

Let's Make Healthy  
Change Happen.



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

**Holland Bloorview**  
Kids Rehabilitation Hospital

3/31/2017

[ontario.ca/excellentcare](http://ontario.ca/excellentcare)

# Overview

Holland Bloorview continues to lead pediatric rehabilitation provincially, nationally and internationally. We are committed to advancing high quality, safe care for our clients and families, measuring success and addressing the issues of equity, diversity and inclusion. Anchored in Carmen et al's (2013) model of patient engagement, we embrace a shared partnership and leadership model with our clients and families; our quality agenda has been co-created to ensure meaningfulness and impact. Leveraging the 'evergreen' philosophy of Health Quality Ontario surrounding quality improvement work, our 2017/18 plan reflects the ongoing journey of our key priorities, building our capacity through the equal partnership of clients and families, while reflecting on system opportunities that will change the face of paediatric healthcare.

The principles of simplicity, focus/priority and partnership guide our work with an overall goal of providing the best possible client and family experience, and partnering in creating that experience. In doing so, we concentrate on three strategic objectives focused on quality:

**Enhance care and eliminate harm.** We will sustain safe, standardized processes for medication reconciliation and fully partner with clients and families to create tools, transition pathways and models of care that are fully understood upon discharge.

**Improve access and integration.** We will minimize the time clients and families must wait to receive service. We will ensure our families feel supported during transitions home or after a service has ended, and feel confident in continuing care for their child. In doing so, we support the important transition from hospital therapy to home, promote access and flow across the system, ensure effective use of public resources and build resiliency and capacity in our clients and families.

**Partner authentically with clients and families.** We will use evidence based outcome tools to monitor effectiveness of care and resolve concerns and issues quickly by listening carefully and responding to the feedback of our clients and families. We will partner in all of our change initiatives fully and equally with our clients and families leveraging their experiences, knowledge and ideas to transform the care experience.

As we prepare for accreditation in the fall of 2017, we have partnered with our families, youth and children by integrating these leaders into every accreditation team, including working groups, and creating the Family Leader Accreditation Group (FLAG) which will support and enable compliance with the client and family experience/engagement criterion throughout the 18 month improvement journey. Two of our FLAG members received an honourable mention for the 2016 Volunteer Champion award through CPSI for their involvement in this work.

To ensure equal voice knowledge and skill of our families, youth and children in our accreditation journey, we trained all of our leaders through the Patient Safety Education Program (PSEP) at the Canadian Patient

Safety Institute (CPSI), with each leader becoming certified in October 2016. Our trained family/youth and child leaders subsequently deepened their partnership with the organization by providing certification sessions and delivering modules of safety, communication, teamwork to our own staff to create synergy and balance in knowledge. This strategic initiative was geared to advance the language of quality, safety and improvement of our clients/families/staff and placing our Family Leaders in positions of executive sponsors of initiatives to elevate the conversation and improvement work.

Our work over the past twelve months is fully aligned with Health Standards Organization (HSO), the entity that sets rigorous standards and requirements to advance high quality safe care. These standards, in addition to our clients/families/staff voices has informed our QIP change ideas, with particular overlap under the themes of authentic partnership and care coordination.

The organization is in the final stages of writing its new strategic plan (2017-2022). Over 900 voices were captured in the planning phase, including our clients and families and community partners. Clearly identified was the desire to revolutionize the way care is provided in a personalized and integrated way, while ensuring the highest quality and safest care.

Holland Bloorview continues to collaborate with a number of system partners to inform our quality agenda, ensuring we focus on local needs as well as needs that extend beyond our walls. Our partnership and engagement efforts include working with the International Pediatric Health Equity Collaborative (PHEC), Accreditation Canada, Canadian Association of Pediatric Health Centres (CAPHC), CAPHC's Canadian Network of Children and Youth Rehabilitation (CN-CYR), Canadian Paediatric Decision Support Network (CPDSN), Ministry of Youth and Child Services (MCYS) Special Needs Strategy, Toronto Central Local Health Integrated Network (TCLHIN), Regional Quality Table, GTA Rehabilitation Network, Rehabilitation Care Alliance and the Toronto Academic Health Sciences Network (TAHSN).

## QI Achievements From the Past Year

Anchored in our change plan of last fiscal year, we continue to focus on engaging, partnering and enhancing the overall client and family experience. This past year has been marked by a number of successes outlined in our change plan, as well as other initiatives that arose in our journey of improvement. Our advancement of client and family experience has been achieved by:

- enhancing access through focused work to reduce our wait times, wait lists and increase productivity;
- proactively understand the contributing factors to clients' missed appointments through retrospective review of data and prospective research;
- ensuring our families understand information provided to them and feel prepared for their transition home;
- advancing how clinicians use outcome tools to set meaningful goals with families;
- co-designing with families the service model of extended hours to enhance service access and;
- co-designing with families the care for the caregiver program to advance resiliency and mental wellness.

