HÔTEL-DIEU GRACE HEALTHCARE

HDGH Board of Directors Meeting

4:30PM

March 20, 2024

1453 Prince Road, East Wing Admin Boardroom (2nd Floor EW-2312)

Windsor, N9C3Z4

HÔTEL-DIEU GRACE HEALTHCARE

March 20, 2024 HDGH Board of Directors Meeting

Agenda

4:45PM	**1.0 Call to order**		K. Blanchette
	1.1 Land Acknowledgement and Prayer/Reflection - 4		K. Blanchette
	1.2 Confirmation of Quorum		K. Blanchette
	1.3 Declaration of Conflict of Interest/Duty		K. Blanchette
4:50PM	**2.0 Board Education; Schizophrenia Demonstration Project**	Information	Dr. A. Steen
	(i) Schizophrenia Demo Project - presentation - 5		
4:55PM	**3.0 Consent Agenda** Motion: to approve the Consent Agenda for the March 20, 2024 HDGH Board of Directors Meeting, consisting of the recommendations and reports	Approval	K. Blanchette
	3.1 Items for Approval		
	3.1.1. Agenda; March 20, 2024		
	3.1.2 Minutes of Previous Meeting; January 24, 2024 - 10		
	3.2 Items to be Received		
	3.2.1. Chief Nursing Executive Report - 13		
	4.0 Board Decisions/Oversight		
5:00PM	4.1 Schulich School of Medicine and Dentistry	Information	Dr. Larry Jacobs
5:10PM	4.2 Quality Committee Recommendations		
	(i) 2024/2025 Quality Improvement Plan (QIP) Suggested Motion: THAT the 2024/2025 Quality Improvement Plan (QIP) be approved as presented.	Approval	Dr. A. Steen
	- HDGH 2024/2025 QIP Narrative - 15		
	- HDGH 2024/2025 QIP Workplan - 25		
	- HDGH 2024/2025 QIP Progress Report - 42		
5:20PM	4.3 Appointment of Dr. Priya Sharma President of Professional Staff Association - 53 Suggested Motion: THAT the Board of Directors appoint Dr. Priya Sharma, President of Professional Staff Association, as ex-officio to the Board of Directors for a one (1) year term 2024/2025, as recommended by the Medical Advisory Committee.	Approval	Dr. A. Steen
	5.0 Executive Highlights		
5:25PM	5.1 Chief of Staff Report	Information	Dr. A. Steen
5:30PM	5.2 President and Chief Executive Officer Report	Information	Bill Marra
5:35PM	5.3 Board Chair Report	Information	K. Blanchette
5:40PM	**6.0 Adjournment** Next Meeting: May 22, 2024		K. Blanchette

5:40PM- 5:50PM	Break and Media Questions

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Land Acknowledgement

We would like to acknowledge that we are meeting in the traditional territory of the Three Fires Confederacy of First Nations, which includes the Anishinaabe (Ah-nish-in-ah-bay), the Odawa (O-da-wa), and the Potawatomie (Pon-A-Wata-Me). people.

We also acknowledge that many Indigenous people crossed this area in their travels due to the surrounding waterways.

Prayer

Enlighten each one of us as we are called to help and to serve those around us,
May our decisions and actions bring forth justice and healing.
May we embrace those around us with the same tenderness that we ourselves require,
We pray for God's supportive love, wisdom and peace in all that we do.
Amen

HDGH BOARD OF DIRECTORS PRESENTATION

MARCH 2024

SCHIZOPHRENIA DEMONSTRATION PROJECT

MHCC Partnership and Goals

- Project Purpose:
  - The Mental Health Commission of Canada (MHCC) and Ontario Shores will collaborate on the Schizophrenia Quality Standards Project to improve the delivery of care to adults living with Schizophrenia.
  - 4 healthcare organizations (demonstration sites) will be selected and supported to implement quality standards of care, share evidence-based approaches in the treatment of Schizophrenia, and provide coaching, education, and training.

- Project Objectives:
  - Coach, train and educate interprofessional teams at selected sites to implement Schizophrenia Quality Standards as defined by Health Quality Ontario (HQO).
  - Improve patient outcomes and quality of life for those living with Schizophrenia.
  - Advance Schizophrenia treatment in Canada by promoting consistency in treatment of care.
  - Reduce variability of care in treatment practices for schizophrenia.
  - Measure and evaluate project outcomes at each site.
  - Develop a customized and regional approach for each demonstration site.
  - Gather anonymized data and key learning throughout the project that can be used to create future programs, national education opportunities, toolkits, and materials.

Schizophrenia Quality Standards Statements

- Purpose of Quality Statements:
  - To inform clinicians, patients and families of what they should expect of quality care
  - To provide the best care based on available evidence
  - To reduce variability in practice

- The four Schizophrenia Quality Statements for Implementation:
  - Percentage of adults with a primary diagnosis of schizophrenia who **receive** a long-acting injectable antipsychotic medication
  - Percentage of adults with a primary diagnosis of schizophrenia whose symptoms have not responded to adequate trials of treatment with at least two different antipsychotic medications and who **receive** clozapine
  - Percentage of adults with schizophrenia who are screened and/or received cognitive behavioural therapy for psychosis
  - Percentage of adults with a primary diagnosis of schizophrenia who are screened and/or receive family intervention therapy

Implementation at HGDH/CMHA

- Quality Statements are being implemented within the following programs:
  - Hotel-Dieu Grace Healthcare:
    - Toldo Neurobehavioural Institute (TNI) – 3 inpatient units
    - Assertive Community Treatment Programs – 2 teams
    - Wellness Program for Extended Psychosis (W-PEP)
  - CMHA Windsor-Essex:
    - Early Intervention Program

Patient and Family Engagement

- Suggestions for patient and family engagement:
  - Information Sharing about the project
  - Patient and Family Council meetings
  - Inclusion of patients and family members at kick-off planning events
  - Inclusion of patients and family members on Steering Committees and Working Groups
  - Inclusion of patients and family members with the review of documentation templates and communications materials

- Discussion / Questions?

Directors Present

K. Blanchette, Chair, P. Soulliere, Vice Chair, B. Payne, Past Chair, K. Bortolin, J. Clark, A. Daher, C. Gallant, M. Galvin, L. Haugh, C. Stan, D. Wellington, M. Winterton

Directors Absent

Ex-Officio Present

B. Masotti, Patient Family Advisory Rep., J. Topliffe, Patient Family Advisory Rep., F. Bagatto, CHI Director, L. Lombardo, CHI Director , J. Dawson, Chief Nursing Executive B. Marra, Chief Executive Officer, Dr. A. Steen, Chief of Staff, Dr. R. Sommerdyk, Pres. Prof. Staff. Assoc.

Ex-Officio Absent

Administration Present

C. Kondratowicz (Recording Secretary), S. Laframboise, S. McGeen

Guests

Various Media

1.0 Call to Order

The Board Chair called the meeting to order at 4:35PM.

1.1 Land Acknowledgement & Prayer/Reflection
The Chair read the land acknowledgement followed by the HDGH prayer.

1.2 Confirmation of Quorum
Confirmed.

1.3 Declaration of Conflict of Interest/Duty
None.

2.0 Board Education

None.

3.0 Consent Agenda

The Chair asked if anyone wished to remove anything from the Consent agenda to the full agenda for discussion.

