



**Canadian Mental
Health Association**

**Association canadienne
pour la santé mentale**

Windsor-Essex

Integrated Quality Improvement Plan

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Quality Improvement Plan Canadian Mental Health Association Windsor Essex County Branch

In order for a quality improvement plan to be successful it must become part of the fabric of everything that is carried out within the CMHA-WECB. The agency must become an organization that continuously improves structures, processes and outcomes for internal and external stakeholders.

A significant cultural change is required in the way we have traditionally viewed quality. High quality care and service cannot be identified solely on the achievement of meeting standards. Quality must be viewed in two parts: quality in fact and quality in perception. Quality in fact is when we meet understood standards. Quality in perception is only achieved when all stakeholders believe their expectations are being met. The focus of quality must shift from the organization's definition to the consumer's definition.

To facilitate the necessary cultural change, the Quality Improvement Plan includes collaboration of all programs and services at the CMHA-WECB. The responsibility for quality becomes everyone's responsibility and the focus changes from "people problems" to "process problems".

The purpose of the Quality Improvement Program at CMHA-WECB is to provide a framework for accountability within the organization that integrates the eight quality domains identified by Accreditation Canada. It encompasses all programs and services at CMHA-WECB including Risk Management, Safety and Utilization Management.

The CMHA-WECB Quality Improvement Plan builds a firm quality foundation on shared values and common understandings. It is the people within the CMHA-WECB who create the quality culture. The success of the organization's cultural transformation depends on the integration of all systems and processes at CMHA-WECB.

Components of the Integrated Quality Program

- A Quality Council Committee
- Committee Terms of Reference
- A standard indicator/scorecard template
- A Summary Report/Action Plan Template
- Quality Council Report Schedule
- Evaluation Tool for the Quality Council and Quality Working Group
- Annual Feedback Form - Quality Program
- Annual Report
- Risk Management/Safety Program
- Infection Control Program
- Medication Management Program
- Ethics Framework
- Change Management Plan

Opportunities for Quality Improvement

- Recommendations from the Accreditation Canada report/compliance with standards
- Areas of improvement identified by care/service provision teams
- Areas that are problem prone, high-risk, high volume, high cost

- Improvements that are consistent with the organization's service delivery and strategic goals and objectives
- Improvements that are relevant to the community's health needs
- Areas identified through the complaint/suggestion process
- Areas identified through the risk management process
- Areas identified by licensing/accreditation bodies

Improvement Activities

- Critical actions and timelines
- Responsibility/Accountability
- Goals
- Evaluation Tools
- Outcomes
- Next Steps

Monitoring and evaluation continues after improvement actions are taken to determine whether the actions actually improve the care or service and that improvement is maintained.

Alignment with the Strategic Plan

The CMHA-WECEB has an established strategic planning process. The Quality Improvement Plan demonstrates strong linkages between the Strategic Plan ENDS Policies, strategic/operational planning, program goals, quality improvement and the accreditation process.

We measure our success on achieving good outcomes by focusing on the eight elements of quality endorsed by Accreditation Canada including:

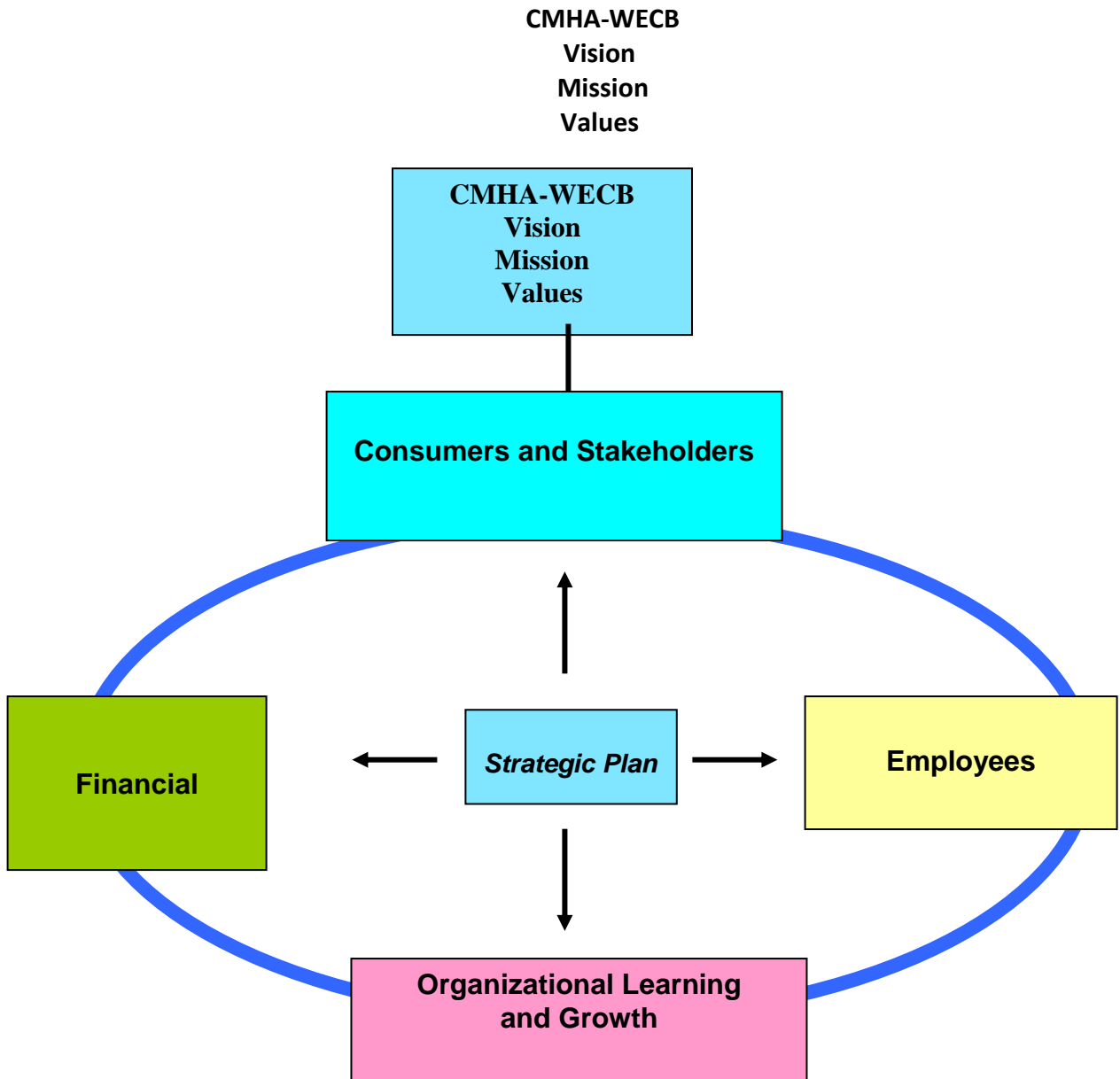
- Population Focus
- Accessibility
- Safety
- Worklife
- Client Centred Services
- Continuity of Services
- Effectiveness
- Efficiency

Also included in the quality domains is Competence – taken from the Mental Health Accountability Framework

The organizational scorecard incorporates the quality domains into four standard quadrants – Consumers, Employees, Learning and Growth and Financial for the purposes of reporting to the public.

