Let's Make Healthy Change Happen.

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

HÔTEL-DIEU GRACE
ESTD HEALTHCARE 1888

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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

Hôtel-Dieu Grace Healthcare (HDGH) is committed to improving the health and wellbeing of the Windsor-Essex community through the delivery of patient-centred, valued based care. Hôtel-Dieu Grace Healthcare is a unique community hospital offering services in Mental Health and Addictions; Rehabilitative Care; Complex Medical and Palliative Care; and Children and Youth Mental Health. We offer a unique blend of services including but not limited to community and home based services. In collaboration with our healthcare and inter-sectorial partners, Hôtel-Dieu Grace Healthcare is providing care in new ways and in new locations throughout the region to address barriers, improve access and patient outcomes and improve the overall patient experience.

The mission of HDGH is to serve the healthcare needs of the community including those who are vulnerable and/or marginalized in any way be it, physically, socially or mentally. As a Catholic sponsored organization we provide patient-centered care treating the mind, body and spirit. We do this by providing holistic, compassionate and innovative care to those we serve.

HDGH's vision "as a trusted leader transforming healthcare and cultivating a healthier community" conveys a strong commitment to providing safe, high quality patient and family centered care and services. HDGH is dedicated to improving the quality of life for patients across the continuum of institutional and community settings.

Rehabilitative Care

HDGH has a number of Rehabilitation programs and services that aim to assist patients in restoring their functional ability and reach their highest level of independence after encountering a catastrophic health event such as an acquired brain injury, cardiac event, stroke, bone break, etc. Through inpatient, outpatient, and community outreach formats, an inter-professional healthcare team works with patients to support personal goals, as well as physical, cognitive, and social needs.

Mental Health & Addictions

HDGH works tirelessly to achieve the reality of becoming our region's Centre of Excellence for Mental Health. Through inpatient, outpatient, and community outreach programs, HDGH works with patients and clients with persistent and/or severe mental health issues, those in crisis, and those battling many forms of addiction. HDGH's Mental Health and Addictions programs offer a range of treatment approaches to assist individuals with the unique symptoms and challenges of their illness, promote personal growth, and enhance quality of life.

Complex Medical and Palliative Care

HDGH's Complex Medical Care (CMC) program provides restorative care for patients who no longer require services in an acute care hospital but because of their care needs require continuation of their rehabilitative journey in a safe environment with medical care oversight. An inter-professional healthcare team assists patients with setting goals, medical needs and working to improve their independence by increasing strength, mobility, and endurance to better manage daily activities and to return to the community.

Through our Palliative Care program, HDGH supports patients who are within the last phase of a life limiting illness, transition through end of life with comfort and dignity. Our Palliative Care program is designed to help patients and families feel and stay as comfortable and peaceful as possible.

Children & Youth Mental Health

HDGH offers comprehensive child and youth mental health services through our Regional Children's Centre (RCC). An accredited children's mental health agency formerly funded by the Ministry of Children, Community and Social Services, and currently in transition to MOHLTC. RCC serves children, youth, and their families who are dealing with social, emotional, developmental, and/or behavioural challenges. RCC offers a variety of crisis stabilization, diagnostic, assessment, treatment, and consultative services in an on-site out-patient, educational and residential format, designed to promote healthy functioning within the home, school, and community. HDGH is also the Lead Agency for this region.

As one of the 31 Lead Agencies in the province, HDGH provides leadership at the local service area to lead practical change that works on the ground to improve services for children and youth facing mental health challenges, and their families. Through its legislated responsibility of planning as identified in Regulation 155/18 under the Child, Youth and Family Services Act, 2017, the Lead Agency works in collaboration with other partners to improve system level planning, consistency of services, and family and client engagement. Lead Agencies are responsible to ensure that core child and youth mental health services are accessible and of the highest quality, that gaps in service are identified and that areas of service duplication are addressed. As a Lead Agency, HDGH compiles data to inform service planning, builds partnerships across sectors, and engages children, youth and their families in order to increase access and improve quality of the services delivered.

The hospital's 2018-19 Quality Improvement Plan continues to be driven by our three strategic drivers: Our Patients; Our People; and Our Identity. The 2019-20 QIP builds on the final year of our five year refreshed strategic plan.