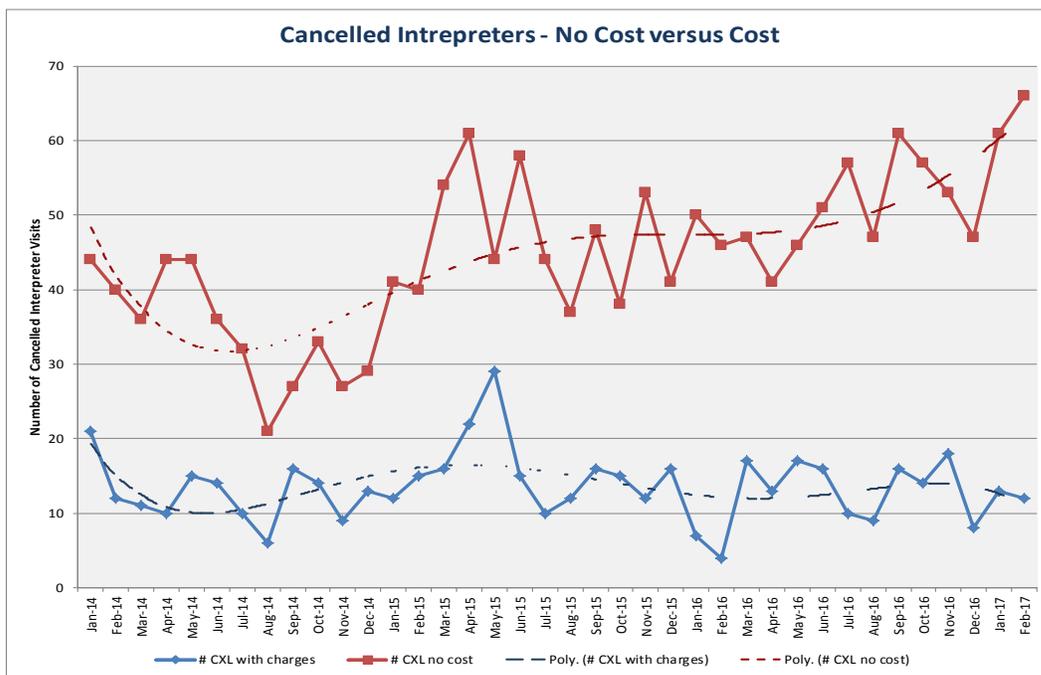
A key piece of improvement we have focused on over the past two fiscal years is within our appointment services area. Continuing in our journey we have made significant strides in implementing the 50+ recommendations of our 2014/15 external review of our ambulatory care setting to enhance the client and family experience. Outlined below are the initiatives completed or still in progress for 2016/17.

Dimensions	Initiatives	Are We There?
Transforming 'how' we engage referring providers	<ul style="list-style-type: none"> <li>Laying the groundwork for an electronic referral platform</li> <li>Education to providers including a 'confirmation' of receipt of referral</li> <li>Communication with both provider and client of all subsequent appointments</li> </ul>	In progress
Transforming 'how' we partner with clients and families	<ul style="list-style-type: none"> <li>Enhancement of upfront communication with clients to reduce cancellations and no show rates</li> <li>Alignment with the Client Portal (Connect2Care) to provide clients with the ability to change their appointment schedule</li> <li>Creation of standardized 'patient response sheets' to respond to client calls</li> </ul>	Complete  Client Experience survey demonstrates a 5 fold reduction in negative responses of staff not making you feel welcome
Innovating 'how' we manage referrals and schedules	<ul style="list-style-type: none"> <li>Creation of an internal handbook for scheduling staff to ensure referrals are completed effectively, efficiently and consistently</li> <li>Referral forms scanned and attached to the electronic health record to ensure providers have accurate and current information</li> </ul>	Complete
		In Progress
Enhancing Efficiency and Productivity	<ul style="list-style-type: none"> <li>Eliminating redundant processes throughout the continuum of care from referral to on-site care</li> <li>Implementing a 'short call' list for families who self-identify flexibility in their schedules to have appointments on short notice</li> <li>Creating 'wait time' statistics that are monitored weekly, monthly, quarterly by operations managers and senior leaders</li> </ul>	In progress
		Complete
		Complete
Enhancing Interpreter Services	<ul style="list-style-type: none"> <li>Reduction of cancelled service charges associated with less than 48 hour notice through 'force function' processes for booking</li> <li>Shifting away from face-to-face interpretation towards increased use of phone interpretation</li> </ul>	Complete (see graph)
		Complete

***Reduction of Cancelled Appointments Charged:*** Ensuring that clients/families have interpreters for their medical and therapy appointments is critical in delivering appropriate care and better health outcome. The cost of interpreters can be significant, and when organizations are charged fees for services not rendered due to families cancelling appointments with less than 48 hours this can be quite costly for the organization. While the issue of cancellations and no-shows is multifactorial, internally reviewing processes and methods to provide service is warranted. In 2015, the organization undertook several improvement initiatives within Interpreter Services that changed the way we booked, cancelled appointments and leveraged technology. What we found were several interesting facts:

1. There was a disconnect in the way we scheduled interpreters for ‘new’ appointments and how the system automatically assumed an interpreter was required for every visit;
2. Our electronic scheduling platform (Meditech®) had internal capacity to flag clinicians if they really required ongoing interpreter services;
3. Over the phone interpretation was equally as effective as face-to-face interpretation in many clinical scenarios but more cost effective service;
4. Families within our organization typically cancel appointments with less than 72 hours’ notice or may not show up to their appointment, which contributes to increasingly high face-to-face interpretation costs.

