of critical falls in rehabilitation and CCC, populations at highest risk of serious injury with falls were identified to include patients within the palliative, stroke and complex medicine populations. By the end of fiscal 2016/17, an **innovative** solution of Smart Cell flooring was installed on the palliative unit at Bridgepoint. The flooring is engineered to absorb the fall impact and designed to decrease the seriousness of harm in the event of a fall. Sinai Health System, as the first Ontario hospital with this type of flooring, has partnered with an academic partner to begin evaluation of the Smart Cell floor. Spread of the flooring to other priority high risk areas has been identified as a change idea over 2017/18.

A second QI highlight was the Quality Aim related to CDI. At the beginning of 2016/17 our acute CDI rates were 0.37 per 1000 patient days and by Q3 year to date (YTD) the acute rate was down to 0.28 per 1000 patient days (equivalent to 20 patients), with rehabilitation and complex continuing care also achieving target at 0.05 per 1000 patient days (equivalent to 5 patients) . As with the Falls Working Group, **foundational** to the oversight of the Aim was the establishment of a joint interdisciplinary/interdepartmental SHS Infection Control Committee and common Infection Prevention and Control department across Mount Sinai and Bridgepoint Hospital. Key change ideas included **standardization and consistent** application of a CDI detection and treatment algorithm, education of environmental services staff with provincial infection standards (PIDAC) and the use of data through an automated tool to support appropriate antibiotic use to reduce Catheter Associated Urinary Tract Infection (CAUTI). Building on our strengths, in 2017/18 there is a planned spread of an existing and **innovative** hand hygiene-monitoring device to all acute medicine, surgical units at Mount Sinai and to begin baseline data collection on one unit at Bridgepoint. This tool will allow for greater accuracy in determining actual hand hygiene adherence compared to the traditional observational audits as SHS continues to seek opportunity for improvement in breaking the cycle of infection transmission.

Population Health

Founded in the principles of population health, Sinai Health System set out to create a new approach to care for high needs and complex patients. Through the transformation of clinical services both within individual settings of care and across the continuum, SHS is developing innovative, integrated approaches to care for high needs and complex patients. Today we continue to do this work in areas such as complex medicine, orthopedics and palliative care by improving the coordination of care through multiple entry points in the system including home care, primary care, emergency, acute, complex continuing care, and rehabilitation. As SHS aligns its efforts to enhance patient experience, improve population health and reduce costs, two particularly innovative approaches have been the Hospital at Home (H@H) program for our complex medical patients and the integrated hip fracture program (i-HIP).

Hospital at Home

The Ministry of Health and Long Term Care (MOHLTC) has proposed integrated funding models to promote high quality patient-centred care across the continuum by bundling payment and incenting co-ordination of care and quality outcomes. In 2016, Sinai Health System, University Health Network (UHN), Women's College Hospital (WCH) and the mid-west subLHIN region were approved by the Local Health Integration Network (LHIN) and Ministry of Health and Long Term Care (MOHLTC) to jointly implement an innovative integrated funding model and care pathways for patients with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) or community acquired pneumonia (CAP). Together, a Hospital at Home program was developed and is based on three defined care pathways from Ontario's quality based procedures (QBP). Appropriate patients presenting to hospital with acute episodes of CHF, COPD or CAP will receive a portion of their hospital level acute care in their own homes after an initial observation and assessment period. During the patient's H@H stay, the team will collaborate with primary care providers and community supports to ensure smooth transition for independent living. Through establishing one plan of care, adopting best practices and through an integrated used of resources, we believe that seamless patient centred care across the continuum is possible. Hospital at Home is an innovative partnership and change idea that will be further advanced through the 2017/18 QIP by beginning pilot implementation in the fall 2017 at one site and spreading across all sites by the end of the fiscal year. The goal of the program is to reduce unnecessary days in the acute hospital setting bring service delivery where patients want it and aligns with our safety Aims by decreasing exposure for patients to the risks of hospitalization including infection and falls in unfamiliar surroundings.