3.1 Items for Approval
- 3.1.1 Agenda; January 24, 2024
- 3.1.2 Minutes of the Previous Meetings; November 22, 2023
- 3.1.3 Finance & Audit Committee Recommendations
  - i. 2023/2024 Financial Statements – up to December 31, 2023
- 3.1.4 Governance Committee Recommendations
  - i. Ethics Framework

Upon motion duly made, seconded, and unanimously carried, the January 24, 2023 Consent Agenda, consisting of the recommendations and reports be approved as presented.

4.0 Board Decisions/Oversight

4.1 President of Professional Staff Association Report

Dr. Ramona Sommerdyk spoke to the written report included in the meeting package and spoke briefly to the Board thanking them for their commitment to HDGH. Acknowledgement was also provided to the staff and organization for all the work in these challenging past few months.

5.0 Executive Highlights

5.1 Chief of Staff Report

Dr. A. Steen provided a verbal report highlighting the following:

- Extending sincere gratitude on behalf of the Professional Staff to the physicians for all their work during the code grey.
- Appreciation was extended to Dr. Sommerdyk for all her work and teachings during this challenging time. Dr. Sommerdyk will be taking a leave of absence for the upcoming year.
- Cerner is back online and physician work is moving back to a more normal process. The flow of information from acute to HDGH is being received once again.
- HDGH in partnership with Canadian Mental Health Association (CMHA) have been chosen to participate in an 18-month schizophrenia demonstration project to help expand the implementation of Ontario Health's schizophrenia quality standards. The project launched by the Mental Health Commission of Canada (MHCC) and Ontario Shores Centre for Mental Health Sciences have only selected four regions to participate in the project. HDGH is very excited and proud to be one of the four sites chosen. Staff will receive the tools and training from MHCC and Ontario Shores. Within Windsor-Essex, four pillars will be offered including injection-based medication, alternate medication for those who are treatment resistant, cognitive behavioural therapy for psychosis, and family therapy. These pillars will be used to track data to help determine if the treatment options improve the quality of life and longevity of life for those living with schizophrenia.

5.2 President and Chief Executive Officer Report

B. Marra provided a verbal report highlighting the following:

- Schizophrenia project – it's an honour and privilege to be chosen as one of the four sites to participate in this project. The work will change lives, improve quality of life and save lives.

<u>Cyber Attack Restoration Update</u>

- Reminder of the pending litigation and ongoing work with law enforcement and insurance.
- The teams at TSSO, iSecurity, and hospitals are working diligently to restore the systems to pre October 23, 2023.
- Daily site lead meetings continue to be held as well as regional calls as needed.
- Gratitude extended to our patient and families for their understanding and patience during this time. As well, to staff, physicians and volunteers for their continued support and understanding.
- December 11th our medical records went live; this is an important milestone.
- Important to note that no programs or services were closed during the incident.
- Downtime procedures and Code Grey worked well. Will revisit the Code Grey and lessons learned following the investigation.
- A fulsome report will be provided to the Board, Community and Staff at a later date.

5.3 Board Chair Report
K. Blanchette did not have a report out to the Board.

6.0 Date of Next Meeting
March 27, 2024

7.0 Adjournment
The Board Chair adjourned the open meeting at 4:57PM.

Bill Marra, Secretary

Ken Blanchette, Board Chair

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CNE Report for Board of Directors Meeting

☐FOR DECISION ☐FOR ACTION X FOR INFORMATION ☐FOR TRACKING

Date: March 20, 2024

Author: T. Caston on behalf of Janice Dawson, VP Restorative Care, CNE

Subject: CNE Report

In 2024, the official first day of spring is Tuesday, March 19, and in alignment with the season, we as an organization spring forward and continue to move towards the goals of our Strategic Plan and its thirteen initiatives. With a clear focus on refining programs and services, leadership and staff development and overall improving the quality of care we delivers, some of the clinical work being carried out is as follows:

Monthly Nursing Education

As part of our Strategic Initiative on "Staff Development", we have been working on providing monthly educational offerings for our staff. These monthly sessions can vary according to educational needs or trends that our Clinical Practice Managers identify through observation and staff feedback on the patient care areas. Attendance is voluntary; however, participants are awarded a certificate of attendance that is placed in their personnel file as part of their professional development plan. All sessions are recorded and saved so that we can utilize them for future orientation of new staff, as well as for any staff who may benefit from viewing the session as part of a learning plan or for their own professional growth.

We are currently utilizing subject matter experts from within our organization to provide this education and training.

To date we have held two education sessions:

- "Palliative Medicine Primer: Top Tips and Myths" by Dr. Nicole Freeman MD and co facilitated by Jennifer Taylor Clinical Practice Manager
- "Positively Inspirational" a review of Respiratory Assessments and case studies by Navjot Virdi one of our Respiratory Therapists and Lindsay Samoila Clinical Practice Manager

Upcoming sessions include:

- "Don't Get Tripped up over Falls" Falls and Neurological Assessment Education by Navdeep Sidhu, Regional Critical Care Educator WRH, Meghan Goodfellow Clinical Practice Manger, Danielle Caille Clinical Practice Manager and Sonya Vani CPM/Ops Allied Health.
- "Wound and Ostomy Care" education session: Lisa Ballah NSWOC and Devon Wargo Wound Care Practitioner.

Of note in the Mental Health and Addictions program, the residents have presented and recorded education for nursing staff and have built a digital library of relevant education (mostly for nursing). Coordinated by Patrick Kolowicz, Director and facilitated by psychiatry, these education sessions are offered to the community. Typically, 5-6 sessions are held annually.

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Model of Care – Rehab and TNI

In alignment with our Strategic Initiative “Optimizing Resources to Patient Outcomes”, and with Hôtel-Dieu Grace Healthcare's (HDGH) ongoing commitment to optimizing care delivery, a comprehensive review and update of care models across all inpatient units was initiated in early 2022 beginning with its Complex Medical Care (CMC) units. Reviewing and implementing new care models aim to develop a resilient health workforce, maximizing skills and expertise through tailored support and training to enhance patient care. Over the last 6 months staff, professional staff, patient and family engagement has been a focus of the TNI transformation project. Rehab staff engagement recently began a few weeks ago. In addition, TNI leadership visited other mental health facilities to look at best practice in delivering mental health care and the rehab team completed a rehab benchmarking exercise with four leading peer hospitals in Ontario to help inform inpatient rehab staffing decisions, ensuring alignment with best practices in nursing and allied health professions. Both efforts resulted in findings where we need to augment other health care provider roles that best meet the care needs of our patients. In both areas, augmenting allied health roles and other support roles aims to improve patient outcomes by leveraging healthcare team expertise and resources, tailored to our unique patient population as a specialty hospital.

Next steps will be to inform union leaders and staff of upcoming changes March 19, 2024. (By the time this report is received at the BOD meeting March 20, 2024, this will have taken place).

Patient Access and Flow and Transitions

In closing, an update on the Strategic Initiative “Patient Transitions and Navigation” focuses on maintaining efficient flow (right patient, right bed, right time), maintain >95% occupancy, reduce ALC rate while improving ALC throughput.

Initiatives underway include: analysis of internal transfers, identify transitional gaps, improve patient experience and communication as well as work with Decision Support and TSSO towards electronic ALC data entry.

Respectfully submitted by:
Janice Dawson, VP Restorative Care and CNE

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 14, 2024

HÔTEL-DIEU GRACE HEALTHCARE

Ontario Health

OVERVIEW

We are pleased to share our 24/25 Quality Improvement Plan (QIP) with our clients, patients, residents, caregivers, staff, physicians, volunteers and members of the community .