The chart demonstrates that our improvement work has increased the number of appointments cancelled well in advance that had no charges attached and a reduction in the number where we did not provide sufficient notice.



What we did and the information we discovered was even more interesting:

1. Our referrals for interpreter services have continued to rise over the past 3 years with 15.6% more families requiring services since 2014;
2. While our absolute cancellation rate has remained stable reflecting the organization’s current challenge with understanding cancellations/no shows for appointments, our ability to decrease the number of cancellations with a fee attached was reduced by approximately 20% since 2015 when the improvement work concluded;

3. Our improvement initiative of leveraging over-the-phone (OTP) interpretation versus face-to-face (FTF) interpretation was successful with a 129% increase in usage and cost savings of 136.4% since the initiative commenced in 2015 (see table below).
4. Our cancellations/no-show rates are our next step in maximizing service provision and reducing costs associated with interpreter services.

	2014	2015	2016	OTP Interpretation	-Improvement
<b>Total # of Calls</b>	335	594	768	129%	 (increased use of OTP)
<b>Annual Cost of OTP</b>	7,440	11,338	15,201		
<b>Minimum FTF Cost</b>	33,500	59,400	76,800		
<b>Maximum FTF Cost</b>	50,250	89,100	115,200		
<b>Cost Savings using OTP</b> (using minimum charge rate of \$100)	26,060	48,062	61,599	136.4%	 (decreased overall costs)

*OTP – Over the Phone interpretation services (using a phone to access interpreters)*

*FTF – Face to Face interpretation services (onsite interpreters)*

We have made significant progress in our critical path towards earlier access, standardized processes and maximizing resources. We anticipate over the next 18 months the remainder of work will be executed with many of the remaining improvements in various stages of progress. The work accomplished this year has resulted in improved communication, relative reduction in interpreter costs and reduced wait times during the referral management process.

We will be focusing this upcoming year in improving access through the co-design work with our families for enhanced service access, reducing the number of cancelled and no-show appointments and diving deeply into our discharge summary process to ensure that all clients leaving Holland Bloorview’s inpatient setting can feel confident a physician discharge summary will be sent to their provider in the community in a timely fashion.

## Population Health

Holland Bloorview is a local, regional, provincial and national resource to clients and families in the areas of childhood disability. On an annual basis we generate a community profile which includes information from many sources including our client experience survey, health equity survey, decision support team, patient relations team and our community outreach.

Over the past several years we continue to see our populations shift in our inpatient setting with younger and more complex children receiving services. In the past year alone we have seen the distribution of clients under the age of 4 doubling, and of those in this category 80% are under the age of two. This shift translates into new ways we experience our families and provide care (e.g. younger vented patients, children still being breast fed). In this strategic planning year, we included over 900 voices, thematically distilled into key areas of focus including transitions across the continuum, neuro-developmental services and integrated personalized care. Below are some quick facts about the population we serve and where they come from.

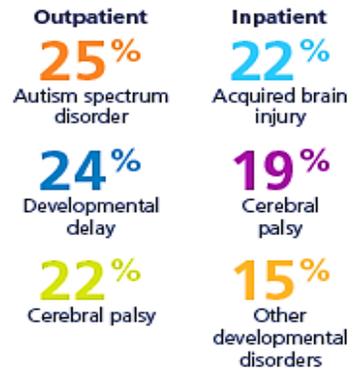
## Quick facts

### GENDER DISTRIBUTION



Total number of  
outpatient  
visits  
was  
**54,935**

### Most common diagnoses



**64.7%**  
of clients we serve  
have three or  
more diagnoses

### COMPLEXITY OF CLIENTS WE SERVE

1 diagnosis	16.1%
2 diagnoses	19.2%
3 diagnoses	13.7%
4 diagnoses	15.6%
5-9 diagnoses	24.5%
10-14 diagnoses	9.4%
15 and more diagnoses	1.5%

**48%**  
of all  
clients served  
were the  
age of 9  
and under

**72%** of our clients at the level of the organization are from the **Central, Toronto Central and Central East** Local Health Integrated Network

### AGE OF CLIENTS



## Equity

Equity, Diversity and Inclusion (EDI) are strong drivers of health outcomes. Equity ensures we provide the opportunities and removes barriers to ensure everyone's needs are met, while diversity challenges us to have broad representation of people's backgrounds, abilities, perspectives and inclusion ensures everyone participates. We all have a responsibility to develop, promote and support an equitable, diverse and inclusive environment for everyone who works, learns, volunteers and receives care at the hospital. We all see the world a little differently and are influenced by things such as gender, age, experience, background, advantages and disadvantages.

Under our strategic pillar of 'Inspire our People' our Equity, Diversity, Inclusion steering committee are actively involved in developing our plan to ensure we are leveraging data to advance our care models, developing tools, such as our equity lens, to guide our practices and ensuring we listen intently to our community to drive change. In 2016 our Steering Committee and Working Groups accomplished the following:

1. Developed, implemented and analyzed a 'Staff Equity Pulse Survey' that was sent out to all employees asking participation. The survey highlighted the need for us to better understand our organizational perception of equity, diversity and inclusion. We believe at Holland Bloorview it is important to identify what EDI challenges, barriers or misperceptions are in order to create a more welcoming and inclusive employee environment.