The diagram on the next page demonstrates the link between these measures and the strategic goals of CMHA-WECEB.

Example Public-Sector Balanced Report Card



Section 1 History of Continuous Quality Improvement at CMHA-WECB

The CMHA-WECB has a strong history of continuous quality improvement. The development of a Quality Program began in 2002, under the lead of the Director of Operations, and following the decision to become an accredited organization under the CARF Model.

From 2002 to 2003 the Continuous Quality Improvement Committee developed a Board approved work plan; began the process of documenting the various programs using a Program Logic Model; training was provided to Managers and staff in the development of goals, outcomes and treatment planning; planning for the development of internal indicators began; and a CQI Board Committee was formed to provide process oversight. A “Manual for Collecting Outcome Measurements at CMHA-WECB” was developed. Tools identified as sources included the Psychosocial Rehabilitation (PSR) Toolkit, a client questionnaire (quality of life), and a client satisfaction questionnaire (satisfaction with quality of service).

In 2004, under the lead of the new Director of Operations, the organization proceeded with the accreditation process through the Canadian Council on Health Services Accreditation (CCHSA). At this time coordinators were hired to oversee the accreditation process and implementation of the Ministry mandated CDS/MIS. Quality improvement initiatives continued to focus on improving client outcomes but the accreditation and CDS/MIS projects had priority.

During 2005 a Quality Framework was developed, existing indicators were collected and reviewed and a sub-committee was formed to assist Managers to develop rate based indicators for service.

The CMHA-WECB implemented the CDS/MIS process and achieved a successful CCHSA accreditation in 2005.

The CCHSA survey team recommendations stated “It is recommended that the agency complete the development and implementation of its quality improvement program. It is further recommended that the leadership team provide direction and guidance to other teams on the development of appropriate indicators for the agency”. This issue was given a risk rating of medium for likelihood, high for severity and high for urgency. The potential for an adverse event was described. “The agency may not be able to benefit from its quality improvement activities if all steps in the development of a quality plan are not addressed”. The reason for the urgency rating was described. “The program is being developed and needs to be implemented with staff involvement. Indicator development needs to be coordinated to ensure that agency priorities are being measured and evaluated”.

The development of a formal Quality Program began in 2005 following the accreditation survey. Quality performance indicators were identified for many programs and were monitored by the Quality Committee. Staff involvement was key to this process and a Quality Program Evaluation Survey was implemented to measure the effectiveness of education initiatives around quality. Much progress was made toward an integrated quality program over the next two years.

In 2008 the organization completed its second accreditation survey through the Accreditation Canada “Qmentum” Program and received a full three year accreditation. Improvements in the Quality Program were recognized by the survey team. The organization was encouraged to continue on this path of improvement and move the program forward with the focus on outcomes.

The position of Continuous Quality Coordinator was developed in September 2008, following the 2008 accreditation survey. The organization wide balanced scorecard was developed and published on the agency website. During 2008 – 2009 each program developed a comprehensive scorecard based on key performance indicators related to program goals. Each indicator was specifically defined and its benchmarks or targets identified. The process for gathering data and for presentation of results, was designed to emphasize ease of use and facilitate staff involvement. The agendas of each unit meeting were required to include educational activities related to quality improvement in addition to the annual mandatory education of all staff. Outcomes of these improvements were monitored for effectiveness.

In 2009 consumer and community perception of services were identified as key outcome indicators. The Consumer Survey (MHSIP) was updated to include the clients’ perception of achievement of their goals, improved functioning and improved social connectedness. Data for the entire organization as well as within programs were gathered and compared to organization-wide and national results. To gain a measure of community satisfaction with service delivery community partner surveys were developed for the Justice Program, Employment Support Program and the Geriatric Urgent Response Program. Internal staff satisfaction surveys were also developed to measure satisfaction with service delivery of Information Management, the File Room and Volunteers Needs Assessment and the Serendipity Café.

All Accreditation Canada Surveys were delivered in late 2009 and early 2010 in preparation for the on-site survey in 2011. The organization completed a successful accreditation survey in May 2011 receiving Accreditation with Exemplary Standing.

Ongoing improvements are part of the culture of integrated quality improvement embedded into the organization. In response to the on-site survey comments an action plan was developed to address specific issues identified.

The following Quality Improvement Plan serves as the foundation of the commitment of the CMHA-WECB to continuously improve the quality of the treatment and services it provides.

Quality Improvement Principles

Quality improvement is a systematic approach to assessing services and improving them on a priority basis. The CMHA-WECB approach to quality improvement is based on the following principles:

- Customer Focus.** High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations.
- Recovery-oriented.** Services are characterized by a commitment to promoting and preserving

wellness and to expanding choice. This approach promotes maximum flexibility and choice to meet individually defined goals and to permit person-centered services.

- **Employee Empowerment.** Effective programs involve people at all levels of the organization in improving quality. Quality is the responsibility of each staff member and volunteer. We demonstrate this by stating it in our position descriptions, reinforcing it in orientation and demanding it in practice. We support those who provide direct care, enabling them to provide quality service that meets the needs of clients/patients
- **Leadership Involvement.** Strong leadership, direction and support of quality improvement activities by the governing body and CEO are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with provider mission and/or strategic plan.
- **Data Informed Practice.** Successful QI processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions. Our approach to quality is evidence-based, modeled on best-practices and informed by current research.
- **Statistical Tools.** For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, histograms, and control charts to turn data into information.
- **Prevention over Correction.** Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.
- **Continuous Improvement.** Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Purpose of the Integrated Quality Program

The purpose of the Integrated Quality Program is to provide a framework for accountability within our organization.

Quality Improvement Framework

The Quality Program Framework incorporates risk management, utilization management, and change management; performance measurement to include monitoring of strategic goals and client safety; and evidence of a systematic approach to assessing services and improving them on a priority basis.

Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the agency leadership, is understood, accepted and utilized throughout

the organization, as a result of continuous education, good internal and external communication and involvement of staff at all levels in performance improvement. Quality Improvement involves two primary activities:

- Measuring and assessing the performance of services through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including the
 - Design of new services, and/or
 - Improvement of existing services.

In 2012, the agency adopted the PROSCI methodology of managing change as part of a quality improvement framework. The recommendation was based on the following attributes of the Prosci method:

- Prosci's tools and methodology for change management are based on best practices research with over 2600 international organizations across all disciplines, including health care and non-profits, in over 60 countries. Every year there is a survey among change managers around the world which is used to produce a benchmarking report made available to users of the Prosci methodology for continuous improvement
- Their tools are used by more than half of Fortune 100 companies and by over 60% of Fortune 500 companies
- It is also holistic, research based, easy to apply and scalable.
- The implementation costs were more manageable

The agency decided to train someone in-house in the methodology to be a continuing resource and champion of change management. The Training and Development Administrator position was selected as the best resource to lead change management in the Agency.

. Organizational approaches to managing change differ according to the type and scope of the change, and its impact on the organization, staff and service providers, clients, families, and the community.