We have completed the roll out of the communications plan on our Quality Framework and Quality Structure and implemented the majority of our Unit Based Councils in our Shared Governance model that encourages all staff to embed quality into their everyday practice. We also implemented a robust scorecard structure across our key Strategic Programs and key quality committees with connection to quality to our Quality Board and Board Committees. Our evidence-informed practice ensures compliance with accreditation standards and Required Organizational Practices and we are preparing for Accreditation, which is scheduled for June 2019.

Continuing to leverage the shared decision making model within a Shared Governance Framework, has proven to be very successful in creating and supporting a truly engaged front line staff; resulting in clinical outcome excellence as well as advancing a culture of patient safety and quality of work life

In the driver of “OUR PATIENTS” – we are committed to improving patients’ quality of life through an evidence informed culture of quality and safety. We have made improvements in many of our quality & safety metrics. We continue to work on enhancement and connection of the patient experience and safety within our clinical operations and transition of the role of our PFAC from information sharing and consulting to more collaborative and advisory in nature. This is in alignment with the Patient’s First model of engagement.

HDGH is seen as a strong and trusted leader in partnership development in the community through the delivery of post-acute and community services with a focus on our patients. Our key initiatives for this year will be related to patient safety and supporting improvement across the healthcare system. Increased engagement activities supported by our expansion of real time survey strategies and expansion of Patient /Family representatives in an increasing number of key committees and quality improvement initiatives will provide a focus on patient voice in all quality improvement strategies and decisions. Our focus from a patient experience perspective will be on the discharge transition and improving the information our patients receive in insuring they feel they have enough information and support on discharge and are confident leaving our organization for their next phase in their recovery. We will be implementing patient surveying to all Mental Health & Addictions programs, as well as our outpatient Rehab areas through standardized tools. We will also focus on information transition from hospital to community so there is timely discharge summary information available in the community for patients follow up care. We will continue the excellent work around ALC and standardized discharge rounds and screening tools to support appropriate admissions with a focus on collaboration with patients /families and partners in alternate level care planning. We are also focusing on Medication Reconciliation on discharge for all inpatient and outpatient programs...

In the driver of “OUR PEOPLE” – we are committed to engaging, supporting and developing our people within a safe workplace. We are a leader in advancing the public conversation around staff injury as a result of violence at work. We are pioneers in having a robust and comprehensive Workplace Violence Prevention Policy firmly in place and supporting the commitment to a safe workplace with ongoing comprehensive education. This aligns well with our corporate focus and strategic priority on our People, their safety and well-being. Our 2019-20 QIP will focus on the Mandated QIP indicator from HQO related to tracking the number of incidents within the OH & S definitions. Our focus this year will continue on ensuring accurate collection of this data and interpretation of the definition to ensure consistent and standard tracking of incidents across the province. With a planned educational rollout and encouragement of reporting, we anticipate our incidents may increase and feel two years of collecting baseline data will improve our ability to provide accurate future target settings. We recognize that incidents do occur, however, our focus is to train staff and support a safety

oriented work environment in order to minimize the occurrence and severity of incidents. We are also focused on our people development through a robust performance management program, opportunities for learning for front line staff and continued leadership development. We are developing an “Awareness Keeps You Safe” video series around the types of workplace violence and looking towards an install of PAL technology solution in 2019-20. We have a commitment from our Board of Directors who have identified safety as a strategic priority. Our CEO is also an active member of the leadership table for the Provincial Committee for workplace violence.

Focus on our third strategic driver of “OUR IDENTITY” – so that those in need understand who we are, the services we provide and our vision for a healthier community. This is highlighted in our strategic plan in the area of research, innovation, partnership and ensuring that we are a learning organization. We will continue to strengthen and increase partnerships within our community that support the best care for our patients. Contributing to these endeavors will help to build upon our medical programs and services; thereby, strengthening our value to the patients and community that we serve. We have set strategic goals to be the cleanest and safest hospital in the province.

Our QIP, this year, will focus on Health Quality Ontario’s priority and mandatory indicators to improve efficiency across the system. We choose to focus on these priorities to support the system based approach communicated to hospitals, as well as consideration for the two major priorities impacting us this year.