Integrated Hip Fracture Program

The SHS has been an early adopter of QBP and Toronto Central Local Health Integration Network (TCLHIN) best practices for Hip Fractures. Prior to the amalgamation, Mount Sinai Hospital had identified a significant opportunity to improve its orthopedic pathway to better address the complex medical needs of **hip fracture** patients. At the time, the average length of stay (LOS) was significantly above best practice targets (19 days) and complications such as delirium and inadequate pain management were identified as significant barriers to discharge. As a result, the team came together to re-engineer the model of care for patients with hip fractures. Based on consultations and an extensive literature review, an innovative co-management program called i-HIP was developed. The goal of the program was to improve several domains of quality including efficiency, timeliness, effectiveness, and patient centeredness. The key aspects of the model are described:

1. **Active co-management by Hospitalists**: During the week, the hospitalist completes preoperative assessments within 24 hours of admission. The Hospitalist coordinates care through direct communication with the orthopedic and anesthesia teams. The patients are then placed on the emergency list for the operating room based on assigned priority. In addition, the Hospitalist

participates in regular interprofessional patient care rounds, family meetings, discharge planning, and creates an electronic discharge summary available on the day of discharge.

2. **Coordination of care**: The interprofessional i-HIP team coordinates care among the various consulting services involved in the management of patients with hip fractures. This includes anesthesiology, geriatric psychiatry, and geriatric medicine. Geriatric medicine provides a comprehensive assessment on all patients aged 65 years and older focusing on fall risk, medications, functional ability, and risk of delirium. The teams' clinical pharmacist completes a best possible medication history, reconciles this to the patients' admission orders and provides medication optimization recommendations for each patient throughout the hospital course. A dedicated team of rehabilitation therapists and a social worker complete an initial functional assessment and evaluation on the first postoperative day with a focus on early mobility and restoration of function.
3. **Local QI projects**: The i-HIP team created an institutional-wide hip fracture steering committee that meets quarterly to review performance metrics and create QI plans. Examples of project that the team has worked on include improving pain management, access to OR, and early mobility.
4. **Standardization of care**: The i-HIP team led the creation of best practice (preoperative and postoperative) order sets and care pathways. These include early mobility, appropriate analgesia and constipation management, thrombosis prevention, and delirium prevention strategies including minimizing the use of high-risk medications in the elderly. Care is consistently delivered in a standardized fashion with all hip fracture patients undergoing appropriate medical and allied health assessments pre- and post-operatively. We are able to achieve 100% adherence to measures such as to pre-operative optimization, access to the operating room without delay, use of order sets, daily care, and discharge planning summaries.

Based on our data collection and analysis we found that implementation of i-HIP reduced cost and improved quality of care. Our LOS was reduced by 14 days with an associated cost reduction of $4953 per hospitalization (estimated annual cost avoidance of over $1,000,000). Time from admission to surgery decreased from 46 hours (pre-intervention) to 29 hours (post-intervention). We have reduced the number of patients receiving peri-operative echocardiograms - from 16% to 9% and other utilization such as unnecessary urinary catheter use. In addition, there was a statistically significant reduction of mortality rate of hip fracture patients at from 5.1 to 2% following i-HIP implementation. According to Health Quality Ontario (HQO), our patients enjoy one of the lowest mortality rates in the province. SHS (Mount Sinai site) was recently the subject of a site visit by HQO and have been invited to present our work at Health Quality Ontario's quality rounds. Our work is in keeping with the quality standards report on hip fracture patients that will be released by HQO.

Leveraging the success of this work and previous improvement efforts in patient care for our orthopedic patients, the amalgamation provided an opportunity to innovate and integrate a new orthopedic pathway across the continuum of care for patients with Hip fractures and Total Joint Replacement (TJR). Beginning with our hip fracture patients, in 2016 Sinai Health System's orthopedic teams across Bridgepoint and Mount Sinai have successfully implemented a standardized and seamless pathway aligned to QBP and best practice guidelines. Through the development of this pathway, we have streamlined the patient journey and reduced total length of stay by 20% (as of YTD Q2 2017/18). We achieve performance superior to targets and benchmarks at both Mount Sinai and Bridgepoint. We have also successfully implemented a streamlined process to ensure more timely access to rehabilitative care within 24 hours, and have reduced the number of "requests for information" from Bridgepoint Hospital.