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 patient-centered 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.

This plan is in support of the Ontario Health system directions, with a focus on effective and timely transitions, Equity education, patient centred priorities and Effective Safe practice. Our hospital work plan includes a continuation of goals for transitions and access to care, medication reconciliation, workplace violence, equity education and patient experience across programs . Some of our major program changes over the coming year involve a best practice reviews and model of care changes in our in our TNI (Mental Health Inpatient) and Inpatient Rehabilitation Programs, as well as Wellness Program , and the opening of our new Outpatient Rehabilitation Area. We will also be starting the first year (Year 1)Implementation and Operating plan for our new strategic plan. We will continue our recovery post Cyber event, which will last the

majority of this calendar year. We will continue development and support of our Windsor Essex Ontario Health Team development, our partnerships with our community as continued focus on being a respected partner and leader, providing the services our residents in Windsor - Essex require.

Hôtel-Dieu Grace Healthcare (HDGH), Windsor's only specialty hospital, is proud to announce our most important achievement this year in that we have successfully been Accredited with Exemplary Standing, the highest designation with Accreditation Canada. During our June 2023 on-site survey, HDGH met 100% of the Required Organizational Practices as well as 98.99% of Accreditation Canada standards, the criteria and guidelines required to provide high-quality care and service.

The Accreditation report highlighted the work that HDGH has done in a number of areas but identified the following as true strengths of the organization:

- Patient and Family Advisory Councils and Patient and Family Advisors
- Patient Experience Framework
- Unit Based Councils
- Strategic Plan 2023 – 2028 engagement
- Board of Directors engagement and high performing
- Designated/Essential Care Partner program HSO Leading Practice Award
- Centre of Excellence in Mental Health and Addictions
- Community Partnerships

"This award designation is the result of our collective commitment and efforts," said Bill Marra, President and CEO. "Despite the challenges and hurdles faced throughout the past four years since our last survey, our organization has stayed true to the mission and values of HDGH, the high-quality care we have become known for, and the partner our community relies on. We are proud to continue this important work and uphold this level of care each day."

In addition to being awarded the highest status by Accreditation Canada, HDGH was awarded with a Health Service Organization Leading Practice Award for our Essential/Designated Care Partner program which paved the way for supporting family visitation during the COVID-19 Pandemic and now supports families in providing hands-on care for their loved ones in hospital. Learn more about this program by visiting the HSO website.

HDGH proudly dons this designation from Accreditation Canada and strives to continually improve the quality of our programs and services.

ACCESS AND FLOW

HDGH believes in continuous improvement and quality initiatives to improve patient experience and to involve patients and families in their care plan. HDGH is an important partner in supporting regional access and flow. To better support transitions and prompted by the

release of Ontario Health Quality Statements for Transitions, a deep dive was done into identifying gaps in our patients' journey and how we can best support a more transparent and seamless transition to HDGH and back to community.
By analyzing data and our patient and family experience surveys as well as speaking with PFAC and our Inpatient Clinical teams, it revealed that there is a need to improve patient preparation and understanding of the HDGH inpatient experience- and to better prepare patients for discharge to community. Coordinated and transparent transitions into HDGH and out to community will benefit our patients, families and care teams allowing for informed decision making, early identification of barriers, concerns re: inpatient and post discharge care. Early preparation and understanding builds relationships and trust.
On July 2023, Ontario Health issued "Operational Direction Rehabilitation and Complex Continuing Care Capacity and Flow" directives. These directives include but are not limited to maintaining occupancy rate of >95%, 7 day per week admissions, expanded hours of admission, proactive surge strategies, and performing ALC (Alternate Level of Care) Leading Practices.
Over the next year, HDGH's focus to support Patient Navigation and Flow includes efforts to:
• Ensure Patients in right bed at the right time and that the appropriate services are in place to maximize patient outcomes/efficient use of resources
• Maintain >95% Occupancy
• Improve Patient Experience and Navigation (Pre-Admission & Post Discharge) to optimize Care Pathway. Positive outcomes would include decreased ER visits, decreased Length of stay and increased ALC throughput.
• Align with provincial sfCare (Senior Friendly Care) Clinical ALC Leading Practices Guidelines

We recognize that individuals with mental health and addictions (MHA) have inequities in accessing care related to stigma, but that these same individuals can also create significant burden on key services such as emergency room (ER) visits. HDGH is working with Ontario Health and partners to pursue innovative programs that create alternative care options to ERs, that simultaneously respect the specialization required within MHA. Recognizing that withdrawal management services (WMS) can also be natural access point and an alternative to ER use, HDGH advocated for funding and subsequently improved the capacity of WMS through the intensive bed project. HDGH has plans to expand the ECT program by offering rTMS as part of a larger strategy to offer new services, and more broadly to improve access to neuromodulation therapy. Within our inpatient mental health program, HDGH is implementing the TNI Transformation to better align care with the best available evidence, improve efficiency and outcomes.

EQUITY AND INDIGENOUS HEALTH

HDGH has strengthened our Equity, Diversity, Inclusion and Indigeneity work over the 23-24 QIP. Specifically, HDGH has grown our EDII Alliance, comprised of over 20 staff, patients, and family advisors, as well as Board members. In June of 2024, HDGH launched a new Strategic Plan that identified 12 initiatives, two of those initiatives are directly related to Equity and Indigenous Health – “Embedding an Equity, Diversity and Inclusion Framework” and “Addressing Truth and Reconciliation Calls to Action for Health.” Members of the EDII Alliance, alongside the EDI Portfolio which includes the Director of Communications and Mission and the newly created position of the Manager of EDI, have developed a draft work plan that will drive the EDII work . Most recently, HDGH hired for the position of Indigenous Peer Support Worker, who primarily provides support to clients in the Withdrawal Management program, with a portion of the role supporting Indigenous clients/patients throughout HDGH. Members of Senior Management Council will also complete mandatory EDII training in 24/25.

PATIENT/CLIENT/RESIDENT EXPERIENCE

The Patient and Advisory Committee (PFAC) developed a work plan to focus on improving the patient and family experience. PFAC plans to redesign the patient whiteboard by engaging with patients, families and staff. PFAC is looking at evolving our Essential Care Partner (ECP) program to identify where we could strengthen our partnership with patients and families. To ensure the patient and family perspectives are captured, PFAC members will be involved with various hospital committees. PFAC members are reviewing opportunities to raise additional resources for the Benevolent Fund. This fund is for patient’s that are in need of support due to a financial hardship and/or unforeseen circumstance.

The Regional Children Centre (RCC) Family Engagement Council is assisting with lead agency by providing feedback on the WeConnectKids website and children mental health multiyear plan. The website is user-friendly for community members to find information about our local children's mental health services. Members are working with RCC on ways to better engage with families when they start services. Some committee members will be participating in Parent/Caregiver Program Design sessions to redesign our community parenting classes.
RCC Kids in Partnership (KiP) having been working on KiP Child Engagement tool kit, a child-friendly satisfaction survey and a "What Stuck Wall". The engagement tool is being used and shared with other agencies. The satisfaction survey are ones the KiP members felt are most important to measure children's experiences at RCC. The "What Stuck Wall" will be put up in the lobbies at ITS and Huot building.