The 2019- 20 QIP for the hospital is comprised of the following key improvement areas:

•*1. I**mprove Patient experience and satisfaction*** - we are aiming to improve responses to key patient experience indicators rating their satisfaction as “excellent “. We are one of the increasing numbers of Ontario hospitals who will focus on improving the “top box” score of “excellent “. Our goal is to improve this performance organization wide over the next 3-5 years. Our continued focus in 19-20 will be:

- *Overall Experience and Would you Recommend our Organization* – these two are important as they reflect the overall experience and help identify what areas of overall experience we may want to focus on at a high level . We will be targeting a 5-10% improvement in both these indicators monitored on our executive scorecard.
- *Coordination of Care* - Information at admission so patients know where they are going, what to expect and feel well-informed before they arrive. This will involve partnership with acute care and HDGH intake team as the majority of our admissions come from acute care facilities.
- *Improvement strategies on information at discharge* so patients feel informed and prepared to leave HDGH. This will be done with partnerships with community partners who largely impact our results.
- *Involving patients in care planning and decision making*

- *Overall treatment of Respect and Dignity* – this is in alignment with our values and our Quality Framework Patient values

2. Maintain provincial levels and continue a focus on sustainment of reduction in ALC days and facilitation of timely discharges through partnership with home care and community partners

3. Increase proportion of patients receiving medication reconciliation upon discharge- in both inpatient and outpatient settings. We will continue to work on all transition points in a patient's journey, including focus on improving patients understanding of medications and reducing medication risk factors involved in transitions and ensuring that medication reconciliation is completed.

4. Reduce employee related workplace violence incidents & injuries - we will continue to be a leader in Workplace Violence Prevention programming and invest in education and training for our staff as well as ensure robust and accurate reporting and encouragement of reporting.

5. Reduce the number of readmissions in mental health – we commit to evaluating readmission rates and continue full case by case reviews on readmissions within 30 days to our facility to ensure any gaps are identified in the system. Our focus will be on single point of contact for access to tertiary and ACT services. This includes improvements planned related to wait list management to facilitate access for clients that need ACT support to prevent acute care admissions

6. Improve information flow to community partners – with timely completion of discharge summaries sent or available from the hospital to primary or community partners within 48 hours of discharge...

7. Early identification of palliative care – Ensure those identified at risk of dying and in need of palliative services have a documented assessment of those need in hospital record using palliative best practice standards

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Hôtel-Dieu Grace Healthcare has two major organization priorities occurring this fiscal year that will impact our overall capacity and quality improvement planning. One is preparing for an organizational wide Accreditation scheduled to occur June 3-7th, 2019. Our organization has strategically used this opportunity to engage staff at all levels of organization. Through the education of twenty-five leaders /PFAC members in Accreditation Canada Tracer Methodology, we are conducting weekly facility-wide tracers and able to provide feedback on change ideas to contribute to rapid change cycle improvements. We will continue these monthly after accreditation to support ongoing improvement initiatives. We mindfully included two of our PFAC members to this team and they will be part of some of our tracers. PFAC members also are partners in collaboration on many of our accreditation teams to ensure the

voice of the patient is included in everything we do. This again, shows our strong commitment to fostering a shared responsibility for continuous quality improvement and a culture of safety with our patients/families. Everyone has a role in quality of care at HDGH.

The second major priority this fiscal year is preparing for a major Clinical Transformation and Regional planning, design, testing and training for deployment of a new Regional Health Information System. Our program, called e-Volve is the implementation of a fully integrated electronic program health information system Our project officially will launch on April 1, 2019 with a planned go live of spring 2020. This will equip our organization with modernized technology which will further enable the delivery of high quality and safe care to our patients and support provincial priorities to advance patient centred care through technology. The project vision statement is "to ***transform the delivery of safest quality care and an exceptional patient experience through an optimized provincial hospital information system***". This will involve significant human resources this fiscal year from our organization and represent a significant investment over a ten year period. Implementation of improvements such as electronic documentation, ability to share information seamlessly, improvements in transitions of care, CPOE and closed loop medication will all lead to many quality improvements across the organization and to our community partners through the transition to modern technology. This will assist in providing the platforms needed to continue movement towards critical provincial Digital Health Strategies

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

In 2018-19 we were successful in advancing and/or achieving targets for the majority of our indicators. The organization has demonstrated resilience and commitment to providing the best possible care to patients through deeply rooted processes that have continued to enable the organization to meet and in many cases exceed performance expectations. The board and leadership embrace challenge as an opportunity to review and further enhance the quality and safety platform. This shared commitment to quality and safety will be used to further strengthen and align processes to support recently announced healthcare restructuring changes and emerging digital innovations which focus on our patients and community.