The Sinai Health System hip fracture pathway has resulted in a more seamless handover in patient care, including comprehensive nurse, physician and allied health handover. By providing electronic access to patient records across Sinai Health System to our physicians and pharmacists, we have enabled timely access to accurate, up to date patient information, which has reduced delays in care plan and information handover. In line with our Quality Aims work, we have collaborated across disciplines to manage patients' medication including pain management during the transition in care from acute care to rehabilitation. This has ensured that during the transition, patients continue with their medication regimen. We are also working towards standardizing admission orders for our orthopedic populations across Sinai Health System consistent with best practice standards for pain management protocol and regimen.

Equity

Health equity allows people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are (Health Quality Ontario). Both Bridgepoint and Mount Sinai Hospital have long histories rooted in compassion and with a focus on caring for underserved populations in health care. This legacy continues today with Sinai Health System's commitment to health equity and to providing exceptional care that is accessible to all. Our Human Rights and Health Equity Office and associated program of work is tightly aligned to our quality agenda and includes:

- Assisting members of the health system community to address and resolve complaints of harassment and discrimination that violate the Ontario Human Rights Code as well as complaints of non-Human Rights Code harassment
- Providing education and training to raise awareness of human rights issues as they relate to health care including: the **Are you an ALLY campaign**, Leading Equity, symposia on

health equity, and **annual events** such as Lunar New year, Black History month, National Day of Remembrance and Action on Violence against Women, Pride and others.

- Operationalizing the work out of the Hospital Violence against Women Action Committee to educate and develop policies on domestic violence and health care. Over 900 nurses were trained on screening for abuse and domestic violence. Education materials to assist patients and staff were developed.
- Developing policies to guide our understanding and actions related to current human rights and equity issues.
- Translating the "Respect, Rights, and Responsibilities" brochure into our top 7 preferred languages
- Leading the "Measuring Health Equity in the TCLHIN" project by providing support in the planning, implementation and coordination of demographic data collection across Toronto's network of hospitals and Community Health Centres

Looking forward to 2017/18, this QIP further commits SHS to building on our legacy by:

- Ensuring 80% of our leadership team attends Leading Equity training
- Ensuring 80% of the Quality, Patient Safety and Clinical Risk Committee will attend Cultural Safety training to strengthen the membership's understanding and innovation opportunity
- Ensuring demographic data is collected from 75% of all patients at SHS to provide a better understanding of who we serve
- Adding to our electronic incident reporting system a question: "Does the patient prefer to speak to their health care provider in a language other than English?" to understand the relationship between having limited English proficiency and the type, severity and frequency of patient safety incidents
- Ensuring translation of all safety education materials within the Quality Aims to SHS's preferred top 5 languages

Integration and Continuity of Care

A key underpinning to our vision and transformation initiatives as a system is to engage partners across SHS, and in the broader health and social services system, to improve care for the highest needs and most complex patients we serve. This includes collaboration with academic partner organizations, community and social support agencies, primary care and home care. We continue to explore new and innovative ways to partner with other health care organizations and care providers to better meet the needs of our complex and high needs patients, and to align and integrate care.

Palliative Care

In line with Health Quality Ontario's new strategic plan, Sinai Health System has recognized the need to transform the way we deliver palliative care. As a first step to address the growing need for more comprehensive, integrated palliative care services across the healthcare continuum, Sinai Health System is establishing a new Inter-Departmental Division of Palliative Care. A Divisional Director was recently appointed, and will lead a system-wide approach to transforming care through an innovative palliative care model, including primary care, hospital care and home care.

Planning is underway to integrate our palliative care services across the system that include the 32-bed palliative care unit at Bridgepoint, the Temmy Latner Centre for Palliative Care with its large ambulatory and community based program and its consultative palliative program at Mount Sinai Hospital, and Circle of Care with its community-based hospice program.

To launch the planning process, the organization held a visioning session together with 45 palliative care stakeholders from a variety of health disciplines and health care sectors. From that session, we have established a cross-site Palliative Care Planning Committee to develop a future clinical and academic model to optimize care delivery across the system and to ensure seamless transitions for patients, their families and caregivers. The committee has begun focused work to achieve three initial goals:

- Enrich and expand the Palliative Care Unit (PCU) at the Bridgepoint site
- Enrich and expand the inpatient consultation services offered through the Temmy Latner Centre
- Improve the utilization of the building/facilities at the Bridgepoint site to enhance the quality and continuum of services available to patients and families.