Fifty-nine percent of our staff responded to the survey and the findings were presented to the Disparities Leadership Program in Boston Massachusetts, receiving an award for best overall international project.

2. Development of an EDI lens which was disseminated across the organization to foster more respectful environments, reduce barriers to participation and support better work outcomes. The lens was created to address different scenarios:
  - Creating an equitable work environment
  - Creating and running an inclusive committee or project
  - Creating or reviewing a clinical program or service
  - Creating communication materials

### Examples of Tips from our Equity Lens

 **Who uses this lens?**  
All of us! Managers, all staff, committee chairs, student and volunteer supervisors.

 **How do we clearly communicate that inappropriate behaviours are not acceptable (e.g. offensive jokes, hurtful comments)?**  
Refer to the Employee Code of Conduct and Mission, Vision and Values, available on Viewfinder.

 **TIP** Equity, diversity and inclusion council Viewfinder page has many resources and supports.

 Consider nominating someone for a Spotlight award when they advance an equitable work environment.

 **TIP** Review the diverse groups listed in the guide. Are the people informing this work representative of the diverse backgrounds and experiences of those who might use the program or service?

 **TIP** Check out the *Creating communications materials Lens* for more information.

 **Checklist for participation:**

- Day(s) of week
- Time(s) of day
- Location of program
- Length of program
- Accessibility barriers
- Transportation barriers
- Parking
- Childcare needs
- Financial barriers
- Other \_\_\_\_\_

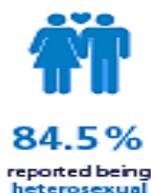
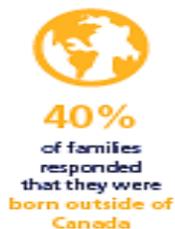
3. Deep dive into the barriers which exist that prohibit clients and families from attending appointments. Through rigorous statistical analysis we have found that geographic area, income, and age of child are linked to missed appointments. We are conducting several initiatives to better understand how we can remove barriers to enhance access to services.

Through our Health Equity survey, we were able to better understand our community and we continue to reflect on how we might measure and advance key performance metrics using this data for better health outcomes.

Our 2015/16 Equity Survey administered to clients and families provided us with a snap-shot of our population, their diversity and other socio-demographic factors.

## Who we serve – 2015/16

### Health equity survey



#### FAMILY INCOME



\$0 to \$29,999	15.5%
\$30,000 to \$59,999	14%
\$60,000 to \$89,999	14.2%
\$90,000 to \$119,999	10.6%
\$120,000 to \$149,000	9.1%
\$150,000 and over	18.4%
Other	18.3%

#### TOP 4 ETHNIC GROUPS OF CHILDREN



#### TOP 4 ETHNIC GROUPS OF CAREGIVERS



Source: Toronto Central Local Health Integrated Network survey 2015/16.

In 2017 our EDI Steering Committee will continue to focus on analyzing and further understanding the opportunities to advance EDI at Holland Bloorview. Two key initiatives will include the exploration of Aboriginal Cultural Competency and Implicit Bias Training for staff.

Planned for June 2017 Holland Bloorview will be hosting the International Paediatric Health Equity Collaborative (PHEC) with members across Canada and the United States with a shared interest in removing barriers to care for children and their families, and developing tools for system use internationally.

# Integration & Continuity of Care

Integration and coordination of services continues to be a key system focus within healthcare. Ensuring clients have their healthcare needs met at the right time in the right location is of paramount importance. For paediatrics, the well-being of the entire family is a determinant of health outcome. As a healthcare system, every organization has a responsibility to understand the linkages, maximize resources, provide high quality safe care in the right location to help Ontarians and their families reach their healthcare goals.

Within the pediatric realm, integration and coordination becomes exceedingly important for our clients and their families as funding is multi-sectorial, across geographical boundaries and care provided in a variety of environments (e.g. school, home). Access to care spans different locations, requires strong partnerships across sectors and agencies with an intimate knowledge of services that are often geared to specific age ranges. Transitions between organizations are a reality of their journey through the rehabilitative process. Some families may experience very few transitions, while others navigate transitions often. Transitions can take many forms (e.g. acute care, rehabilitation, children's treatment centres, school and home), often are difficult, confusing and leave families questioning if they have missed any element in their child's care. System integration is vital to care being maintained across transitions, and along the journey of paediatrics to adulthood.

Holland Bloorview endeavors to create seamless transition pathways that reduce risk, reduce readmission rates to acute care facilities, enhance the trust from our clients and families, and eliminate waste within the system. Bridging the gap to ensure that clients and families are supported when they transition to the community requires planning and deliberate effort. We must ensure that families receive support, feel safe in their caregiver roles within the community, understand what is expected of them as caregivers and be part of the evaluation of transitions to understand how to enhance value and effectiveness from the perspective of clients and their families.

With this in mind, Holland Bloorview, in its second year of the 'evergreen' plan, will continue to focus its efforts on system integration through the following activities:

1. **Understanding medications upon discharge.** Medication reconciliation is a key safety activity that takes account of all pieces of information provided by organizations, families, clients and health providers to ensure consistent evaluation and communication across transition points. Evidence suggests that transition points are often areas of risk and where incidents occur.