Improvement in % of medication reconciliation's completed on admission was one of our greatest (QIP) quality improvement initiatives achievement in the past year. To improve medication reconciliation process we were able to secure commitment from senior leadership in having an organizational-wide focus on medication reconciliation by securing additional pharmacy resources to ensure compliance. Having an organizational focus and resources on medication reconciliation proved invaluable in our ability to make tremendous progress on the admission med rec process. Our starting performance was ranging from 30-40%, with target set for 95% and we are proud to report that we have consistently sustained 100% compliance. By incorporating pharmacy techs and pharmacists, related to collection of the Best Possible Medication History (BPMH), who are important collaborative partners in healthcare team, improved the accuracy and completion of the medication reconciliation process.

We have also focused on the next segment of the med rec process, the transfer/discharge med and the med rec process in our 16 outpatient clinic areas. We have employed value stream mapping to identify current state, identified gaps and ideal state. We developed a Standard Operating Procedure (SOP) to establish key role expectations, timelines, and standardize the work and templates to improve consistency of practice and improve quality of the information. A learning package has been established with plans for training and roll out will be progress

Some other key highlights supporting our Quality Improvement Plan:

- Overall Rating of Care – we had 10% improvement in overall rating of care in our real time survey results in past year
- 100% of complaints are responded to in 72 hours.
- Implementation in January 2019 of a new Admission Welcome Kit for patients based on real time survey results and input from patients. /families and PFAC as to what information is needed. The new kit is based on feedback and impact of new package is being evaluated.
- Implementation of benchmarking improvement project in Complex Continuing Care through dedicated implementation teams of front line staff
- Significant improvements in CMI (Case Mix Index) which supports accurate patient care documentation of CCRS (Complex Care Reporting System) data elements, education to staff and focused auditing and case reviews. This has resulted in increased from .99 in 17-18 to YTD 1.03 CMI. This also impacts funding for this program and ensures we are capturing true patient activity and care. This was through focused resources and education roll out to staff.
- Established an ALC avoidance framework assisted in achieving better than target ALC rates over this last fiscal year, 11.7% YTD which overall is below our target of 19.9 as well as the provincial levels for post-acute care of 14.5%. Intake guidelines were implemented reinforcing restorative model of care which has assisted in ALC avoidance.
- Improving Hand Hygiene Compliance and Reducing Hospital Acquired Infections (HAIs) has been an area of focus for many years at HDGH. Hand Hygiene Compliance – before contact continues to improve at 97% YTD compare to 93% YE last fiscal year (overall). Our HAI's has resulted in a decline and a > 20% improvement YTD. Our success is due to a multi-disciplinary approach and a combined implementation of multiple strategies to sustain performance. Some of the following strategies that has led to our sustainment and success:
    - "Secret Shopper" methods of obtaining hand hygiene audits
    - Training of all managers to the "Just Clean Your Hands" methodology to assist with hand hygiene audits
    - Establishment of process to ensure nursing students/volunteers receive training on hand hygiene, and 150 students have been trained this year.
    - CDI policy and order set updated to reflect best practice
    - Use of ATP technology by Environmental Service (ES) to measure environmental bio-burden has helped ES to focus in areas with high bio-burden as per ATP testing