The Mental Health and Addictions (MHA) PFAC members had the opportunity to provide feedback regarding the implementation of the national demonstration project: Improving Care and Treatment for People in Canada Living with Schizophrenia. The Mental Health Commission of Canada (MHCC) and Ontario Shores Centre for Mental Health Sciences (Ontario Shores) are partnered with Hotel-Dieu Grace Healthcare (HDGH) and Canadian Mental Health Association Windsor Essex Branch (CMHA-WECB) (organization) to focus on this initiative. A grant application for part of the Substance Use and Addictions Program (SUAP) 2023 Call for Proposals was co-designed with a MHA PFAC member.
A previous co-designed PFAC research project and conference

supporting Caregivers was formally published in Science Direct/Elsevier: Caring for the caregiver: An exploration of the experiences of caregivers of adults with mental illness - ScienceDirect. The resources from our conference have also been adopted on our local OHT website: https://www.weoht.ca/resources/caregiver-resources/

Patient experience survey data and feedback is provided to all programs, PFAC and senior leadership tables. These are used in the development of quality initiatives at the unit and program levels and also leveraged when setting annual Quality , Patient Safety Plans and guides strategic planning processes and actions. The PFAC's and Patient Voice is at the center of our Quality Committee Structure.

PROVIDER EXPERIENCE

There continue to be significant health human resources challenges post-pandemic including recruitment and retention, increases in sick time and professional practice support. Innovation has been a theme throughout many human resources initiatives including:

Introduction of Weekend Workers for PSWs and Exploration of Weekend Workers for RN & RPN classifications

Expansion of our Nursing Float Team – RN & RPN

Clinical Scholar Program and Mentorship Days for New RNs & RPNs

Nursing Extern Program

Scheduling Survey with nursing frontline staff (explore potential for extended tours)

Re-booting of Attendance Support Program

Purchase of staff call-in software

HR recruitment practices have been adjusted to include proactive recruitment for classifications that are challenging to attract and retain; booking interviews with each new RN applicant upon receipt of application and interviews conducted within 30 days or less; streamlining of orientation to ensure flexibility in hiring; introductions of electronic processes for postings and tracking of positions.

We continue to review models of care in all areas and have done extensive work with our Inpatient Mental Health team to gain feedback from staff to inform our Transformation Plan.

There continues to be tremendous work to support and engage staff:

Wellness Committee “Beat the Winter Blues Fest” chili/soup lunch with fellowship, games, popcorn corn and HDGH toques to all staff in March 2023

Distribution of Kindness Cups to all staff during Strategic Plan Kickoff June 2023

Employee Appreciation Week in October 2023 including HDGH T-shirts, food trucks, booster juice, snack cart and other daily giveaways for staff as well as Minute to Win It challenges

Late Summer/Fall Wellness Committee Walking Challenge

Wellness, Health and Safety Fair in September 2023 promoting community partners, health and wellness activities, the HDGH Joint Health and Safety Committee and other HDGH departments

Employee Service Awards and Recognition Evening in October 2023; included awarding of $30,000 in scholarships to staff and children of staff

Flu/Covid vaccination clinics in October and November 2023

12 Days of Christmas offering fabulous staff prizes

Wellness Committee random giveaways of Thank-You cookies to promote Culture of Kindness

Jersey Day

Yoga, Employee gym

Christmas Day and New Year's Day surprise boxes to each unit/department

Staff Christmas Luncheon

Leadership retreat for Senior Management with plans to roll out leadership training to entire leadership group

Re-introduction of New Leader Orientation

Re-introduction of in-person non-violent crisis intervention training for high-risk areas and new e-learning module for all other areas

Weekly Wellness Clinic with onsite physician appointments available for staff

SAFETY

Hotel Dieu Grace Healthcare's safety culture is supported through our continued commitment to deliver safe, compassionate and high quality care by investing in the development of our people while equipping them with the necessary tools and support to provide exceptional and safe care to our patients and clients. Processes are in place to share learnings across our organization from patient safety incidents that have occurred. Organizational committees that support these processes include:

- Morbidity and Mortality case reviews through our Medical Quality Assurance Committee
- Program and Staff Huddles to share learnings from incidents and case reviews
- Patient Safety Professional Practice Committees where safety incidents and trends are reviewed and quality improvements are established by the inter-professional team.
- Patient Stories
- Critical Incidents are reported to the Quality Committee of the Board, Medical Quality Assurance, Medical Advisory Committee and any learnings are shared with the Patient Safety Professional Practice Committees
- QCIPA reviews to the Quality Committee of the Board and the Medical Advisory Committee
- "Need to Know" –learnings shared through communications

newsletter to all staff
The organization has identified the following initiatives to advance the delivery of compassionate and individualized care to each patient:
1. Staff Development: Education and training to all employees to be experts in providing the highest level of quality care and service.
2. Culture of Kindness: Embed a culture of kindness for our people and all persons for whom we provide care.
3. Leadership Development: Provide formal and structured training to the Leadership team to enhance their ability to lead their respective teams.
4. Best Service for Patients and Clients: Reviewing the service gaps in the community within our areas of expertise and matching resources to meet individual patient care needs.

POPULATION HEALTH APPROACH

Windsor-Essex's population of older adults is growing faster than any other region in Ontario. As such, the local healthcare system has seen challenges with ALC and an influx of demand for health specialized geriatric services. According to recent statistics, the proportion of older adults in Windsor-Essex is expected to grow to almost one quarter of the region's population by 2029. In addition Windsor-Essex has a high proportion of complex patients (four or more chronic conditions), with Windsor ranking as the second-highest region in Ontario and the highest rate of high-cost users. Lastly, the number of older adults with neurocognitive and/or mental health concerns is over 8,000 individuals.

HDGH recognizes that individuals with mental health and addictions (MHA) have inequities in accessing care related to stigma, but that these same individuals can also create significant burden on key services such as emergency room (ER) visits. HDGH is working with Ontario Health and partners to pursue innovative programs that create alternative care options to EDs that simultaneously respect the specialization required within MHA.
With the growing need for MHA services, our Outpatient (OP) programs have focused on implementing best practices for OP care, a model of service recovery (MCRRT) along with expansion of hours and are collaborating with Ontario Shores and MHCC on a project focused on Schizophrenia.
HDGH recognizes the need to work with system partners to develop an innovative integrated system that will provide alternate spaces for patients and clients to seek and be given care, and, when needed, provide timely interventions that take pressure off acute care

EXECUTIVE COMPENSATION

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

- President & Chief Executive Officer;
- Vice President of Medical Affairs, Mental Health & Addictions,
- Quality & Performance, Chief of Staff
- Vice President of Clinical Services, Restorative Care, Chief
- Nursing Executive (CNE)
- Chief Financial Officer (CFO)
- Chief Human Resources Officer (CHRO)

Each of the above named executive's compensation, in the amount of 5% for CEO and 2% for respective VP's and CFO /CHRO, 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 for executive compensation are selected as follows:

1. % admissions meeting designated target wait times from acute care
2. % of staff who have completed relevant equity , diversity, inclusion, and anti-racism training
3. Did you receive enough information on discharge?"(% excellent score)
4. Overall Perception of Care – MH IP (rate)
5. Medication reconciliation on discharge – The total number of patients with medications reconciled as a
proportion of the total number of patients discharged from Hospital.

Each indicator is weighted equally (20% each).
If less than 50% of the target is achieved, no P4P is paid.
If more than 50% 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. It would be pro-rated based on the % of the target.