While many organizations capture medication reconciliation on admission only, we will continue to monitor this safety measure across all transfer points within our inpatient and outpatient settings. This year there will be a continued focus on educating clients and families on medication protocols, especially on their 'Leaves of Absence' (LOA) to assist them in feeling supported and understanding all medication protocols to prepare them as they transition home in the safest possible way.

2. **Safe Transitions Home:** Transitions take on many forms in pediatric rehabilitation encompassing the entire continuum of care. Discharge is often one of the most challenging elements of one's journey through the health system. Transitioning from a safe and highly structured environment such as a hospital setting back home often creates anxiety and concerns

for many families as there are significant amounts of information, and specific activities that require follow through. While this process can be seamless, through focus groups and surveys with families, we recognize having a touch point shortly after discharge is of benefit. Reaching out to our clients and families enhances the patient discharge experience, provides families the opportunity to ask questions surrounding their child's care and enables the organization to identify and plan improvement initiatives. Our 72 hour post inpatient discharge calls contributes to a safe transition home and provide an opportunity for follow-up. Novel this year is the shift from a process measure to an outcome measure asking our clients/families if they felt supported in the discharge process. Over the past two years we met our target of reaching families within 3 days, 90% of the time. This evolution of measurement will ensure the collection of both quantitative and qualitative information that will allow us to further refine our patient oriented discharge summary (PODS). Understanding a family's perspective, coupled with a fulsome review of our internal discharge processes will ensure safe and meaningful transitions for families whose reintegration back into the community may be overwhelming.

This warm handover is conducted by a clinician and key questions are asked to ensure families feel supported, safe and confident at home, while being proactive in addressing any potential issues. During our engagement with families, the discharge call was seen as a necessary and helpful process. Families indicated they wanted this type of 'warm handover' to be incorporated in an outpatient setting.

Continued in 2017/18 will be implementation of a 'warm handovers' within the medical feeding clinic. Children who are seen in this clinic have an array of feeding, swallowing and speech challenges that require careful care. As a complex interdisciplinary clinic, the information is often dense and requires that family's link to several aftercare steps. While many learnings have been achieved within our inpatient setting, ambulatory care is typically longer-term as many of our children continue to receive care until age 19.. This past year has been a journey of understanding, building structure, processes and skill for our clinicians. In year two we will be evaluating the information, while having a future lens of creating a blueprint for other outpatient services that will guarantee our clients and families are supported following their appointment.

3. **Authentic Client and Family Partnerships:** Clients and families want to be empowered to advocate for their needs, or their child's needs, to allow them to be the 'integrator and system connector' for themselves or their child. At Holland Bloorview, partnership is authentic and includes active participation in decision making and having an equal voice in initiatives that impact care. In the 2017/18 QIP, partnership will take shape in three key activities:
  - a. Resolution of moderate complaints within 21 calendar days;
  - b. Using outcome tools in partnership with families to set goals for rehabilitation;
  - c. Monitoring the client experience through a pediatric rehabilitation tool that can be benchmarked internationally; and
  - d. Hearing back directly from our kids about their care experiences through an innovative child-focused feedback process.

Supportive listening, shared accountability and a commitment to advance care are ways that we engage with our clients and families. Every year, we challenge ourselves to have clients deeply engaged in conversations about care.

**Building** from the 2016/17 QIP into our 2017/18 QIP will be the ongoing partnership and collaboration with SickKids to enhance transitions between both facilities. Over the next 12 months both organizations will be partnering on common initiatives and collecting baseline measures to increase patient flow between organizations, enhance the family experience and build system capacity for managing kids who are medically complex. While this year a joint measure on the QIP will not occur, the plan is to create the foundation for future integrated measures.

Initiatives		How will we know we have been successful?	
		Process Measure	Outcome Measure
Family Readiness for Transfer	Improving the quality, consistency and timing of information provided to families	Implementation of Information Sheets	72 Hour Discharge Survey asking families of their 'readiness' for transferring from site to site  Transition Rate of Clients from Sick Kids to HB  % of kids transferred back to Sick Kids within 72 hours
	Redesign of Holland Bloorview (HB) Welcome Package	Implementation of 'orientation' process	
	Information sheet of HB services for Sick kids staff		
	Easier access to HB orientation <ul style="list-style-type: none"> <li>Methodologies (e.g technology)</li> <li>Transportation to HB</li> <li>Timing of the orientation</li> </ul>		
	Easier access to accommodations		
Transferring Tracheostomy Populations to HB for Rehabilitation	Identify those clients with tracheostomies for rehabilitation services	Implementation of Care Pathway	# of patients being transferred to HB for tracheostomy training  Reduced Average Length of Stay at Sick Kids  % of kids transferred back to Sick Kids within 72 hours  Client Experience – trust in their providers  Client Experience – trust in their own skills to provide care
	Implement a tracheostomy care pathway	Development and Implementation of Standardized caregiver education tools	
	Standardize caregiver education across both institutions		
	Standardize transition planning across both institutions		
Enhancing Processes between organizations to improve access	Generate processes and tools specific to Complex Care: <ul style="list-style-type: none"> <li>Referral Tool</li> <li>Handover Tool</li> <li>Optimized Intake Meeting</li> </ul>	% of inappropriate referrals  Implementation of a referral tool, handover tool, intake meetings.	Length of time between identification, acceptance and transfer
	Enhance timely access to complete information through the exploration of Information Technology solutions		

Holland Bloorview and SickKids are committed to clients and families receiving the best possible care that will achieve the best possible outcome while meeting the psychosocial needs of the family. This year will be a journey of partnership, shared understanding and solution focused system partnerships to ensure timely access to effective care.