Enhancing System Access to Obstetrical Care

Sinai Health System and Women's College Hospital (WCH) have worked collaboratively to identify opportunities to enhance system access to women's health care services. This has led to the creation of the Joint Department of Obstetrics and Gynecology across WCH, Mount Sinai Hospital (MSH) and University Health Network (UHN) under the leadership of one Chief of Obstetrics and Gynaecology. The goal of this partnership is to optimize service delivery and to provide more seamless and integrated care across Mount Sinai and Women's College. This is also an opportunity to leverage existing areas of expertise to better serve patients in the most appropriate setting.

As a first step towards these goals, Women's College Hospital's Family Practice Obstetrics Program will join the Mount Sinai Family Medicine Obstetrics Program so that delivering mothers in the downtown Toronto area can receive birthing services at Mount Sinai. These delivering mothers are predominantly residents of the WCH catchment area and chose to get their ongoing primary care downtown at Women's College Hospital. By repatriating these deliveries, the majority of patients would be receiving care closer to home, including a sub set of marginalized women from Massey Centre, Crossroads Refugee Program, and South Riverdale Community Health Centre. The WCH Family Practice will continue service in downtown Toronto. This repatriation is an opportunity to strengthen linkages between downtown community outreach services and hospital, ensuring continuity in care and a more integrated patient experience.

Access to the Right Level of Care – Addressing ALC Issues

The term alternate level of care (ALC) is used to describe patients who are waiting for an appropriate level of care to meet their needs. The extent of the ALC challenge in Ontario's hospitals is a serious, system-wide issue. Long waits for appropriate levels of care are a symptom of significant issues related to *patient flow, access to care, system integration, availability of care and service options, system capacity and resources*. The rate of ALC days (as a percentage of total hospital days) has been identified as an important indicator of health system performance overall. Excessive waits for appropriate or alternate levels of care in hospitals create a domino effect across the system.

In January 2016, Sinai Health System established a system-wide ALC Avoidance and Management Committee to provide a forum to develop strategies for SHS, and to ensure that these are aligned with TC LHIN policies, priorities and Ministry-LHIN Accountability Agreement (MLAA) performance targets. Since that time, Sinai Health System has developed a harmonized, comprehensive approach and plan to address ALC challenges. This includes establishing of a three-year ALC Quality Aim to decrease overall percentage of ALC for Medicine and Complex Continuing Care to less than 20%. Our goal is to implement best practices and protocols to improve the management of ALC patients across hospitals through a standardized collaborative approach. Initial milestones have included:

- Establishment of a System Wide ALC Committee to complete current state and gap analysis against best practice guidelines for ALC prevention and Management, and implement cross system standards.
- Develop a Knowledge Transfer Strategy to raise awareness of ALC as a system-wide priority. This presentation has been shared with numerous stakeholder committees and groups with the goal of securing corporate-wide engagement and support among staff and physicians in ALC activities and fostering greater understanding of the "burning platform" and case for change.

- Implementation of specific “tests of change” initiatives at both sites including:
  - Development and implementation of Transition Planning Risk Assessment Screening Tool (T-PRAS) administered early in the admission process to identify patients at risk of becoming ALC and to initiate timely communication with patients and families about transition;
  - A new and stronger partnership with the Community and Social Services (CSS) sector, including community housing facilities, to support transition to the community; ALC rounds include representation from community partners such as WoodGreen Community Services
  - Improved communication with families and Substitute Decision Makers (SDM) through common messaging about the importance of transitioning from hospitals, options for transitioning from hospital, etc.
- Harmonization of processes and approaches to complex discharges and patient centered resolution
  processes.
- Development of a common Discharge/Transition Policy for the Sinai Health System.
- Active participation and SHS leadership representation at the TCLHIN-led ALC activities including development of standardized tools (letters, messages, brochures) for use at the systems level

Looking forward to 2017/18 we continue with the overall Quality Aim to decrease the overall percentage of ALC for medicine and CCC to less than 20%. New change ideas include:

- Continuing to focus on implementing ‘leading practices’ included in the TC LHIN ALC Avoidance and Management Framework
- Spread of the Transition Planning Risk Assessment Screening Tool (T-PRAS) across General Internal Medicine and Bridgepoint
- Participation in the TCLHIN sponsored Behavioural Support Transition Resource (BSTR) service as part of a pilot project being initiated in the Toronto Central LHIN across SHS
- ALC Lean Event (with CCAC): Focused on completion of Home First assessments; completion of capacity assessments; back filling re: sick time and vacation; investigation of factors contributing to long LTC Lists and waits at BH site)
- Collaboration between Pharmacy and Medicine for medication optimization in support of patient discharge