CONTACT INFORMATION/DESIGNATED LEAD

Alison Murray
Chief Privacy Information Officer
Director, Digital Health , Quality & Performance , Research & Project Management Office
alison.murray@hdgh.org
519-257-5111 x 73096

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 on

_____

Board Chair

Board Quality Committee Chair

Chief Executive Officer

Other leadership as appropriate

Access and Flow

Measure - Dimension: Timely

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% admissions meeting admission target (ready to admission)	C	% / All inpatients	In house data collection / 2425	84.30	80.00	With the implementation of the Ontario Health directive of maintaining an occupany rate of 95% bed availability, there may become a challenge in transitioning patients within the current target of 2 days. Rehab /Complex : within 2 days / TNI : within 14 days In addition to ALC numbers continuing to be on the rise because of community resource contrants, LTC bed accessility and assisted living/retirement living affordability.	Acute Care hospitals , Ontario Health , LTC , Home & Community , Assisted Retirement Living

Change Ideas

Change Idea #1	Maximize strategies related to acute care transitions to post-acute care beds to improve access adn flow efficiencies and assist in resolving system wide patient flow challenges		
Methods	Process measures	Target for process measure	Comments
Data will be collected by the Intake team and decision support to monitor strategies and analyse and report on weekly flow. Methods include 1. Assign patients to off service beds when required. 2. Move the physiatrist/geriatrician consult up front in the referral process to direct the referral and admission process based on medical stability criteria and the RCA framework 3. HDGH will continue to remain diligent in reviewing referrals and working with acute care partners in educating them on eligibility criteria and referral processes. This is especially important to ensure that patients are transitioned safely to the right bed at the right time and in addition avoid unnecessary ALC designations	The occupancy level will be monitored in each inpatient area and reported weekly and monthly . This indicator will be monitored as well by the Performance & Utilization Committee .	The target is 95%.	

Measure - Dimension: Timely

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate Level of Care Throughput Ratio	C	Rate / All inpatients	WTIS / Q2	CB	1.00	HSAA target	Home & Community, acute care partners, ontario health, LTC, Assisted Living

Change Ideas

Change Idea #1	Work with OH and partners to support the establishment of a resolution table specific for patients with developmental diagnoses		
Methods	Process measures	Target for process measure	Comments
Continue to advocate with Ontario Health for resolution table	Plan to establish a resolution table by December 2024. Number of cases reviewed at resolution table	December 2024 Number of Cases - Collecting Baseline case # in 2024. (Q4)	

Change Idea #2	As per the OH Directive for maintaining an ALC throughput ratio of >1, HDGH will re-educate all care providers on the process for ALC designation as per the provincial ALC leading practice guide.		
Methods	Process measures	Target for process measure	Comments
1. Adopt weekly rounds with Home and Community Care Services to identify challenges and barriers for discharge 2. HDGH is building relationships with BPSO and RGP and will be introducing an Elder Life Program to strengthen interactions with our patients and reduce the risk of delirium 3. HDGH has implemented a pilot project called the Geriatric Urgent Response Team (GURT) that will go to patient's homes to assess their cognitive well-being and assist with system navigation to advert ED visits 4. Re-educate staff on ALC definition and leading practice guide.	1. Track weekly rounds adherence with Home & Community Care will be tracked by Intake Manager 2. Target Date for Elder Life Program Establishment 3. # of GURT visits and tracking if adverted ED visit by Intake Manage 4. % of group identified for retraining on ALC designation which includes Hospitalists, Charge Nurses, Managers, Discharge Planners which will be tracked by Intake Manager	1. 100% rounds occurring weekly need targets 2. January 2025 3. # of GURT visits - Collecting Baseline Data 4. 100% by December 2024	

Change Idea #3	Through the sub-region Access and Flow table, patients identified as long stay complex discharges to the community will be discussed via a resolution table whereby all key stakeholders gather to review the case and identify solutions for appropriate and safe discharge.		
Methods	Process measures	Target for process measure	Comments
• One of the greatest barriers for the long stay complex discharge is accessibility to specialized beds including patients needed dialysis and those with cognitive behavioural care needs • Development of referral process and Utilization of resolution table to review long stay complex patients for discharge to appropriate community setting	Review # times patient is referred once the referral process is setup .	Collecting baseline data in 2024	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.00	100.00	In alignment with 5 year strategic plan related to training . Target is to complete 100% of identified senior leadership and physician leadership team . Senior leadership will be mandatory for completion by March 2025. Full leadership team and physicians will be optional for 2025 but encouraged to complete and report . These groups will be mandatory in 2025/26. This includes nine modules which includes Anti-Black Racism , Gender Diversity , Indigenous Cultural Awareness (4 modules) and French Language	Ontario Health

Change Ideas

Change Idea #1	Implementation of Education for Senior executive team (SMC) - Mandatory 100% completed. Leadership FOrum - Optional - Collect baseline by March 2025 Physicians - Optional - Collect baseline for OH Identified Training. RCC (Regional Childrens Center) - Rainbow Health Training - Optional (RCC will be funded by Lead Agency)		
Methods	Process measures	Target for process measure	Comments
a. TAHSN Anti-Black Racism e-Module Training b. Intro to Gender Diversity c. OPTIONAL: Rainbow Health Ontario Foundations Course d. Indigenous Relationship and Cultural Awareness Courses (All 4 below) i. First Nations, Inuit and Métis Culture Colonization and the Determinants of Health ii. Indigenous History and Political Governance iii. Cultural Competence in Healthcare iv. Truth and Reconciliation Commission of Canada (TRC) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)). (90 minutes) e. One of the following: i. https://flsonlinetraining.ca/ ii. https://www.activeoffertraining.ca/	% education completed in identified employee groups. 1. Senior Management - Mandatory 2. Leadership - Optional for 2024 3. Physician - Optional for 2024 4. RCC - Rainbow Training - Optional - all staff (funded by Lead Agency)	1. SMC - 100% by March 2025 2. Leadership - Optional to complete March 2025 - Collecting Baseline 3. Physicians - Optional to complete March 2025 - Collecting Baseline 4. RCC - Rainbow training	

Measure - Dimension: Equitable

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Staff were sensitive to my cultural needs	C	% / Other	Hospital collected data / Q2	3.54	4.00	Uses 4 point Likert Scale. 3=Good, 4=Very Good. We are starting with a small sample size and leverage learnings to scale to other areas. Clients need to understand the definition of cultural needs. We are targeting 4.0 to target , when applicable , we strive to be "very good" and place of excellence. If selected not applicable , they are not included.	

Change Ideas

Change Idea #1 Increase sample size of completed OPOC surveys in RCC and provide education to clients on cultural needs definition . Many patients indicate not applicable .

Methods	Process measures	Target for process measure	Comments
1. Develop process for increasing use of OPOC, Use OPOC across wider range of RCC programs. 2. educating clients on how cultural needs are defined 2. In consultation with RCC PFAC , develop engagement strategy related to education for cultural needs awareness.	1. # Completed OPOCs per quarter and Monitor Response Rates 2. Completion of PFAC consultation and plan strategy by September 2024	1. Increase to 25 completed OPOCs per quarter. 2. Strategy development by Sept 2024 for education plan.	Aim to get consistent OPOC completion throughout the year in order to provide reliable baseline data to be used in future QI initiatives.