A formal change management process requires a clear vision for change which is presented to staff, service providers and volunteers. It is implemented by an operating plan in which the roles and responsibilities of those managing it are clearly defined and for which adequate financial and human resources are made available for its implementation, monitoring and evaluation.

Section 2

Leadership and Organization

Leadership

The key to the success of the Continuous Quality Improvement process is leadership. The following describes how the leaders of the CMHA-WECB provide support to quality improvement activities.

The **Quality Council** of the Canadian Mental Health Association, Windsor-Essex County Branch, is delegated by the Board to prioritize and coordinate all organization-wide quality/performance improvement activities in accordance with the approved Quality Improvement Plan and Strategic Plan, in response to the demand for accountable service delivery within the mental health delivery system. The role of the Council is to show responsibility and leadership by monitoring the productivity of the Branch's services; review benchmark achievements; and, monitor the efficiencies and outcomes of our publicly funded programs.

FUNCTIONS

1. To provide leadership for quality improvement and foster a quality improvement culture throughout the organization.
2. To recommend performance measures to the Board of Directors and to monitor performance measures, ensuring that they meet minimum performance expectation in the accountability agreement with the LHINS and Accreditation Canada.
3. To receive and analyze performance data and information trended over time.
4. To ensure that feedback is obtained from clients, staff, service providers, key stakeholders, and the community.
5. To identify opportunities for improvement and recommend actions to address them.
6. To monitor identified risks to the organization, client safety initiatives and promote ongoing quality improvement.
7. To monitor improvement/action plans and ensure outcomes are met in a timely manner.
8. To encourage open communication and a blame-free dialogue about client safety issues, incidents and potential problems.
9. To promote the ongoing search for leading practices and benchmarking opportunities.
10. To ensure transparency with stakeholders in terms of organizational performance and to produce a public balanced scorecard.
11. To oversee and support the cross-functional, multidisciplinary activities of the Quality Council Working Group.
12. To provide reports, information and recommendations to the Governance Team for Accreditation regarding the Quality Program.
13. To provide leadership to the accreditation process in relation to the Quality Program.

MEMBERSHIP

This Chairperson of the Quality Council shall be a member of the Board of Directors. Representatives on the Council will include the Director of Operations and the Accreditation/Quality Improvement Coordinator. Additional members will be ad hoc.

The Board Chair and CEO will be ex officio members of the committee and receive all agendas and minutes. At any time staff members may be requested to participate and/or present to the Council as determined by the agenda.

The **Quality Council Working Group** of the Canadian Mental Health Association, Windsor-Essex County Branch, has been struck by the Quality Council to promote a quality culture within the organization and

develop leading practices. The role of the Working Group is to support the activity and functions of Quality Council and to provide operational responsibility and leadership by monitoring the productivity of the Branch's services; review benchmark achievements and monitor the efficiencies and outcomes of our publicly funded programs.

This Working Group will analyze data, recommend indicators and benchmarks for quality improvement developed from data gathered for the purpose of monitoring the effectiveness of each service and making recommendations to the senior management team and Quality Council in regards to improvements to our service delivery.

The Working Group will provide information and reports to support the work of Quality Council and will attend Quality Council meetings as necessary to present scorecards and improvement plans.

This Working Group will also take staff leadership to ensure ongoing accreditation of CMHA WECB services.

FUNCTIONS OF THE WORKING GROUP

1. To provide staff leadership for quality improvement and foster a quality improvement culture throughout the organization.
2. To analyze data, and information trended over time and make recommendations/develop action plans for improvements, indicators and benchmarks for the Organizational Scorecard and Quality reports for each service area.
3. To provide reports, scorecards, action plans and outcomes for enclosures to the agenda for Quality Council, ensuring that the minimum performance indicators for the LHINS accountability agreement and Accreditation Canada have been met.
4. To identify opportunities for improvement and recommend actions to address them.
5. To monitor identified risks to the organization, client safety initiatives and promote ongoing quality improvement, providing quarterly summary reports to Quality Council.
6. To encourage open communication and a blame-free dialogue about client safety issues, incidents and potential problems.
7. To identify and promote the ongoing search for leading practices and benchmarking opportunities.

MEMBERSHIP OF THE WORKING GROUP

Chair: Director of Operations

Director of Finance & Corporate Services

Senior Manager, Fund Development and Community Engagement

Director of Human Resources

Managers:

Manager Mental Health Services Team #1

Manager Mental Health Services Team #2

Manager Mental Health Services Team #3

Manager, Mental Health Services Team #4

Manager, Community Health Centre

Manager Housing, Facilities & Employment Services

Accounting Manager

Integrated Director, Outpatient and Community Services

Psychologist/Psychiatrist
Manager, Housing, Facilities & Employment Services
Continuous Quality Improvement (CQI) Coordinator
1 – 2 Community Support Workers
1 Support Staff

Administrative Assistant to Director of Operations

The **Board of Directors** also provides leadership for the Quality Improvement process as follows:

- Supporting and guiding implementation of quality improvement activities at the CMHA-WECB.
- Reviewing, evaluating and approving the Quality Improvement Plan annually.
- Proactively seeking solutions to ensure resources are available to meet the needs and achieve the goals and objectives of the Quality Improvement Plan

The Leaders support QI activities through the planned coordination and communication of the results of measurement activities related to QI initiatives and overall efforts to continually improve the quality of care provided. This sharing of QI data and information is an important leadership function. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, recipients and family members have knowledge of and input into ongoing QI initiatives as a means of continually improving performance. Planned communication takes place through the following methods:

- Regular reports to the Board through the Board representative on Quality Council
- Regular reports to the Board through the agency Chief Quality Improvement and Privacy Officer
- Regular reports to the Board through the agency Chief Quality Improvement and Privacy Officer through the CEO
- Reports to staff through the Director of Operations or Chief Quality Improvement and Privacy Officer
- Regular program presentations to the Quality Council on program specific indicators, actions, improvements, outcomes

** All above reported information may be on an as necessary basis communicated to the Board of Directors through the Quality Report.

Section 3

Goals and Objectives

The Quality Council identifies and defines goals and specific objectives to be accomplished each year. These goals include training of clinical and administrative staff regarding both continuous quality improvement principles and specific quality improvement initiative(s). Progress in meeting these goals and objectives is an important part of the annual evaluation of quality improvement activities. A monitoring schedule is in place to ensure all activities are completed according to the requirements.

The ongoing long term goals and annual goals for the CMHA-WECB Integrated Quality Program are identified in Appendix A.

Section 4

Performance Measurement

Performance Measurement is the process of regularly assessing the results produced by the program. It involves identifying key processes, systems and outcomes that are integral to the performance of the service delivery system, selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis. Continuous Quality Improvement involves taking action as needed based on the results of the data analysis and the opportunities for performance they identify.

The purpose of measurement and assessment and selection processes for performance measures are identified in Appendix B

Section 5

Quality Improvement Initiatives

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify a continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon agency/program priorities. The model utilized at CMHA-WECB includes the following steps:

- Identifying preliminary opportunities for improvement. At this point the focus is to analyze data to identify concerns and to determine anticipated outcomes. Ideas for improving processes are identified. Affected staff or people served are identified, data compiled, and solutions proposed.
- Using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.
- Data is again collected to compare the results of the new process with those of the previous one.
- Making the changes a routine part of the targeted activity. It also means acting to involve others (other staff, program components or consumers) - those who will be affected by the

changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned.