Engagement of Clinicians, Leadership and Staff

The SHS Quality Aims are the foundation of the 2017/18 QIP and have been widely socialized across SHS. By the start of the second year of the Quality Aims, the majority of staff have heard about the aims and are part of key stakeholder groups to develop change ideas. The year 2 change ideas to achieve the Quality Aims were developed through numerous frontline content experts and clinical teams. These ideas were refined through various stakeholder groups including the SHS Senior Management Team, Medical Advisory Committee, Nursing Advisory Committee, Health Disciplines Advisory Committee, Centres of Excellence and Program Committees. An understanding of what quality means to patients and families through numerous stories and solicited patient and family feedback grounded the work of the Quality Aims and the QIP. Oversight of the development of Quality Aims and QIP was through the SHS Quality, Patient Safety and Risk Committee with final approval and adoption provided through the SHS Executive, Patient Safety and Quality Board Committee and overall SHS Board.

Our focus this year will be to further support measurement for improvement at the frontline. To that end education and capacity building with leadership and frontline staff will occur to connect further the Aims with the change ideas and data to help local teams understand if improvement is happening. Building on SHS's cascading metrics across various committees and programs a series of touchscreen monitors will be trialed and deployed across SHS. In collaboration with SHS Communications, staff, patients and families infographics on the Quality Aims will be developed to make QI and performance more accessible for everyone including patients and families.

Resident, Patient, Client Engagement

Providing person centered care is at the core of the SHS vision, mission and values of the organization. Reflecting on the Quality Aims, our objective is to improve the experience of patients as they receive care and to engage with them in the design of new care models to improve patient outcomes. Patients and families have unique perspectives and insights that are invaluable for improvement. Incorporating the HQO Patient Engagement Framework (HQO, 2017) below, SHS has used all elements of the engagement spectrum:

Share, Consult and Deliberate

We have conducted a comprehensive review of the feedback from the Canadian Patient Experience Survey and aggregate complaints. To further our understanding two engagement sessions were held to discuss with fourteen patients and families opportunities for improvement with patient experience, quality and professional practice. Through these consultation and deliberations, themes have emerged as SHS's priorities for patient experience. Our top areas of focus include information sharing, discharge and transitions and coordination of care. In the words of SHS patients and families:

Dimension	
Information Sharing	"Did lots of tests, but diagnosis was not shared in a timely way" "When I asked why am I taking this medication? The answer is "because it's ordered"
Discharge/Transitions	"Staff assume patients know what to do and who to call for community services" "People are left in the dark about discharge"
Coordination of Care	"So much left for families to do and care for loved ones" "When there's no hand off, it leaves the patient/caregiver at the centre trying to relay information between all teams"

While it is always humbling to get feedback on areas where we can do better, system improvement cannot happen without engaging with patients and families to understand the gaps. To that end SHS's QIP 2017/18 is well aligned to address the priority issues as defined by patients and families. In 2017/18, we look forward to advancing the work of an electronic patient portal to support information sharing, and continuing to support Patient Oriented Discharge Summaries (PODS) to improve discharge and transitions. A priority change idea is a co-designed integrated care plan to coordinate care helping patients, family caregivers and staff to be focused on common goals. At SHS, we recognize the importance of families in improving patient experience and outcomes. As a result, our leadership team will be taking the Canadian Foundation for Healthcare Improvement's (CFHI) "Better Together" pledge committing to developing a family presence policy that changes how we perceive family members from being 'visitors' to being an integral part of the care team supporting the patient.