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Increase awareness of of Diversity, Equity and inclusivity through implementation of approved Project Plan - % milestones achieved	C	% / Health providers in the entire facility	Hospital collected data / 24/25	CB	100.00	the expectation is that once the final plan is approved by Senior Management , the milestones set for each fiscal year, in conjunction with Strategic Plan and Implementation quarterly goals will be met.	Ontario Health , Regional EDI leads- Regional Partners

Change Ideas

Change Idea #1 Implementation of EDII work plan that will drive initiatives in alignment with strategic plan

Methods	Process measures	Target for process measure	Comments
Monitoring of milestones for Year 1 approved work plan	% of milestones achieved (milestones completed /milestones identified)	100% of identified milestones identified for Year 1 , by end of fiscal year March 2025.	The work plan identifies milestones identified for the next three years in alignment with our strategic plan .

Experience

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	97.19	95.00	Actual Performance last year was 88% , target set at 90 for this year. The higher trend is only in two quarters (Q1, Q2) , Q3 was 92% . We are setting it at 95% which we feel is more realistic and still a stretch target with increasing and higher occupancy rates. The higher % also may be reflecting a pilot project with a post discharge transition call which we are hoping to put back into place during this fiscal year with Charge Nurse changes in Spring /summer 2024.	Home & Community Care

Change Ideas

Change Idea #1	Through collaboration , the Quality Advocate , who conducts real time patient experience surveys on discharge and the Discharge Transition Nurse , will ask for details if they indciate they did not receive enough information or information was missing on discharge. These details will continue to be analyzed to identify possible trends and developed improvement initiatives accordingly. The Quality Advocate will ensure if the answer is sometimes or No, that comments are obtained and tracked through the discharge survey for every patient on what information is missing or would be helpful.

Methods	Process measures	Target for process measure	Comments
• % of comments received for answers that do not indicate the person received enough information. Analysis completed quarterly on response data and suggestions. Trending information provided to the indicator lead for development of discharge information improvements and shared with programs and Managers.	Track % of negative responses at have comments provided starting in Q2; 100% completion of quarterly analysis and feedback process to programs and Managers.	80% of sometimes/no responses have a comment provided. 100% quarterly analysis and infographic and survey details provided to managers quarterly.	Total Surveys Initiated: 462 Note that Patient Experience results will also be shared quarterly with PFAC for any feedback /suggestions.

Change Idea #2	Review strategy to include scheduling of primary care follow up appointment, prior to discharge , within 7 days of discharge (prior to leaving the hospital and included in discharge package)

Methods	Process measures	Target for process measure	Comments
Identify a process in which follow up appointments for primary care is arranged prior to discharge from the hospital. Standard work to complete this task to be established by May 2024.	Where an appointment for primary care is identified, track the % of patients who have their primary care appointment booked prior to leaving the hospital.	Target : 50% of eligible population by Q4 24/25	Eligible population includes: discharged home or vulnerable/at risk for re-admission

Change Idea #3	Explore strategy to have Charge Nurse phone patient's post discharge to assess how transition home went and answer any clinical /discharge questions they are worried about .

Methods	Process measures	Target for process measure	Comments
Establish standard work and script for follow up call, as well as links to support services in community if required. Complete Standard work by May 2024	Percentage of patients who do not have enough information and require access to other community services over total patients called	Target : < 20% of patient by Q3/Q4 fiscal year end , and will include only those discharged home or identified as at risk population .	

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Overall Perception of Care - MH Inpatient	C	% / Mental health patients	Other / 2324	3.03	3.33	Targeting an overall perception of care improvement of 10% . This is in alignment with planned improvements as a result of MOC changes for TNI . The target is by Q4, 24/25	

Change Ideas

Change Idea #1 "Implement the revised staffing model as part of the TNI Transformation Develop standardized processes to attach patients to relevant group programming as part of the TNI Transformation ". Focus on opportunities for improvements identified in OPOC surveys

Methods	Process measures	Target for process measure	Comments
Increase activities for patients for afternoons and weekends Increase involvement of patients in decision making - OPOC #12 - current : 78.6% Increase staff knowledge and competence through MOC changes - OPOC #17 : 87%	OPOC #33 - There were enough activities of interest to me during free time OPOC #12 - I was involved as much as I wanted to be in decisions about my treatment and support OPOC # 17 - I found staff knowledgeable and competent OPOC # 1 - the wait time for services was reasonable to me	5% improvement in each of the four identified process measure indicators 1. OPOC 33- current 75.5% , target - 79.5% 2. OPOC 12 - current 78.6 , target - 82.5 3. OPOC 17 - current 87% , target - 91.4% 4. OPOC 1 - current 76.3%, target - 80%	The process measures identified to improve the overall perception of care are those identified in the OPOC as Areas of involvement and based on top average scores of disagree and strongly disagree. These are the four key areas /questions will be focusing on to improve overall perception of care.

Measure - Dimension: Patient-centred

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
MH RCC % overall quality care	C	% / Pediatric Patients	Other / April 1- March 31	43.80	60.00	50% rated Agree so overall 93.8% positive . The target is to move to "Strongly Agree"	

Change Ideas

Change Idea #1 Focus on specific OPOC questions for improvement planning to impact the overall quality of care indicator . compile strong baseline data to inform future QI initiatives.

Methods	Process measures	Target for process measure	Comments
1. Monitor OPOC results throughout program changes occurring this fiscal (IOT expansion and closure of live-in treatment) 2. increase sample size of completed OPOCS.	1. Monitor # of completed OPOC's per quarter 2. Monitor response rates 3. Monitor Q3 : I felt that i was a valued member of the care team for my loved one . 4. Q30 - The services and supports my loved one received helped them deal more effectively with the challenges in their life 5. Q31 I think the services or supports provided here are of high quality .	1. Increase by 25 surveys quarterly by Q3 , 2024 2. Response Rate - target 25% 3. OPOC Questions - improve each questions by 5% from baseline (April 1, 2023 -January 2024) by end of Q3 24/25	

Measure - Dimension: Patient-centred

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rehab Outpatient Experience Indicator - Outpatient Rehab clients feel they have met their goals prior to discharge for the program	C	% / Other	Other / YTD 23-24	60.00	70.00	We are targeting a 10% improvement . The perception is patients do not want to leave the program so a focus will be on communication and understanding of the program and setting goals for program that are realistic .	

Change Ideas

Change Idea #1 Gain a better understanding of why clients feel they didn't meet their goals •

Methods	Process measures	Target for process measure	Comments
1. Develop patient literature and standard messaging for clients and their families as well as links to support services in community upon discharge when required 2. Analysis completed quarterly on response data. Trending information provided to the indicator lead for development of quality improvements to be shared with programs and Managers	1. % of comments received that indicate the client did not achieve their established goal and identify what goals were not met to better understand why they feel are not meeting goals.2. comments analyzed quarterly and information provided to indicator lead, program and managers to develop improvement plans	100% of comments reviewed, analyzed and shared quarterly .	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	95.68	97.00	In alignment with current target and impact of action plan for 24/25	

Change Ideas

Change Idea #1 Establish clear definition, role and scope for Medication Reconciliation on Discharge for Physicians and Pharmacists. Identify "Physician Champions" for each program: Rehab, CMC and MHA where regular performance updates can be reported and process improvements put in place.

Methods	Process measures	Target for process measure	Comments
• Focus on re-education and monitoring of "transitions" by program. Review incomplete Medication Reconciliation errors and follow up with individual physicians for learnings and improvements. This will include a workflow review for "HOLD" medications pending results process	1. % transitions that have Medication Reconciliation completed 2. number (#) of incomplete medication reconciliation due to med rec error	1. Reduce number of transitions incomplete by 50% by fiscal year end; 2 .reduce the number of incomplete due to error by 50% by end of fiscal year	Working with CNE /Chief of Staff to identify Physician champion for each program.