- Documenting and reporting findings and follow up. Ensuring established goals are met.
- Recognizing and celebrating the contributions of everyone involved.

Section 6

Evaluation

An evaluation is completed each year by review of the organization wide and program specific scorecards. Outcomes, improvement initiatives, status and trends are evaluated. The annual evaluation is conducted by the Chief Quality Improvement and Privacy Officer and program representatives. These documents are reviewed along with MIS, CDS, QOSR and other statistical reports by the Quality Working Group, Quality Council, CEO and Board.

The evaluation summarizes the goals and objectives of the CMHA-WECB Quality Improvement Plan, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings.

Each program scorecard includes a summary report that is updated annually.

Section 7

Education/Learning Support

The CMHA-WECB is committed to ensuring all employees are competent in their daily practice. The pursuit of competency based educational programs will support and maintain the required competency. Quality improvement learning is provided through the orientation process, annual education sessions, unit presentations and staff representation on the Quality Council Working Group. Annual education is provided for all as mandatory training. Attendance is documented and reported as a quality indicator. The attendance target for mandatory education is 100% attendance. Education is also provided to the Board on the role of the Board in Quality Improvement and Safety. Building capacity for staff to understand and participate in quality and change management is key to an excellent workforce. The implementation of a talent management process that is transparent and equitable is expected to create an environment for people to develop their skills in preparation for a range of future possibilities thereby preparing the workplace for changing roles.

Section 8

Recognition and Celebration

A culture of quality will only exist if value is placed on quality and efforts to improve quality. Evaluation of a commitment to quality must be part of the performance review process for all staff, with acknowledgement of exemplary contributions to quality.

The Annual Quality Awards Presentation celebrates quality improvement efforts in the organization and serves as an opportunity to share and build knowledge regarding the implementation of quality improvement projects and how to measure and improve results.

In 2009 the award selection process was revised to include recognition of quality initiatives in all eight of the Accreditation quality domains. This will allow for a broader recognition of program quality improvement initiatives other than those related to direct client care.

The award selection process was revised in 2010 to include all staff voting for first, second and third place awards. This process received excellent feedback and will continue. All quality award recipients are posted on the Intranet Quality Tab and award recognition is provided at the all staff meeting and the annual general meeting.

In 2010 processes were implemented to acknowledge the work of staff at all levels and include different types of recognition at unit meetings, feedback from clients about individuals, and public recognition of achievements through announcements at general staff meetings and postings. A staff appreciation form was added to the agency Intranet in 2010.

The agency adopted a new recognition in 2014 called the Fancy Awards.

The criteria for the Fancy Awards are as follows:

CARING

Client Focused; a person who displays an exceptional level of compassion. Someone who is a natural at helping others when they require emotional support, empathetic, able to relate to unique situations and individual circumstance, without being compromised, in an effort to help wherever possible, considerate

SETTING A GOOD EXAMPLE

A person you look up to and whose work ethics are exemplary, efficient, follows the rules, works within the established system, person of integrity, compassionate, sensitive and pragmatic, moral compass is unwavering, dedicated and loyal

CREATIVITY

Someone who solves problems using cleverness. This person thinks of things no one else would have come up with, solution focused, able to deconstruct a problem and reassemble the solution, innovative and productive

LEVITY

This person makes you laugh. It is someone whose sense of humour matches no other, able to lighten the mood while remaining focused upon the task at hand, truly funny, seeing the silver lining in almost everything, able to make others feel good about themselves, able to make you smile

Fancy award winners were selected by all staff through a survey process.

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Appendix A

Goals	Outcome Measures
To implement quantitative measurement to assess key processes or outcomes	<i>Organizational Scorecard, Program Scorecards</i>
To bring managers, clinicians, and staff together to review quantitative data and major clinical adverse occurrences to identify problems	<i>Quality Council Working Group, Quality Council, presentation schedule, agendas and minutes/actions, annual quality report, team self-evaluation, program evaluation, Serious Occurrence Report</i>
To carefully prioritize identified problems and set goals for their resolution;	<i>Review of scorecard indicator status, presentation of improvement plan</i>
To achieve measurable improvement in the highest priority areas;	<i>Scorecard reports – status and trend over time for each performance measure</i>
To meet internal and external reporting requirements;	<i>Accreditation Canada, MOHLTC, LHINs, Financial reports in compliance with reporting schedules</i>
To provide education and training to managers, clinicians, and staff and the Board;	<i>Annual mandatory education, ongoing staff education and monitor attendance</i>
To develop or adopt necessary tools, such as practice guidelines, consumer surveys and quality indicators.	<i>Annual reports on all quality indicators, consumer perspective (internal and external), implementation of family survey process</i>

Year	Annual Goals	Process	Outcome
2007-2008	<ul style="list-style-type: none"> Staff Education Program Indicators 	<ul style="list-style-type: none"> Annual education provided to all staff Program indicators presented at Quality Council meetings and presentations evaluated 	<ul style="list-style-type: none"> Some components of the quality program presented at staff meetings. Feedback from evaluation process reviewed and improvements needed. Plan in place March 2008

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Year	Annual Goals	Process	Outcome
	<ul style="list-style-type: none"> Quality Plan 	<ul style="list-style-type: none"> Accreditation Coordinator assigned development of plan 	
2008-2009	<ul style="list-style-type: none"> Organizational scorecard Program Scorecards Streamline Quality Process Improvements in communication All staff education 	<ul style="list-style-type: none"> Drafted Program involvement Indicators reviewed and refined, quality working group & council in place, evaluation process improved, Intranet Tab for quality, presentations standing agenda item for unit meetings, revision to award process Monitoring schedule in place Training Day October 2009 Quality as a standing agenda item for unit meetings 	<ul style="list-style-type: none"> On website Completed Improvements completed – positive feedback. Staff knowledge of program and awareness of program indicators – marked increase Ensure all components monitored and reported Attendance 96.4% Regular presentations delivered in 2009 for CSS, SS, Outreach. WHS and CCHC added in 2010
2009-2010	<ul style="list-style-type: none"> Link program indicators to program goals Revise quality plan to include goals and outcome measures Improve staff recognition process Quarterly newsletter to support communication Education 	<ul style="list-style-type: none"> Work with Program Managers/Staff to develop links and monitor achievement of goals. CQI to work with programs to link indicators to goals Plan reviewed/revise Jan. 2010 and presented to Quality Council for review. Staff recognition/quality award process revised and approved by EMT/Quality Council in Nov. 2009 Newsletter drafted for Jan/2010 Education Day & Board 	<ul style="list-style-type: none"> Indicators on org. scorecard in line with strategic plan and Accreditation Canada Requirements Feedback for April 2010 Quality Council reviewed all nominations April 2010 for award presentations in May Posted on Intranet Quality Tab – targets met for staff awareness Nov./10, Dec./10
2010-2011	<ul style="list-style-type: none"> Focus on ensuring completion of all quality reports and completion of action items in preparation for Accreditation Canada on-site survey May 2011 	<ul style="list-style-type: none"> Preparation of all reports in hard copy and electronic format in a central location for easy review 	<ul style="list-style-type: none"> Completed April 2012 – successful accreditation survey with positive comments from surveyors on effectiveness of the quality program.
2011-2012	<ul style="list-style-type: none"> Review functions of Quality Working Group vs. Quality Council to ensure better use of resources Revise standing agenda items for Quality Council with focus 	<ul style="list-style-type: none"> Review by Quality Council January 2012. Review by Quality Working Group February 2012 Development of agenda and committee membership review Formation of sub-committee to 	<ul style="list-style-type: none"> April 2012 and present to Quality Council for approval