# Access to the Right Level of Care – Addressing ALC Issues

Alternate Level of Care (ALC) is the percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying a hospital bed (acute care or rehab) has finished their phase of his/her treatment and requires alternative care. Within a paediatric setting, ALC has a slightly different implication as our challenges are across the transition from child into adulthood and finding placement, as well when families are not able to take a child home based on modifications to support the transition.

Our ALC is primarily situated within the complex continuing care service which meets the needs of clients with unstable chronic illnesses and/or multi-system diseases. Many clients have tracheostomies or require mechanical ventilation. Although clients may be admitted to the respiratory/complex continuing care unit for extended periods, the goal is to facilitate discharge to the community. In 2016, many of our 'ALC' clients were successfully transitioned to an adult facility, and we remain committed to ensuring that clients and families receive care in the most appropriate setting. Transitioning children continues to be a 'system' challenge with Holland Bloorview engaged in multiple strategies:

- Internal transition strategy
- System partnership with Sick Kids, West Park, Anne Johnston Station
- Provincial engagement in Wait Times Information System (WTIS) ALC data collection
- Toronto Central –Local Health Integration Network (TC-LHIN) Strategy for long stay ALC Rehab patients
- Toronto Central –Community Care Access Centre (TC-CCAC) partnership

While ALC remains a provincial strategy, Holland Bloorview continues to work with all stakeholders to ensure safe and appropriate transition of clients across the continuum of care.

## Engagement of Leadership, Clinicians and Staff

Quality continues to be a shared commitment and accountability throughout all levels of the organization. Engagement is the cornerstone of our development, planning and implementation of improvement initiatives that impact care. Staff across the organization participates actively in various quality committees, working groups and huddles to advance the organization's integrated quality management plan (IQMP). We continue to measure our success through our IQMP while anchoring our work across three fluid domains that are foundational, operational and strategic.

## What informs our integrated Quality Framework?

Legislation  
(e.g. Essential Care for All Act, patient safety Indicators, Bill 46, Bill 8, Patients First Act)  
Hospital Services Accountability Agreement with the TC-LHIN  
Regulatory bodies  
Board of Trustees  
External stakeholders (HQO, ISMP, CPSO)  
Clients and families  
Scientific literature  
Ministry of Health  
Ministry of Education  
Ministry of Child and Youth Services  
Special needs strategy



## What will we achieve with our integrated Quality Framework?

Financial sustainability  
Increased organizational capacity  
Strategic succession planning  
Horizontal/vertical integration of quality and safety  
Leaders in client and family integrated care  
Stable and experienced workforce  
High performing organization  
System leaders in paediatrics quality and safety  
National and international partnerships  
Shared accountability for care  
Enhanced leadership skills  
Corporate plan that promotes learning  
Improved navigation and access  
Increased evidence based guidelines  
Building capacity in our family/youth leaders to make system change  
In quality/safety (PSEP)

Contact:  
Sonia Pagura, senior director, quality, safety and performance, ext. 3235

Our QIP development process continues to be rigorous and staged to enable the engagement of multiple stakeholders while incorporating time for iterative review, feedback, revision before finalization. Over the duration of the QIP process we engaged well over 200 clinicians and leaders through various committees, focus groups and open forums. Through each iterative engagement the plan was refined and ultimately 'signed off' by each group to ensure agreement in direction and improvement work.

## Patient/Resident/Client Engagement

Client and Family Integrated Care (CFIC) is a key strategic focus of the organization. Building upon the success of last year's engagement process we our Family Leaders, Youth Leaders, Child Leaders and Family Advisory Committee informed the strategic priorities of the QIP and change plans. Engagement strategies included surveys, group activities, one-on-one interviews, focus groups and feedback from our Family Leaders at the Quality Committee of the Board. Over the course of the 3 month engagement process we listened to 50+ Family Leaders, 14 Youth Leaders and 6 Child Leaders that helped us to refine our plan.

What we heard from our clients and families were the following key themes:

- i. More clear and concise explanation of medical results – making it easy to understand;

- ii. Detailed explanation of what the next steps are to continue care at home;
- iii. To include more patient feedback, and not just parental feedback;
- iv. Focus on transitions beyond the walls of Holland Bloorview and;
- v. Focus on mental wellness for clients and their families.

Some quotes excerpted from the surveys and focus groups that were analyzed and incorporated into the thematic analysis are as follows:

***What’s important to you?*** “Every client has a different trajectory of what they like to do, what their goals are, and you need to cater to that, here are these options”.