Collaborate

This past year has seen SHS collaborate with patients and families in 40% of all Quality Aims to address issues and design solutions. Examples have included having Patient and Family Advisors on co-design sessions to ensure timely pain support in the orthopedic program, expansion of the Patient Oriented Discharge Summary (PODS) customization for the Brain Injury and Medicine units. Patient and Family Advisors partnered with SHS staff to design falls education material and advise on the pressure injury prevalence activity. Other notable collaborations outside of the Quality Aims (see Other for listing of engagement examples at SHS) included having patients participate in mock fire training, ongoing NICU

Parent Advisory contributions including newsletters for NICU alumni and Shadow Boxes on the NICU. A Family and Patient Advisor was part of the hiring panel for a Patient Relations intake position. When asked "why do you partner with SHS" a veteran parent said:

> "As a parent of 26 week fraternal boys I travelled the NICU rollercoaster for 4 months and was hospitalized for 1 month. I felt I was attached to Mount Sinai, so I became a parent buddy. My goal was to bridge the gap between Spanish speaking families and staff, as well as to fully inform parents on as much information as possible to make their NICU journey less stressful. I felt that my experience in the Family Integrated Care Pilot Study would be helpful to other parents as well. I felt compelled to do more for the families and Mount Sinai as a way to give back for the medical care and support provided during my journey."

As we consider the spectrum of engagement described by Health Quality Ontario, SHS has been building on our experience to collaborate with patients and family caregivers. Experienced Based Co-Design (EBCD) is a method endorsed by SHS to achieve this and has been successfully used in previous improvement work. We are building on our capabilities to spread the use of EBCD further with an additional twenty SHS staff, caregivers and patients participating in an Experience Based Co-Design workshop sponsored by The Change Foundation. The two day workshop will be delivered by the London, England based Point of Care Foundation Faculty.

Caregiver Friendly Hospital and Community Hub

Finally, Sinai Health System in partnership with WoodGreen Community Services was successful in obtaining a multi-year grant from The Change Foundation to achieve over the next three years a shared vision to fundamentally redesign the caregiver experience. Most Ontarians have been or will be a family caregiver at some point. Like the Change Foundation, we believe that by recognizing, facilitating and supporting the role of family caregivers, we can improve patient experience, coordinate care more effectively and meet our strategic priority of clinical excellence. At SHS, our goal is to create a system that better responds to the changing needs of patients and families. Through the deliberate strategic efforts of The Change Foundation, we have an opportunity with this collaboration to accelerate our work to find innovative health solutions. By working with patient and caregiver advisors to re-design processes of care, our goal is to create a Caregiver Friendly Hospital and Community Hub across the continuum. Over the next several years we envision changes in our physical space and our philosophy of care in which caregivers are partners and not visitors. This initiative will bring together caregivers, patients, clinicians, researchers, and administrators to connect and collaborate to drive improvement and innovation both within the hospital and in the community. We are very excited about the work ahead. In a discussion lead by Caregivers for Caregivers about their experience, the need for this work and the expected outcome was made clear:

> "I need to feel safe when I'm away from my wife, that I know she's taken care of so that I don't have to stress. I felt like I needed to do more, or I needed to stay longer, and I needed to do everything on my own. That's the feeling that I had. So alleviating that from me would be a huge thing." Bridgepoint Caregiver, 2016

Staff Safety and Workplace Violence

Workplace violence is an issue that affects health providers across the continuum. At SHS, we define workplace violence as a threat, attempt or actual exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Over the past year, SHS developed a harmonized workplace violence policy and mandatory learning modules have been disseminated to all staff. Violence prevention posters and brochures on workplace violence, harassment and ALLY campaign have been developed and distributed. Reports on workplace violence are shared with senior leadership on a quarterly basis. In addition, SHS has conducted a comprehensive risk assessment (which looked at the physical work environment, workplace culture, policies and procedures, job design, etc.) from a lens of violence prevention. Based on this assessment, a workplace violence prevention program, a training program, communications and resource materials were developed.

The *Safe Patients/Safe Staff* developed at the Mount Sinai site is an award winning (2015 National Healthcare Safety Award from the Canadian College of Health Leaders) exemplar of SHS's efforts to improve staff safety. A stay in hospital can be very distressing and disorienting for some patients, particularly elderly patients who suffer from dementia or other mental health issues. Certain health conditions can also cause delirium in patients with no history of mental illness. The result can be impulsive or defensive behaviour that can put patients at risk by compromising their care, and increasing the likelihood of staff experiencing harm and burn-out as they care for these patients. The *Safe Patients/Safe Staff* program provides resources to help staff safely and effectively care for patients who are at risk of aggressive or dangerous behavior while in hospital. The program has two key areas of focus:

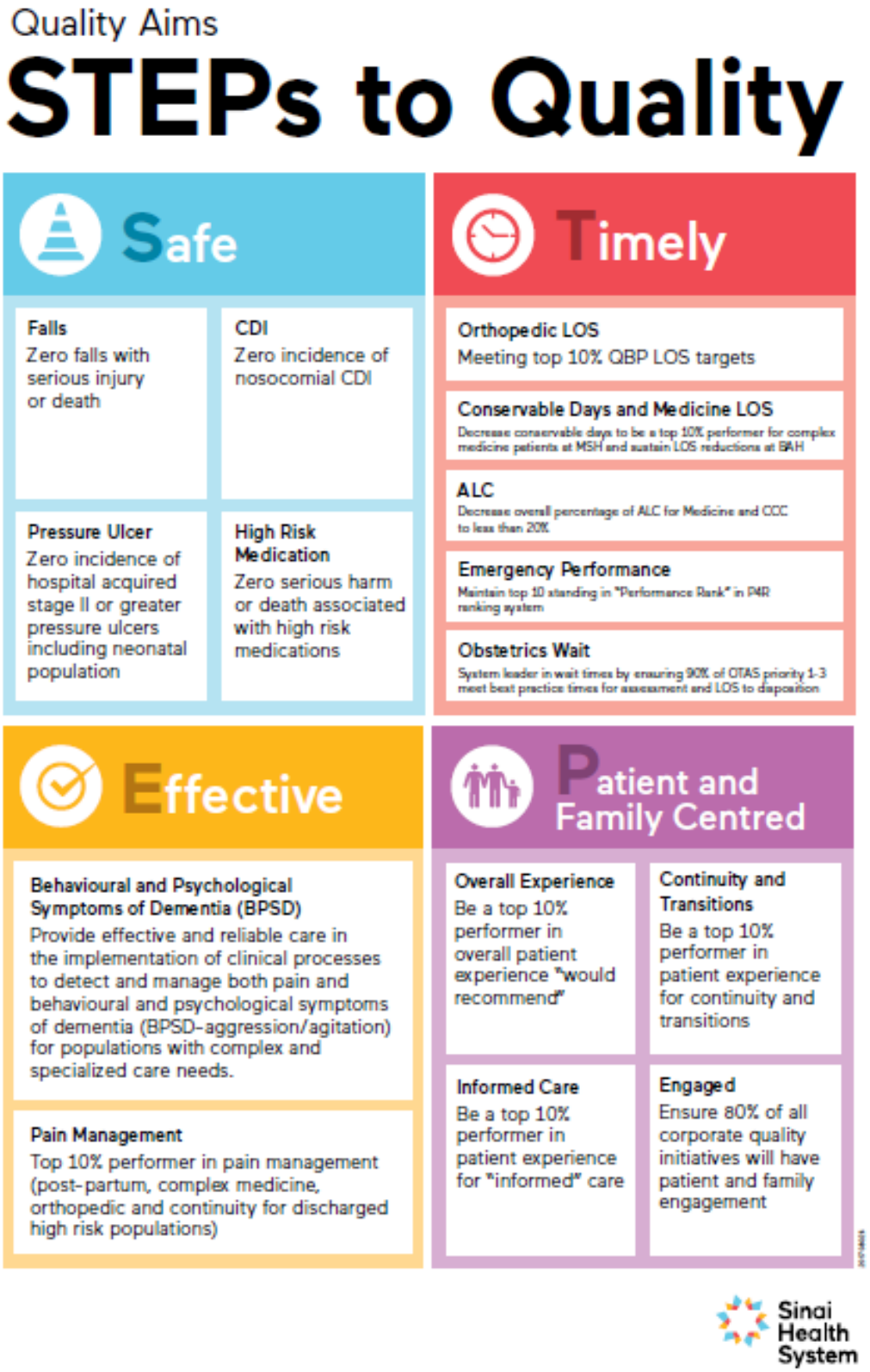
- Identifying risk factors for dangerous behavior early, before an incident takes place. This ensures that staff can deliver compassionate care and ease vulnerable patients through stressful situations. It is done using staff training, electronic screening of medical chart and regular updates at meetings; and
- Mobilizing of a special team of nurses called BOOST (Behavioural Optimization and Outcome Support Team), who immediately perform an assessment and engage any specialists required. Together with the original care team, they determine a strategy for managing the risk and a care plan that will meet the patient's needs.