    - Implementation of the use of Clorox 360, an electrostatic technology that helps deliver disinfectants and sanitizers onto hard-to-reach surfaces
    - Ongoing education and positive reinforcement to staff, patients and families on the importance of hand hygiene.
- Sustaining Infection Control Practices is the key to keep our patients safe and reduce the spread of infections, our hospital has not experienced any HAI outbreaks over the past year. Our IPAC and ES team received acclaim from Public Health Ontario for its collaborative working relationship in reducing HAIs, and working together to be the Cleanest Hospital in Ontario
- Implementation of Wound Champion Program
- Implementation of naloxone strategy in collaboration with Windsor Essex County Health Unit for access to naloxone, policy development, training strategy and roll out across the organization, .This includes distributing kits to those who report opioid use. HDGH has distributed over 60 kits to patients this year.
- Best Practice submission to Accreditation Canada for “Workplace Violence prevention “and “Quality Improvement Advocate Program and Quality Improvement Advocates /real time admission and discharge surveying.
- Focus on readmission review in Mental Health and improvement strategies started on central access, home supports (ACT /Outreach programs) to support post discharge needs so patients do not attend ER /acute care. In the past year (YTD), there have been only two cases of readmission (3%) compared to nine in last fiscal and thirty cases in 2014/15.
- One of our MH & A program’s most innovative projects this year has been around our effort toward the adoption of a standardized, evidence based addiction screening assessment and referral process for Windsor –Essex. . We have built capacity within the community on the short screener and engaged leaders across diverse settings. The short screener is the first component of the GAIN assessment that screens the person to see if they have an addiction issue versus MH issue etc. HDGH collaborated with CAMH to rollout training for relevant community partners to utilize the screening tool. The purpose of this to ensure appropriateness of referral to Assessment/Referral, especially in our community where addiction resources are so scarce. We want to ensure those who are being referred truly have an addiction issue. We have received overwhelming positive feedback from community partners on this. Another example of positive change was from House of Sophrosyne – they provided us with an example where they used the screener and through this it changed where they referred. In this case they referred someone to TSC instead of Assessment Referral. This is exactly the results we were looking for. Also more longer term, by building capacity on the screener, we can decrease the time required to refer to other forms of addiction treatment. Creating a responsive system with timely access is key for addictions. This strategy will be presented by HDGH /CMHA in May at the Addictions and mental Health Annual Conference(AMHO)as this is considered a new leading best practice
- Operational review completed by Jill Mustin Powell on Withdrawal Management Services (WMS) with 80% of recommendations implemented in past year – remaining recommendations will occur over the next two years.
- Expansion of Transitional Stability Centre (TSC) and increased partnership with CMHA

- Key improvements in clinical performance monitoring and communication of performance results with revised scorecards and alignment of key monitoring of metrics and action plans. Patient Safety boards on the units for the public will be implemented in March 2019.
- Mapping of all key work flows and optimization planning across the organization in preparation of moving to regional electronic health information system
- Development of Quality Matters, People Matters & Identify Matters communication to public
- Development of Quality Matters Quarterly Infographic to highlight key quality achievements and improvement initiatives for each quarter
- CNE job shadowing project to increase visibility at unit level for staff and to assess staffing impact on patient care. Allowed direct contact with patients on feedback on quality of their care, and opportunity for staff to discuss any concerns/challenges. This assisted in sharing their best practices/learnings and process improvements. This will be extended to Rehab and TNI in this fiscal year. This resulted in progressing work on standardization of job roles of the charge nurse and unit clerk so that unit clerks can assist with acknowledging call bells and flagging calls to staff. A call bell project was initiated from this review.
- Collaboration with acute care and HDGH on a standardized communication patient transfer tool to capture key patient information with goal of improving patient handoffs. Staff education on utilization of tool was completed and rolled out throughout both organizations. An escalation process at both organizations was also implemented. We have established quarterly meetings between organizations to discuss process improvements, develop action plans and share any learnings.

Quality care is an on-going strategic goal of our Board of Trustees and Senior Management team. As an organization we value continuous quality improvement and acknowledge that quality care is the responsibility of all employees, physician's and volunteers in collaboration with our patients/families. It is our organization's expectation that all leaders are accountable in remaining committed to seeking ways to improve patient safety, patient programs and the overall quality of care and service provided at Hôtel-Dieu Grace Healthcare.