CMHA WECB Quality Program 2015

Year	Annual Goals	Process	Outcome
	<p>on completion and reporting of improvement plans to ensure outcomes/goals have been achieved.</p> <ul style="list-style-type: none"> To develop an organization wide Change Management Plan To develop an organization wide Talent Management Plan 	<p>revise plan, terms of reference</p> <ul style="list-style-type: none"> Change Management Plan developed 2012, updated 2014 Talent Management Plan developed 2014 	<ul style="list-style-type: none"> Aug./12 tools in place PDSA, process mapping. In development – Prosci, LEAN. PDSA projects listed in Quality folder LEAN projects – in process CMHA Intake, CCHC client Flow Draft Change Management Plan & Policy done 2012, finalized 2014 Draft Talent Management Plan in place 2012, finalized 2014
2012-2015	<p>To examine risks associated with staff and personal cell phones</p> <ul style="list-style-type: none"> To hire a consultant to provide a client service review: file documentation, caseloads, etc. (July 2014) To research the development of a family council 	<ul style="list-style-type: none"> FMEA committee addressed staff personal cell phone risks (privacy, security, safety) FMEA committee requested staff feedback in regards to personal cell phones (survey monkey) FMEA committee made recommendations to EMT for the purchase of agency owned cell phones Focus groups with frontline staff and managers A review of processes from the client’s perspective Mapping exercises Comprehensive review of the data base and clinical information Survey developed and mailed out to family members Review of best practice models/family councils 	<ul style="list-style-type: none"> Agency purchased cell phones for front line staff Updated mobile communication policy New Informed Consent for email and texting with clients Updated email policy Development of new screening tool for intake program OCAN administered within the first 90 days of service Discharge planning to begin on admission Expanded low back pain services CCHC Information gathering Focus group/March 2015

Appendix B Measurement, Assessment, Selection of Performance Measures

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify and celebrate program strengths.
- Identify problems and opportunities to improve the performance of processes.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment **involves:**

- Selection of a process or outcome to be measured, on a priority basis.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance with regard to these indicators at planned and regular intervals.
- Taking action to address performance discrepancies when indicators indicate that a process is not stable is not performing at an expected level or represents an opportunity for quality improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

Selection of a Performance Indicator

A performance **indicator** is a quantitative tool that provides information about the performance of the agency's process, services, functions or outcomes. Selection of a Performance Indicator is based on the following considerations:

- Relevance to mission - whether the indicator addresses the population served
- Clinical importance - whether it addresses a clinically important process that is:
 - high volume
 - problem prone or
 - high risk

Characteristics of a Performance Indicator

Factors to consider in determining which indicator to use include;

- Scientific Foundation: the relationship between the indicator and the process, system or clinical

outcome being measured

- Validity: whether the indicator assesses what it purports to assess
- Resource Availability: the relationship of the results of the indicator to the cost involved and the staffing resources that are available
- Consumer Preferences: the extent to which the indicator takes into account individual or group (e.g., racial, ethnic, or cultural) preferences
- Meaningfulness: whether the results of the indicator can be easily understood, the indicator measures a variable over which the program has some control, and the variable is likely to be changed by reasonable quality improvement efforts.

The Performance Indicators Selected for the CMHA-WECB Quality Improvement Plan

For the purposes of this plan, an indicator(s) comprises 10 key elements:

Name,

- Definition
- Source of the data to be collected
- Quality dimension as defined by Accreditation Canada:
 - Population Focus
 - Accessibility
 - Client Centred
 - Continuity of Service
 - Efficiency
 - Effectiveness
 - Safety/Risk
 - Worklife
 - Competence
- Type of indicator
 - Structure
 - Process
 - Outcome
- Benchmark/Target
- Results and Frequency of Monitoring
- Analysis
- Improvement Plan
- Communication

Assessment. Assessment is accomplished by comparing actual performance on an indicator with:

- Self over time.
- Pre-established standards/benchmarks, goals or expected levels of performance.
- Information concerning evidence based practices.
- Other similar service providers.

Sources:

Accreditation Canada
MOHLTC
LHINS
Mental Health Accountability Framework
Best Practices
Internal Requirements for Program Improvements

APPENDIX C Quality Improvement Tools

Following are some of the tools available to assist in the Quality Improvement process.

a. Flow Charting: Use of a diagram in which graphic symbols depict the nature and flow of the steps in a process. This tool is particularly useful in the early stages of a project to help the team understand how the process currently works. The “as-is” flow chart may be compared to how the process is intended to work. At the end of the project, the team may want to then re-plot the modified process to show how the redefined process should occur. The benefits of a flow chart are that it:

- 1) Is a pictorial representation that promotes understanding of the process
- 2) Is a potential training tool for employees
- 3) Clearly shows where problem areas and processes for improvement are.

Flow charting allows the team to identify the actual flow-of-event sequence in a process.

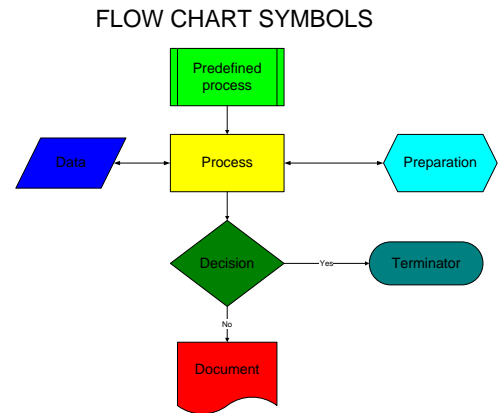
b. Brainstorming: A tool used by teams to bring out the ideas of each individual and present them in an orderly fashion to the rest of the team. Essential to brainstorming is to provide an environment free of criticism. Team members generate issues and agree to “defer judgment” on the relative value of each idea. Brainstorming is used when one wants to generate a large number of ideas about issues to tackle, possible causes, approaches to use, or actions to take. The advantages of brainstorming are that it:

- 1) Encourages creativity
- 2) Rapidly produces a large number of ideas
- 3) Equalizes involvement by all team members
- 4) Fosters a sense of ownership in the final decision as all members actively participate
- 5) Provides input to other tools: “brain stormed” ideas can be put into an affinity diagram or they can be reduced by multi-voting.

c. Decision-making Tools: While not all decisions are made by teams, two tools can be helpful when teams need to make decisions.