Safe Patients/Safe Staff is the type of innovative program that may be adapted for different care environments and is expressed in the SHS QIP as a change idea to spread to the Bridgepoint campus in the next year.

Performance Based Compensation

Hospital leadership at Sinai Health System is held accountable for achieving QIP targets through performance-based compensation, to ensure organizational alignment and leadership focus on continuous improvement in quality of care. In 2017/18, as in 2016/17, executives will have at least 30% of performance-based compensation tied to a subset of the indicators in the QIP. The selected QIP indicators will be derived from the complement of indicators outlined in the QIP Improvement Targets and Initiative spreadsheet, including targets for improvements in high-leverage, system-wide measures of patient safety, timely access, and patient and family-centred care.

Other


Quality Aims
STEPs to Quality
Safe
Falls
Zero falls with serious injury or death
CDI
Zero incidence of nosocomial CDI
Pressure Ulcer
Zero incidence of hospital acquired stage II or greater pressure ulcers including neonatal population
High Risk Medication
Zero serious harm or death associated with high risk medications
Timely
Orthopedic LOS
Meeting top 10% QBP LOS targets
Conservable Days and Medicine LOS
Decrease conservable days to be a top 10% performer for complex medicine patients at MSH and sustain LOS reductions at BAH
ALC
Decrease overall percentage of ALC for Medicine and CCC to less than 20%
Emergency Performance
Maintain top 10 standing in "Performance Rank" in P4R ranking system
Obstetrics Wait
System leader in wait times by ensuring 90% of CTAS priority 1-3 meet best practice times for assessment and LOS to disposition
Effective
Behavioural and Psychological Symptoms of Dementia (BPSD)
Provide effective and reliable care in the implementation of clinical processes to detect and manage both pain and behavioural and psychological symptoms of dementia (BPSD–aggression/agitation) for populations with complex and specialized care needs.
Pain Management
Top 10% performer in pain management (post-partum, complex medicine, orthopedic and continuity for discharged high risk populations)
Patient and Family Centred
Overall Experience
Be a top 10% performer in overall patient experience "would recommend"
Continuity and Transitions
Be a top 10% performer in patient experience for continuity and transitions
Informed Care
Be a top 10% performer in patient experience for "informed" care
Engaged
Ensure 80% of all corporate quality initiatives will have patient and family engagement
Sinai Health System

Patient and Family Engagement at Sinai Health System

A core value at Sinai Health System is person centred care – one that makes clear that patients and families are our partners. We have a strong history of working with patients and families through our Declaration of Patient Values, the Neonatal Intensive Care Unit Family Advisory Council, Redevelopment, and Patient Oriented Discharge Planning (PODS). These initiatives are highlights among the many engagement opportunities occurring across the system.

To describe and categorize our patient and family engagement initiatives, Sinai Health System uses the Carman Model[1] as a framework. Partnering with patients and families organizationally and at the bedside has been energized by the renewed focus from Accreditation Canada, Health Quality Ontario and the Ministry of Health and Long-Term Care.

Patient and family engagement is a process that we are fully committed to, as outlined in our Quality Aims and embedded in our annual Quality Improvement Plan.

Informal feedback leads to more comfortable experience for ambulatory patients

Leadership safety walk arounds include patients and families

Breast milk scanner provides peace of mind to parents of premature babies in the NICU

Sinai Health System hosts patient ombudsman to open conversation about patient experience

Piloting a resource to support patient and family engagement

Patients and staff improve transition from hospital to home

Consultation | **Involvement** | **Partnership and Shared Leadership**

Patients and families consult on future design of key care areas

Resources to support healthy ageing informed by Patients and Caregivers

Biomedical scanner access ensures parents keyless access to NICU

Mental health program serves Chinese community

Patients and families help improve experience for rectal cancer patients

Learning from patients in a new interprofessional education program

1. Carman K., Dardess P., Maurer M., Sofaer S., Adams K., Bechtel C., Sweeney J. Patient and family engagement: a framework for understanding the elements and developing interventions and policies. Health Affairs. 2013 Feb; 32(2):223-231.

Sign-off

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

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Gary Newton,
President & CEO
Sinai Health System

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Paula Blackstien-Hirsch
Chair, Patient Safety and Quality Committee
Sinai Health System

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Brent Belzberg
Board Chair
Sinai Health System