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Patient/client/resident partnering and relations

Patient feedback from comments and responses to surveys continues to guide our targeted quality improvement initiatives and projects. Implementation of our pilot Quality Improvement Advocate positions and real time personal connection with new admissions and real time survey process in house has proved extremely beneficial to selecting and moving forward with timely, patient-centred improvement projects. Our unique model includes Quality Improvement Advocates, who are retired nurses personally greeting a high % of our new admissions to organization (currently 62%). Through that greeting and discussion on their transition from acute care to our organization, we have specific questions that we ask to glean transition and admission experience information and how they were treated. We have recently expanded this

project to include our PFAC members completing a random check-in with patients/families on monthly basis. This is another lens into really understanding what our patients are experiencing and how can we take that feedback and change their experience in a positive way. In having a former patient/family member from PFAC interview /survey our patients, our patients are reacting very positive to this model and love that they can talk to someone that was a patient, just like they are. We have submitted this new initiative as a Best Practice Submission to Accreditation Canada and presented at the International Patient Symposium held in Windsor this year. Please see our video on this amazing pilot project – we are so proud of our Quality Improvement Advocates and our PFAC members. We plan to expand the number of PFAC members conducting check in real time face to face surveys with fellow patients over the next year. To learn more, visit: https://www.youtube.com/watch?v=Jo1ikws3-qA&feature=youtu.be

The hospital's Patient and Family Advisory Council is now well established, and has contributed to a new Declaration of Values for patients and staff and provided consultation and collaboration on content and considerations on all the new material for the Welcome Package. The hospital is committed to recognizing patients and families as members of the care team, and to engaging with them in all aspects of the patient journey, from provision of direct care to system planning. Staff are becoming more comfortable with doing things with patients and families rather than to them. Our experience scores related to feeling involved as much as they would like to be in planning and decisions on cares has increased by >30% positive and responded definitely Yes.

Plans are moving forward to add Patient Advisors to key hospital committees such as Quality and Ethics. We have a PFAC member on the Quality Board and Board of Directors in addition to numerous committees within the hospital. They often attend some Unit Based Council meetings and connect with front line staff. They will be participating on specific departmental work, such as equipment selection and the user experience. They also have a special "seal of approval" that is used on any brochures or information provide to patient/families which indicates that they have reviewed the material and contributed to the content with "patient eyes".

PATIENT & FAMILY ADVISORY COUNCIL

Review of the hospitals Quality Improvement Plan and patient experience survey results have become a standing Agenda item at Patient and Family Advisory Council meetings. The Council was also involved in the development of the hospital's Quality Improvement Plan through a review of patient experience results for the year and discussion on each QIP indicator from a patients view lens. This advisory information is then shared with the QIP leads so they include this in all Action Plans and change plans. We also collate the patient experience feedback from both NRC and Real time survey's and these are always included in improvement planning and we find opportunities to link metrics in the survey's to the quality improvement projects we are working on or to identify opportunities that are most important to our patients. The quality improvement idea of having members of our PFAC survey/interview patients came from one of our PFAC members. They also developed the three key questions they wanted to ask the patients. Our member felt that connecting with current patients would help them glean even

more information on things important to patients as some of our members may have not been a patient or family member at HDGH for a few years. They felt this was a great way to connect directly with current patients and bring that back to the full PFAC team. It would also give them direct visibility to what patients were feeling and enable them to ask what they would want to improve most.

The hospital remains committed to ensuring that the patient voice remains strong. Expanding on opportunities to further improve patient care and service delivery from the patient and family perspective is now embedded in our daily practices

Workplace Violence Prevention

It is well documented that Healthcare workers are at high risk of injury due to aggression and for this reason; the Minister of Health and the Minister of Labour created provincial committees to study what else can be done by organizations to reduce/eliminate these injuries in the future. The CEO and CHRO of HDGH, continue to be involved in the provincial work. In addition, HDGH has pursued a strategic partnership with the Ontario Nurse's Association that has culminated in joint site visits to other employers seeking best practices as well as a joint media event to highlight the leading workplace violence prevention practices HDGH has implemented. HDGH is a leader in development of Workplace Violence Policies and Procedures and Staff Safety is a key strategic goal under our Driver of "Our People". In fact, our Strategic Plan has identified our goal of being the "Safest Hospital in Ontario". To that end, we have added an FTE to our Health and Safety Team whose primary responsibility will be to audit our initiatives to ensure compliance among our staff and leadership team. Our goal is to prevent incidents and injuries due to violence through various initiatives and processes. In particular, by implementing mandatory non-violent crisis intervention training programs that are refreshed annually and de-briefing each and every incident to analyze root causes and put measures in place to reduce the likelihood of a similar injury occurring again. We will continue to monitor through our Executive Scorecard, our HDGH custom indicator related to injuries against incidents. The mandated Workplace Violence indicator related to total incidents will continue on our QIP this year, as in accordance with the OH & S definition.