- 1) Multi-voting is a group decision-making technique used to reduce a long list of items to a manageable number by means of a structured series of votes. The result is a short list identifying what is important to the team. Multi-voting is used to reduce a long list of ideas and assign priorities quickly with a high degree of team agreement.
- 2) Nominal Group technique-used to identify and rank issues.

d. Affinity Diagram: The Affinity Diagram is often used to group ideas generated by brainstorming. It is a tool that gathers large amounts of language data (ideas, issues, opinions) and organizes them into groupings based



on their natural relationship. The affinity process is a good way to get people who work on a creative level address difficult, confusing, unknown or disorganized issues. The affinity process is formalized in a graphic representation called an affinity diagram. This process is useful to:

- 1) Sift through large volumes of data
- 2) Encourage new patterns of thinking

As a rule of thumb, if less than 15 items of information have been identified; the affinity process is not needed.

e. Cause and Effect Diagram (also called a fishbone or Ishakawa Diagram): This is a tool that helps identify, sort, and display. It is a graphic representation of the relationship between a given outcome and all the factors that influence the outcome. This tool helps to identify the basic root causes of a problem. The structure of the diagram helps team members think in a very systematic way. The benefits of a cause-and-effect diagram are that it:

- 1) Helps the team to determine the root causes of a problem or quality characteristic using a structured approach
- 2) Encourages group participation and utilizes group knowledge of the process
- 3) Uses an orderly, easy-to-read format to diagram cause-and-effect relationships
- 4) Indicates possible causes of variation in a process
- 5) Increases knowledge of the process
- 6) Identifies areas where data should be collected for additional study.
- 7) Cause and effect diagrams allow the team to identify and graphically display all possible causes related to a process, procedure or system failure.

f. Histogram: This is a vertical bar chart which depicts the distribution of a data set at a single point in time. A histogram facilitates the display of a large set of measurements presented in a table, showing where the majority of values fall in a measurement scale and the amount of variation. The histogram is used in the following situations:

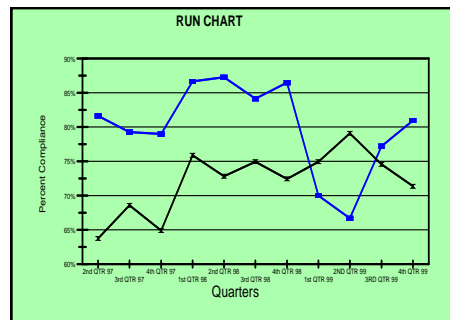
- 1) To graphically represent a large data set by adding specification limits one can compare;
- 2) To process results and readily determine if a current process was able to produce positive results assist with decision-making.



h. Run Chart: Most basic tool to show how a process performs over time. Data points are plotted in temporal order on a line graph. Run charts are most effectively used to assess and achieve process stability by graphically depicting signals of variation. A run chart can help to determine whether or not a process is stable, consistent and predictable. Simple statistics such as median and range may also be displayed.

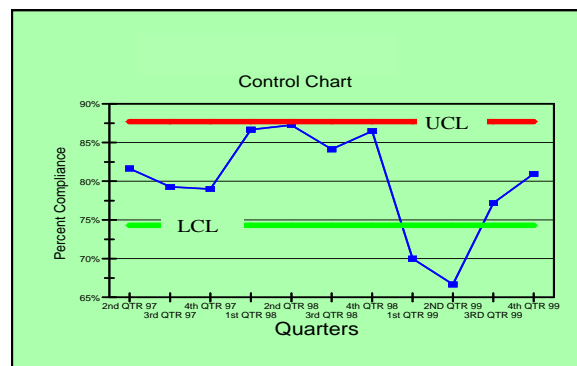
The run chart is most helpful in:

- 1) Understanding variation in process performance
- 2) Monitoring process performance over time to detect signals of change
- 3) Depicting how a process performed over time, including variation.
- 4) Allows the team to see changes in performance over time. The diagram can include a trend line to identify possible changes in performance.

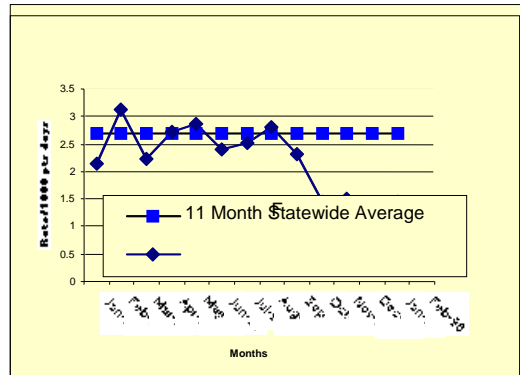


i. Control Chart: A control chart is a statistical tool used to distinguish between variation in a process resulting from common causes and variation resulting from special causes. It is noted that there is variation in every process, some the result of causes not normally present in the process (special cause variation). Common cause variation is variation that results simply from the numerous, ever-present differences in the process. Control charts can help to maintain stability in a process by depicting when a process may be affected by special causes. The consistency of a process is usually characterized by showing if data fall within control limits based on plus or minus specific standard deviations from the center line. Control charts are used to:

- 1) Monitor process variation over time
- 2) Help to differentiate between special and common cause variation
- 3) Assess the effectiveness of change on a process
- 4) Illustrate how a process performed during a specific period



j. Bench Marking: A benchmark is a point of reference by which something can be measured, compared, or judged. It can be an industry standard against which a program indicator is monitored and found to be above, below or comparable to the benchmark.



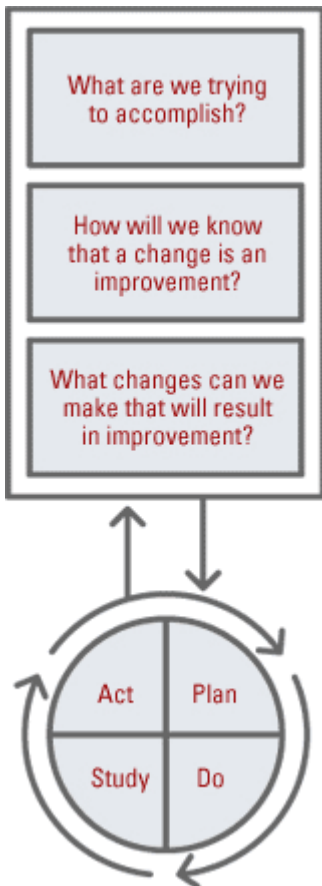
k. Root Cause Analysis: A root cause analysis is a systematic process for identifying the most basic factors/causes that underlie variation in performance.

APPENDIX D *The Model for Improvement*

The Model for Improvement is a powerful tool for accelerating improvement. The model is not meant to replace existing strategies that are effective but to enhance and accelerate improvement.

The model has two parts :

- 1) Three fundamental questions which can be addressed in any order.
- 2) The **Plan Do Study Act Cycle** PDSA (developed by Dr. Edward Deming) to test and implement changes in the real work settings. The PDSA cycle guides the test of change to determine if the change is an improvement.



Setting Aims

Improvement requires setting Aims. The aim should be time-specific and measurable; it should also define the specific population of patients that will be affected.