Change Idea #2 Establish a process for Pharmacy consult to be generated for patients upon discharge to assist with Medication Reconciliation and patient education.

Methods	Process measures	Target for process measure	Comments
Establish criteria to trigger Pharmacist consult and standard process. Identify Pharmacist champions established to help create standard work and process.	1. # of patient's who meet eligibility for pharmacy consult, versus actual # of patients who have pharmacy consult on discharge	1. 85% of patients eligible for pharmacy consult received pharmacy consult	

Measure - Dimension: Safe

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	1.00	0.00	our target is zero , as in alignment with our workplace violence strategic stance of zero tolerance	

Change Ideas

Change Idea #1	Our target for violence incidents is zero as an organizational strategic goal and set to be consistent with our message of zero tolerance. We continue to have a process to review each incident and apply learnings. We continue to experience a large decline in incidents of the past years from 74 incidents in 20/21 to 32 incidents in 21/22 to ?43 incidents in 22/23 and (fiscal year end forecast) 32 incidents in 23/24. Fiscal Year was used.

Methods	Process measures	Target for process measure	Comments
Monitor impacts of full resumption of all in-patient, residential and ambulatory services and resumption of regular visitor and Designated Care Partner programs across the organization and impacts on incidents against employees.	1. % of incidents with/without injury 2. Monitor # of incidents by program/time period - baseline .	1. 100% without injury is target 2. 20% reduction in # incidents overall by program/service categories.	We continue to experience a decline in reported workplace violence incidents against employees despite the resumption of more normalized operations at HDGH post-COVID. Full resumption of visitor and Designated Care Partner programs have also not impacted incidents against employees. Through 23/24 we returned to providing verbal de-escalation and physical disengagement refresher training for all HDGH employees, and introduced PPE Safety Packs to RCC employees given the number of incidents we continue to see coming from that specialized program. We continue to emphasize education to all patients and visitors regarding zero tolerance for violence towards employees which is further supported by the HDGH Security team and our Safe Workplace Advocate

Access and Flow | Efficient | Custom Indicator

Indicator #1

% transitioned in accordance to targets from "Ready/Eligible " in Acute Care to "Admission " to HDGH .
(Hotel-Dieu Grace Healthcare)

Last Year		This Year	
87	**87**	**84**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Maximizes strategies related to internal transitions from complex to rehab to help address flow issues to CMC.

Process measure

- Monitor referral process and wait time from ready status transition from CMC to Rehab

Target for process measure

- 90% transitioned from CMC to Rehab within 2 days of "ready" status. (Internal transfers)

Lessons Learned

While HDGH met the target there remains, at times, a discrepancy between “patient ready” in acute care and “patient ready” as it pertains to the established HDGH medical stability criteria and RCA framework
• HDGH will continue to remain diligent in reviewing referrals and working with acute care partners in educating them on eligibility criteria and referral processes. This is especially important to ensure that patients are transitioned safely to the right bed at the right time and in addition avoid unnecessary ALC designations.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Review wait times collection processes and optimize accuracy of data

Process measure

- Complete review of data and provide a work plan for improvement of wait time data collection with quarterly milestones by June 30 , 2023 . Review % of work plan items completed quarterly.

Target for process measure

- 85% of work plan items identified that are completed each quarter.

Lessons Learned

We are lacking a standardized approach to recording and collecting wait times between programs – Mental Health and Addictions and Restorative Care
Efforts were made in providing education to the Mental Health and Addiction care providers to support standardized processes in capturing data between them and Restorative Care and as such ensuring greater accuracy in reporting wait times. Challenges include system limitations that we will be working in collaboration with Transform Shared Service on optimization opportunities with our HIS system (Cerner)

	Last Year		This Year	
Indicator #2 Alternate Level of Care (ALC) days expressed as % of all inpatient days in the same period (Hotel-Dieu Grace Healthcare)	**13** **Performance (2023/24)**	**14.50** **Target (2023/24)**	**9.50** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☐ Implemented ☑ Not Implemented

AS per the ALC leading practice guide from Ontario Health, we will be developing a sfCare strategy and plan and integrating that as a foundation of care across the organization . This is focused on Organizational Leadership & Support and Older Adult & Caregiver Communication and Involvement . In alignment with Accreditation Canada standard that "services are co-designed to meet the needs of an aging population" and is considered high priority criteria.

Process measure

- Development of work plan to support sfCare Strategy Plan completed by December 2023 . % of milestones achieved annually in the approved work plan.

Target for process measure

- Achievement of 80% of identified milestones identified annually, by the end of each fiscal year

Lessons Learned

Not implemented as intended : While intended to create a work plan, priorities shifted with ALC being aligned with the provincial sfCare Strategy. Opportunities still exist to develop HDGH's sfCare Strategy however in the meantime the organization is focusing its efforts on ALC throughput and 95% occupancy rates to enhance local patient access and flow (OH Directive). In winter of 2023, HDGH opened a 20 bed surge unit. We learned very quickly that our region lacks access to beds for patients with cognitive behaviours such as dementia and Alzheimer like diseases

Comment

• HDGH is building relationships with BPSO and RGP and will be introducing an Elder Life Program to strengthen interactions with our patients and reduce the risk of delirium. In addition HDGH has implemented a pilot project called the Geriatric Urgent Response Team (GURT) that will go to patient's homes to assess their cognitive well-being and assist with system navigation to advert ED visits

Equity | Equitable | Custom Indicator

Indicator #4	Last Year		This Year	
Increase awareness of diversity, equity, and inclusivity; project development milestone goals (Hotel-Dieu Grace Healthcare)	**CB** Performance (2023/24)	**CB** Target (2023/24)	**CB** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Establishing an EDII work plan that emphasizes key areas of learning and development and contribute meaningfully to organizational strategic direction.

Process measure

- Development of strategic plan that embeds EDII in all that we do by September 2023 Creation of EDII work plan that will drive EDII initiatives and education in alignment with the strategic plan

Target for process measure

- Implementation of finalized EDII work plan and milestone identification for the next three years in alignment with strategic plan

Lessons Learned

Identified in Strategic Plan and one of the key initiatives. Work plan developed and education plan started for senior leadership level. Draft work plans for both EDI and Indigenous work have been completed and submitted to the Senior Management Council for approval. The EDI work plan was developed with the OH Framework in mind, however, the Indigenous work plan will need review now that OH released their First Nations, Inuit, Metis, Urban Indigenous work plan. Following approval of SMC, the EDII Alliance will begin implementing the plan. To note – HDGH hired an FTE Manager of EDI, who reports to the Director of Communications and Mission. This position, in place since the fall of 2023, has begun to implement items that are pending SMC approval. Items include – defining what is EDI at HDGH, and creating a statement of inclusion for Job Postings. Further to this, we have rolled out mandatory training for our SMC members based on recommended training from Ontario Health. These are items that are directly correlated to the HDGH draft EDII work plans.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #7 Percentage of respondents who responded "Completely/Always" to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital. (discharged) (Hotel-Dieu Grace Healthcare)	**88** Performance (2023/24)	**90** Target (2023/24)	**97.50** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Gather details from patient experience surveys and through the Discharge Transition nurse follow up call process, from those who feel they did not receive enough information. use language that corresponds with the information they receive (i.e., purple HDGH folder)

Process measure

- % of comments received for answers that do not indicate the person received enough information. Analysis completed quarterly on response data and suggestions. Trending information provided to the indicator lead for development of discharge information improvements and shared with program Unit Based Councils as well as PFAC (Patient Family Advisory Committee)

Target for process measure

- 1. 80% of negative responses will have comments starting in Q2. 2. 100% completion of quarterly analysis and feedback process to programs, Unit Based Councils & PFAC

Lessons Learned

Data collection is within the discharge survey completed by Quality Advocate within 72 hours post discharge and when respond No or Sometimes to this question, they ask for details. These are then shared with the experience survey results distribution channels.
The Discharge Transition nurse follow up call process has been put on hold for the time being due to resource availability)
Patient and family greatly appreciated the information given to them and the call to "check-in" on them post discharge to answer any questions or assist with system navigation.
HDGH will strive to reintroduce the Discharge Transition nurse follow up process as soon as resources allow.