We have established the Workplace Violence Prevention Committee and have established regular monthly reports and metrics for this committee to monitor. In addition, we have partnered with both ONA and PSHSA to update and introduce the VARB tools into our workplace, including the chart flagging process and tool. A small working group of key personnel are actively working on the establishment of a chart-flagging policy and process – this is a complex project given our unique inpatient, outpatient and off-site programs. We will conduct a refreshed violence risk assessment in 2020 using the PSHSA online tool. A broad communications plan is currently rolling out that will include on-line and poster publication to educate our staff, patients and public that we have zero tolerance for violence, aggression or disrespect of health care workers and to encourage employees to report incidents of violence or aggression. In addition, we have initiated the creation of a four part series of videos for use in educating our staff called "Awareness keeps you Safe" – the first is Lockdown/Active Shooter and this has been completed. Next year we will complete three more – Patient/Family Violence, Worker to Worker Violence and Domestic Violence.

As for metrics on the mandatory indicator, we can report the total number of incidents that meet the OHSA definition of violence. We are in the process of tracking these in RL6 via safety/security incidents and cross checked against the data that our Safe Workplace Advocate maintains in RL6 as well to ensure accuracy and standardization of reporting. When we have at least two years of data, we will set a target and this target may actually be an increase due to the significant effort being made to raise staff awareness of workplace violence prevention and encouraging staff to report all incidents of violence. Our primary messages to staff are “Violence is Not Part of the Job” and “It Hurts to be Quiet”.

Executive Compensation

In 2014, the Province began the process of developing public sector compensation frameworks to manage executive compensation in the BPS. The Broader Public Sector Executive Compensation Act of 2014 (BPSECA) authorized the government to establish frameworks, and set out principles that all designated employers must follow. These included ensuring that there is a consistent and evidence-based approach to setting compensation, ensuring that there is a balance between managing compensation costs while allowing employers to attract and retain the talent they seek, and ensuring that there is transparency in how executive compensation decisions are made.

Following consultation with multiple stakeholders in the BPS, in 2016 the Province introduced Ontario Regulation 304/16 in support of the BPSECA, effective September 6, 2016. This Regulation lays out the details and implementation timelines for executive compensation for all employers within the BPS.

The Regulation states that all BPS employers must have a compensation framework in place for designated executives. The framework must be compliant with the Regulation, and have been available for community feedback for a thirty-day period.

The requirements of the BPSECA and Ontario Regulation 304/16 have been considered, and the Policy developed to ensure that HDGH is compliant with the requirements. The HDGH Compensation plan was approved by the Ministry of Health in February 2018.

Positions included:
The following positions at HDGH are included in the Performance-based compensation plan as described herein:

- President & Chief Executive Officer;
- Vice President, Medical Affairs;
- Vice President, Clinical Programs;
- Vice President, Corporate Services, Business Development & Chief Financial Officer;
- Vice President, External Affairs & Executive Director, Foundation; and
- Chief Human Resources Officer

Each of the above named executive’s compensation is linked to the achievement of specified performance targets which are reflected in the annual Quality Improvement Plan (QIP).

Achievement of performance targets is evaluated annually the period of April 1- March 31of the given year to determine executive compensation. All the executives are evaluated against the same performance indicators and targets.

The performance indicators are selected as follows:

- ALC Rate - % of patients who are ALC (all inpatients)
- Improve information flow to primary care with timely discharge summaries sent from hospital to community
- “Did you receive enough information on discharge?” – percent excellent score
- Medication reconciliation on discharge – The total number of patients with medications reconciled as a proportion of the total number of patients discharged from Hospital.
- Readmission Rate for Mental Health

Each indicator is weighted equally (20% each).
If less than 50% of the target is achieved, no P4P is paid.
If more than 50% of the target is achieved, that percent of the P4P is paid out (for example, if a target is 60% achieved, then 60% of the P4P for that indicator would be paid out.

Note 1: The mandatory violence indicator was not chosen because HDGH continues to collect baseline data. There is a significant education roll out occurring on “reporting” and increasing reporting and we will establish two years of data to establish baseline and ensure alignment of capture of incidents data.
Note 2: We did not include palliative indicator as we are collecting baseline data in 19-20 on this new priority indicator.