***Health care team speaking to you directly:*** “A while ago it was most of the time but now it’s more of me running the conversation, which I prefer because it makes me feel better. It makes me feel a little bit less nervous. I think when you know what’s going on you feel better. Because I can understand what I’m experiencing, I would rather that doctors talk to me about what they are going to do.

***Understanding what the health care team is saying:*** “I think I probably would say “sometimes”. Because they sometimes talk in concepts which I don’t always understand and they say words that don’t always make sense. So I think they should try to talk in a more kid friendly language. When I ask them to explain things they usually do a pretty good job of explaining, but they should try to speak more in words that kids would understand so that I don’t have to ask. It’s not a problem that I have to ask questions, but for some other kids who may have trouble asking some of the questions it might be harder for them to understand. They would be more nervous because they don’t understand what’s going on.”

***Does your health care provider speak to you or your parents?*** “It’s important to progressively encourage the client to speak for themselves and be more vocal as they go along, but again, it’s on a case by case basis so it’s important for the care provider to not assume that when a patient turns 15 they will treat them like they treat every other 15 year old and talking to them and expecting them to know x, y, and z, because they may be dealing with an injury that they haven’t had for their whole life. I think it’s a commonly occurring theme ... being respected as to where you are in your illness and how much you know and it’s important to encourage independence and being autonomous and a person that feels like they know more about themselves than their parents do.

***Does your health care team coordinate your care?*** It depends on if they were all in the same department. From department to department I find that it’s hard to communicate well no matter how much you try. Because they do very different things and sometimes it’s hard to understand.

“So I have a doctor at XXXX who handles my stomach stuff. One of my doctors here told me that I was going to have to get a surgery thing that would help me out, but I really didn’t want that. My other doctor from XXXXXX didn’t know anything about that and then he told me that he would NEVER have anyone do that surgery to me because he really didn’t think that it was a good idea. It would have been a lot easier if the two doctors had talked to each other about it so it wouldn’t have stressed me out.”

The engagement process also included future focused questions of what Holland Bloorview should concentrate on as 3 to 5 years from now. Our clients and families were unequivocal in their unified voices which included:

- Transitions: Continuing to improve transition supports from paediatric to adult health care centres. Ensuring the right information, enough information, understandable information anchored in best practices 100% of the time;
- Resiliency training for children and adults as it relates to mental wellness;
- System planning (service intersection and coordination) in exploring the future needs of clients;
- Equity: translators, translated material, culture issues, advocacy for those with disabilities in the wider population
- Coordinating care: within Holland Bloorview and across the health care system.
- Measuring long term success of young persons with disabilities

At the end of the process our Family Advisory Committee endorsed the QIP and agreed the engagement process was inclusive and reflected throughout the measures and change plans. In continued shared partnership, a one page infographic document will be developed and posted on our website to represent and summarize the work for the coming year.

## Staff Safety & Workplace Violence

Staff is integral in the delivery of compassionate care to our clients and families. Ensuring staff feel valued and safe in their work environment is of paramount importance to Holland Bloorview. Our strategic plan has a dedicated pillar ‘Inspire Our People’ that speaks to our commitment to our staff.

In 2015, the organization became the first in Canada to implement the Schwartz Centre Rounds<sup>®</sup>, the signature program of the internationally renowned Schwartz Center for Compassionate Healthcare, a non-profit organization dedicated to strengthening the relationship between patients and caregivers. Over the past two years we have provided topics on:

- “Shattered, but lived to tell the tale”
- “When goals collide”
- “The things I did not know”
- “Hindsight is 20/20: What I would say to my younger self”
- “The apology: I am not sure what I did wrong”
- “Walking in both shoes, Part One”
- “Letting Go”
- “Fired by the Family”
- “Walking in Both Shoes, Part Two”
- “Caught in the Middle”

As part of the Schwartz Centre<sup>®</sup> evaluation has been critical and what we found is that on average we have 128 clinicians that attend each session, 93% rate the rounds as ‘good or excellent’ and 96% have indicated they would return to future rounds. Surveys administered to staff as part of a larger research initiative found that:

- 97% report new insights into perspectives/experiences of their co-workers
- 90% of respondents reported new insights into perspectives/experiences of patients and/or families;
- 63% of respondents reported feeling better prepared to handle tough/sensitive patient situations;
- 80% feel more open to express thoughts, feelings, and questions about patient care with colleagues
- 74% of respondents felt less isolated in their work with clients.

Excerpts from a staff highlighted that Schwartz Rounds ®:

*“I continue to remember that families have a “bigger picture” outside of their therapies, and that we as clinicians need to take time to listen to their stories.”*

*“I now understand that it is ok to rely on co-workers for emotional support and that situations may arise quickly and unexpectedly”*

*“Schwartz Rounds ® makes me aware that no matter what profession, we are all the same.”*

*“We all have a story we carry with us – makes us who we are...makes us good at what we do. Thank you!”*

In addition to Schwartz Rounds as a focused initiative to support our staff, on a bi-annual basis the organization conducts an employee engagement survey. Our survey in 2016 captured 610 voices or 74% of our staff, well above the average hospital benchmark of 57%. Our overall engagement score was 83%, in the top decile of performance across similar industries. Reviewing our results across the dimensions, less than 3% rated an ‘unfavourable’ score to quality and safety. Aligned with our Enterprise Risk Management (ERM) framework and review in 2015, the focus of activity over the next year will be on the development of a psychological health and safety program that will enable easier identification, prevention, support, reintegration and sustainment of health in the workplace. We will achieve this by the end of 2017 through the following initiatives:

- i. Ongoing quarterly Schwartz Centre Rounds® which provides a ‘safe’ place of sharing and compassionate care;
- ii. Understanding the current state of HBKR as it relates to psychological wellness (e.g. environmental scan, literature review, industry standards, focus groups/engagement and data review)
- iii. Develop a strategy for psychological health and safety (develop and approve) organizationally
- iv. Leadership and staff training on psychological injury and wellness program (e.g. process, assessment, resources)
- v. Evaluation of staff psychological well-being using a standardized framework as part of Schwartz rounds or other initiatives

Healthcare continues to change at a fast pace, and clinicians similar to clients/families are integral to successful health outcome. At Holland Bloorview our focus will continue to remain on compassionate care and well-being of our employees, physicians, volunteers and students.

# Performance Based Compensation

By legislation, a portion of senior executive compensation must be performance-based (“at-risk”) and linked to measures arising from the QIP. Accountability is spread across all executives with equal weighting of all indicators selected. The selection of the 2017/18 indicators is aligned with the strategic direction of the hospital and reflects stretch goals in areas of desired improvement. In 2017/18 the ‘pay for performance’ indicators will be pulled from the safety and access dimensions.

**Table 1**

Dimension	Measure	Proposed Target	Performance Corridor		
			Zero payout	100% payout	120% payout
Safety	% of families rating that health care providers gave an understandable explanation of medicines	90%	Less than 81%	81 to 90%	Greater than 90%
Safety	% of families and clients reporting they felt they were adequately supported in preparing for discharge <b>‘new’</b>	90%	Less than 81%	81 to 90%	Greater than 90%
Access	Wait times: 80th percentile in length of wait time for clients accessing Autism or Neuromotor services measured in days.	137 days	Greater than 151 days	137 to 151 days	Less than 137 days

The percentage of QIP at risk pay for each executive is uniformly twenty-five percent of total at risk pay, with 3.75% of the President & CEO salary at risk and 2.5% of all other ‘executives’ salary at risk for QIP measures and targets.

## Contact

If you would like to know more about our initiatives, engagement process or key learnings, please feel free to contact Sonia Pagura, Sr. Director of Quality, Safety and Performance at [spagura@hollandbloorview.ca](mailto:spagura@hollandbloorview.ca).

## Other

***Mapping pediatric rehabilitation services across Canada:*** Rehabilitation continues to evolve across the Canadian landscape and takes place in hospital, in children’s treatment centres, at school and at home. A continued strategic focus on how to better provide care to children and youth that aligns with local, provincial and national mandates is required. The Canadian Network for Child and Youth Rehabilitation (CN-CYR) under the Canadian Association of Pediatric Health Centres (CAPHC) has strategically led a pan-Canadian focus on pediatric rehabilitation over the past decade. The work aimed to better understand rehabilitation services and the challenges and opportunities that exist. Through the generosity of donors to the Holland Bloorview Kids Rehabilitation Hospital Foundation, a mapping initiative of rehabilitation centres and services was conducted to capture both quantitatively and qualitatively the key challenges within rehabilitation. Preliminary findings across the 119 sites surveyed and 30+ focused interviews of administrators suggest that further exploration is required surrounding:

- i. Core paediatric rehabilitation services (e.g. physiotherapy, occupational therapy, speech language pathology) are not what families voiced as their primary rehabilitation ‘needs’;
- ii. Complex ministerial funding policies, shrinking overall funding, powerful advocacy groups, and recruitment and retention issues create gaps for clients and families;
- iii. The lack of services in adult care and the drastic growth of certain diagnostic populations (e.g. autism) create significant service issues.

In 2016 foundation funding was secured again to test the preliminary findings with families.

**Pediatric Rehabilitation Reporting System (PRRS):** There is little information in the pediatric rehabilitation sector on the access, effectiveness, efficiency and overall quality of services. Historically, organizations have collected information locally in the hopes of guiding the planning of services as it related to community needs.

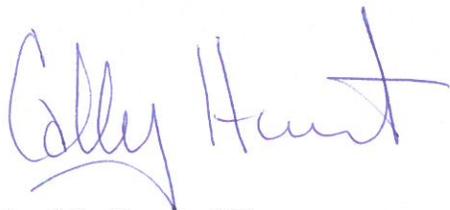
The PRRS is a standardized approach to collection, analysis and dissemination of valid and reliable outcomes measurement data related to the pediatric rehabilitation. With these standardized data collection and reporting practices, the healthcare system at all levels will be able to measure and compare the quality of care with a view to addressing critical gaps and improving services and outcomes across the care continuum into adulthood.

PRRS has now commenced flowing data nationally to the Canadian Institute for Health Information with an expected report to be released in early 2018. Holland Bloorview continues to lead the initiative, and the access measures in the QIP reflect the alignment with this national endeavor.

## 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



Chair of the Board of Trustees  
Cally Hunt



Chair of the Quality Committee of the Board  
Laurie Hicks



President & CEO  
Julia Hanigsberg