Establishing Measures

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes

All improvements requires making changes, but not all changes result in improvement. Organizations therefore must identify the changes that are most likely to result in improvement.

Testing

The PDSA (Plan-Do-Study-Act) cycle is shorthand for testing a change in the real work setting - by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.

Implementing Changes

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale. (such as an entire population or an entire unit.)

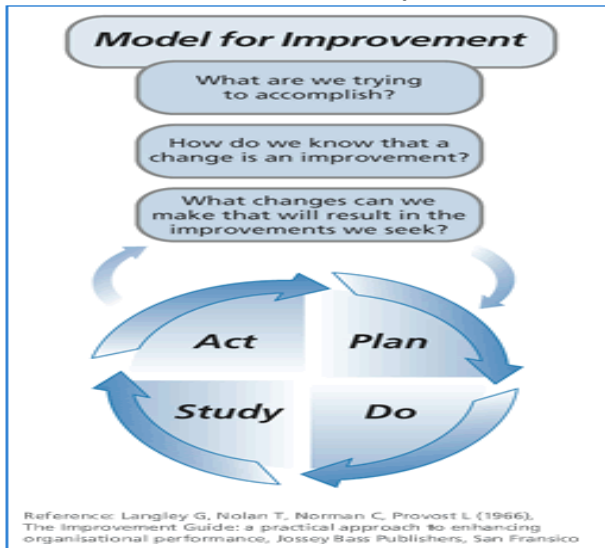
Spreading Changes

After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other departments. A formal communication plan is set up for each project.

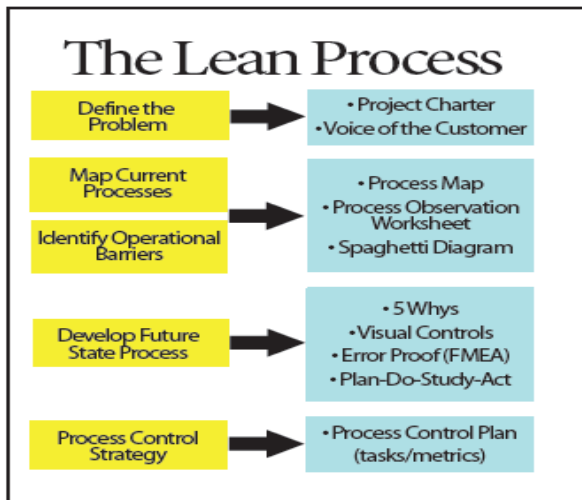
Sources: Langley GL, Nolan KM, Nolan TW, The improvement Guide: A Practical Approach to Enhancing Organizational Performance.

APPENDIX E Change Management Tools –

a) PDSA



b) LEAN



c) PROSCI

ADKAR - The Prosci Acronym

ADKAR, or Prosci's model of individual change stands for Awareness, Desire, Knowledge, Ability, and Reinforcement. Prosci believes that for change to work in an organization, *individuals* must change and understand change. Looking closely at the ADKAR process, we can see how we might implement Prosci's methodology into our projects.

Awareness - This is recognizing the need for change.

Desire - Who needs to participate in the change?

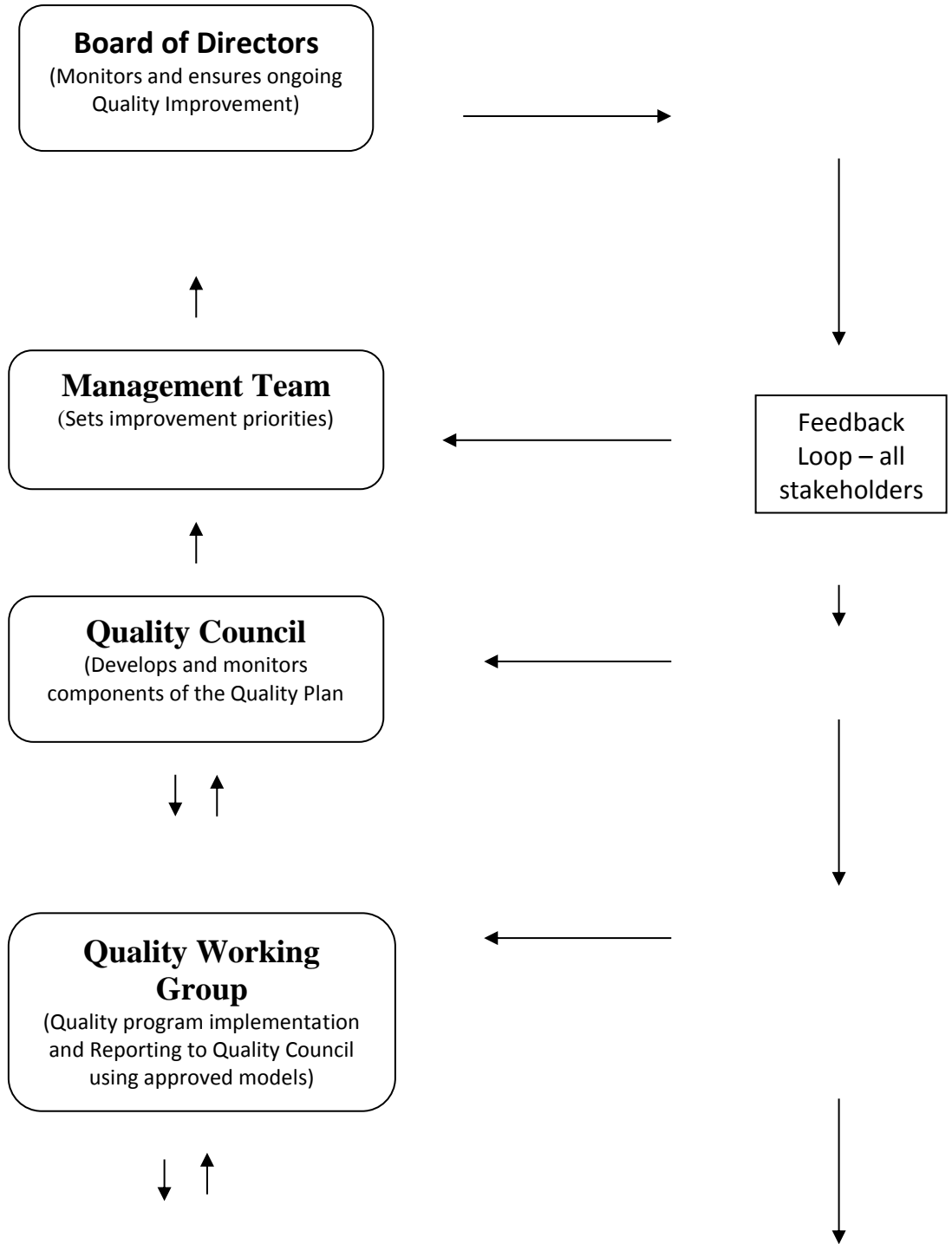
Knowledge - Who has the knowledge to guide the change?

Ability - Who will implement skill sets and change behaviors?

Reinforcement - Who will lay the foundation for change initially and for the future.