Change Idea #2 ☐ Implemented ☑ Not Implemented

Review strategy to include scheduling of primary care follow up appointment within 7 days of discharge (prior to leaving the hospital and included in discharge package)

Process measure

- Where an appointment for primary care is identified, track the % of patients who have their primary care appointment booked prior to leaving the hospitals. A process will be identified and tested in a pilot phase for 6 months to collate data and evaluate effectiveness.

Target for process measure

- Target to be identified once the strategy is developed and pilot is completed to establish a baseline.

Lessons Learned

This has not been completed and will be transitioned to 24-25 Action Plan.

Indicator #3

I think the services provided here are of high quality -Inpatient Mental Health OPOC (Hotel-Dieu Grace Healthcare)

Last Year		This Year	
92.50	**93**	**93.80**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Development of monthly structured rounds with a checklist and trial of new version of rounds

Process measure

- 1. EDD targets discussed and/or set where applicable within 30 days of admission (to be developed) 2. MH Rounds attendance will be tracked for physicians (to be developed) 3. Monitor OPOC (Ontario Perception of Care) results " #12-I was involved as much as I wanted to be in decisions about my treatment and support " (baseline: 73 % Agree/Strongly Agree) 4. Monitor OPOC results " #10 - I received clear information about my medication " (baseline: 80% Strongly Agree/Agree)

Target for process measure

- 1.% of patients with an EDD discussed within 30 days post admission. (To be developed) 2.% attendance at rounds monthly (to be developed) 3. OPOC indicator #12 - involved in care - increase by 5% 4.OPOC indicator #10 - I received clear information about my medication -increase by 5%

Lessons Learned

In progress : Transitioned new Operations, Clinical Practice Manager, and Inpatient Psychiatry Lead for TNI.
Completed comprehensive engagement strategy for TNI model of care review with PMO support. New supportive roles for management (coordinator and analyst) will materialize in the fall to support this change initiative. Participating in the National Schizophrenia project with the Mental Health Commission and Ontario Shores which will include standardized scripting for physicians as it relates to important prescribed medications (Clozapine and LAIs). Project will launch in April. EDD - In progress - working on standard data collection process 2. Rounds attendance tracking - in progress -rounds are every 2 weeks and not currently an issue with attendance. Will be reviewed with TNI transformation planning. 3. OPOC #12 - increased to 78.6% from 73% 4. OPOC #10 - increased to 93.3% from 80% .

Change Idea #2 ☑ Implemented ☐ Not Implemented

Develop a plan around increasing activities available to patients(i.e nurse led grounds, input from patients on what activities they are interested in having)

Process measure

- Monitor OPOC indicator related to enough activities from patient perspective. Monitor # of code white to determine if activities help reduce the number of incidents (due to boredom)

Target for process measure

- 1. Increase OPOC indicator for " #33-there were enough enough activities of interest to me during my free time " target to increase strongly agree/Agree by 5% . 2. Develop a target for Code White reduction by September 2023.

Lessons Learned

In Progress: New roles within the model of care targeted for fall implementation will improve the availability of activities on the unit, including evenings and weekends. Program coordinator will help attach patients to activities in a way that is customized, and patient centered, in collaboration with program leadership. OPOC Question : Enough Activities : 75.5%

Safety | Effective | Priority Indicator

Indicator #5

Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Hotel-Dieu Grace Healthcare)

Last Year		This Year	
CB	**97**	**95.68**	**97**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Pharmacy /Physician Leads to continue to review monthly completion of medication reconciliation and follow up with individual physicians as required.

Process measure

- 1. % transitions that have Medication Reconciliation completed 2. number (#) of incomplete medication reconciliation due to med rec error

Target for process measure

- 1. Reduce number of transitions incomplete by 50% by fiscal year end. 2. Reduce the number of incomplete due to error by 50% by end of fiscal year.

Lessons Learned

The area of focus for improvement is "transitions" by program.
Identified need to review workflows for "hold " medications.

Safety | Safe | Priority Indicator

Indicator #6	Last Year Performance (2023/24)	Last Year Target (2023/24)	This Year Performance (2024/25)	This Year Target (2024/25)
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Hotel-Dieu Grace Healthcare)	43	0	24	NA

Change Idea #1 ☑ Implemented ☐ Not Implemented

Our target for violence incidents is zero as an organizational strategic goal and set to be consistent with our message of zero tolerance . We continue to have a process to review each incident and apply learnings. We have experienced a large decline in incidents over the past years from 74 incidents in 20/21 to 32 incidents in 21/22 and 33 incidents in 22/23. Fiscal Year was used.

Process measure

- % of incidents with/without injury Monitor # of incidents by program/time period.

Target for process measure

- 100% without injury is target 20% reduction in # incidents overall by program/service categories.

Lessons Learned

Monitoring impacts of increasing clinics and programs and the increase of visitors/Designated Care Partners back into the building has not impacted our workplace violence incidents by causing an increase in incidents against employees. Of the 24 incidents , there was only 1 case that resulted in lost time. The significant majority of the reported incidents at our organization continue to occur in our Regional Children's Centre which is a program specifically designed to service children experiencing a high level of behavioural escalation. We also continue to have incidents (<10) reported in our Mental Health programs (both residential and in-patient) which would reflect the vulnerable emotional state of these clients/patients. Incident reports from Restorative Care programs continue to remain low and are most typically associated with patients demonstrating a medical condition that impacts cognition and behaviour.

Comment

there may be some gaps in data due to cyber security event and data is currently being captured manually as system restoration has not taken place yet.

DR. PRIYA SHARMA

PRESIDENT OF THE PROFESSIONAL STAFF ASSOCIATION (2024-2025)

Dr. Priya Sharma was elected by her colleagues at the March 2024 Quarterly Staff Meeting as President of the Professional Staff Association, having completed a one (1) year term as Vice-President of the Professional Staff Association. In this role, Dr. Sharma will act as a liaison between the Professional Staff Association, the CEO, and the Board with respect to all matters concerning the Professional Staff (medical staff).

Dr. Sharma graduated from residency at the Western psychiatry program in London in 2017 and then completed a fellowship in geriatric psychiatry at Mount Sinai in New York. She is currently working at the Geriatric Mental Health Outreach program at HDGH and as well providing consultations to the Geriatric Assessment Program. Clinical and research interests include geriatric mood and psychotic disorders.

Outside of work, she is a mother to two girls, and enjoys visiting bookstores and coffee shops, caring for her plants and cooking!

We welcome Dr. Sharma in this new role as President and wish her well in her term!