APPENDIX F

Quality Reporting Process



OPERATIONALIZATION ACROSS THE SYSTEM

APPENDIX G

DEFINITIONS OF TERMS

QUALITY FRAMEWORK:

The agency uses the framework based on the **Model for Improvement** that is promoted by the *Institute for Healthcare Improvement*, the *Quality Health Institute*, CMHA Ontario Division and is being used by other CMHA. The framework is also based on the Accreditation Canada Guide for Developing Qmentum Plans and Frameworks and Accreditation Canada quality domains.

QUALITY PLAN

The Quality plan describes the objectives for the Quality Council for a given fiscal year. This plan is shared with Management, Board and staff of the agency.

QUALITY COUNCIL

The purpose of the quality council is to carry on activities for the purpose of studying, assessing and/or evaluating the provision of health care with a view to improving or maintaining the quality of the health care or the level of skill, knowledge and competence of the persons who provide health care.

The Quality Council is a Committee formed to:

- Create a forum for learning about the application of process improvement thinking to our services.
- Create a forum for integration of quality initiatives.
- Create a forum for monitoring and reporting of results internally and externally.
- Produce the organization's balanced scorecard.

ACCREDITATION

Accreditation is a tool that helps health services organizations look at and improve the quality of the services they provide to their clients. This tool involves completing a self- assessment based on nationally recognized standards of excellence and peer review, evaluated by a team of surveyors from Accreditation Canada.

Required Organizational Processes

Required Organizational Practices for Client Safety (ROPs). Accreditation Canada has Required Organizational Practices that each agency must have implemented in the organization to meet the expectations for accreditation. CMHA WECB tracks all activities related to ROPs and completes the required reports for Accreditation Canada.





Prospective Safety Analysis

Failure Mode and Effects Analysis (FMEA) is a team-based systematic and proactive approach to identify ways that a process or design can fail, why it might fail, the effects of that failure, and how it can be made more safe. An annual FMEA is required by Accreditation Canada.

INDICATOR TRACKING TEMPLATE

The Template is the standard format used to identify, monitor and report on an indicator being tracked.

APPENDIX H (i) – Program Scorecard Template

-  Meeting or exceeding targets
-  Monitoring to establish benchmark or slightly lower/higher than target
-  High Priority to improve
-  Baseline – first reporting period, target, status and trend to be determined



Client Centred/ Acceptability	INDICATOR (MEASURES)	PERFORMANCE TARGET	ACTUAL	STATUS	TREND
Accessibility/ Capacity	INDICATOR (MEASURES)	PERFORMANCE TARGET	ACTUAL	STATUS	TREND
Safety	INDICATOR (MEASURES)	PERFORMANCE TARGET	ACTUAL	STATUS	TREND
Continuity	INDICATOR (MEASURES)	PERFORMANCE TARGET	ACTUAL	STATUS	TREND
Competence	INDICATOR (MEASURES)	PERFORMANCE TARGET	ACTUAL	STATUS	TREND
Population Focus	INDICATOR (MEASURES)	PERFORMANCE TARGET	ACTUAL	STATUS	TREND
Effectiveness/ Appropriateness	INDICATOR (MEASURES)	PERFORMANCE TARGET	ACTUAL	STATUS	TREND
Worklife	INDICATOR (MEASURES)	PERFORMANCE TARGET	ACTUAL	STATUS	TREND

Domains = Key Performance Indicators represent program improvement processes that relate to the **Mental Health Accountability Framework and Accreditation Canada** quality domains.

Definitions:

- **Accessibility:** Providing available, timely and equitable services. The ease with which services can be accessed in a timely manner and deals fairly with all concerned. Ability of people to obtain services at the right place and right time based on needs.
- **Client Centred/Acceptability:** Putting clients and families first. The degree to which the system actually functions by placing the client at the centre of its delivery of services. Increasingly measured as the client's experience of care with the emphasis on caring. The degree of conformity to the wishes and expectations of the users and their families. Services provided meet expectations of service users, community, providers and government.
- **Safety:** Keeping people safe. The system has the right structures, renders service and attains results in ways that prevent harm to the users, providers and environment
- **Worklife:** Supporting wellness in the work environment
- **Continuity of Service:** Experiencing coordinated and seamless services over time. Measured by the client's perspective. The system is sustainable, comprehensive, and has the capacity to provide seamless and coordinated services across programs, practitioners, organizations, and levels of service, in accordance with individual need.
- **Competence:** Knowledge, skills and actions of individuals providing service are appropriate to the services provided
- **Population Focus:** Working with the communities to anticipate and meet needs
- **Effectiveness:** Doing the right thing to achieve best possible results. The degree to which an activity or initiative is successful in achieving a specific goal
- **Efficiency/Appropriateness:** Making the best use of resources. Ensuring the resources are used to yield maximum benefits or results. Services provided are relevant to service users needs and based on established standards.

Indicator Selection:

Indicators were selected based on:

- a) Recommended Indicators for 2009/2010 Service Accountability Agreement
- b) Accountability and Performance Indicators for Mental health Services and Supports
- c) Intensive Case Management Service Standards
- d) Mental Health Accountability Framework
- e) Accreditation Canada Top Indicators Identified for Mental Health
- f) Michigan Mental Health National Outcome Measures

APPENDIX H (ii)

**CMHA WECB
Quality Program
Program Goals Linked to Quality Performance Indicators**

Program:

Strategic Goals	Program Goals		Quality Performance Indicators
	Long Term	Annual	

APPENDIX H (iii) Indicator Summary Template

Indicator	Benchmark /Target	Actual	Improvement Plan	Impact	Continue to Collect & Monitor or Discontinue?	Why and Based on What Reporting Need
			<p>Action:</p> <p>Assigned To:</p> <p>Date Assigned:</p> <p>Expected Outcome:</p> <p>Report to Q.C Date:</p>			
			<p>Action:</p> <p>Assigned To:</p> <p>Date Assigned:</p> <p>Expected Outcome:</p> <p>Report to Q.C Date:</p>			
			<p>Action:</p> <p>Assigned To:</p> <p>Date Assigned:</p> <p>Expected Outcome:</p> <p>Report to Q.C Date:</p>			

APPENDIX H (iv)

Model for Improvement Worksheet (Plan, Do, Study, Act Model)

Project Title:

Team Lead:

Team Members:

Aim Statement (What are we trying to accomplish? Numerical target for improvement.)

Measures (How will we know we are improving?)

Outcome Measure:

Process Measures:

Balancing Measures:

Change Ideas (What can we try that will result in an improvement?)

Plan:

Do:

Study:

Act:

Business Case (Are system costs reduced by addressing the problem?)

Link to Organizational Strategy

Terms of Initiative

Start Date:

Stop Date:

Project Budget:

Report on Measures

**APPENDIX H (v)
APPLICATION FOR QUALITY TEAM AWARD**

CMHA WECB is committed to the continuous quality improvement process (CQI). CQI focuses on setting standards for performance, measuring results, analysis of results, ensuring evidence of outcomes (goals met) and using the information to make changes that will improve the quality of the care or service.

The quality award has been developed to recognize process improvement initiatives.

The **Quality Award** recognizes the contribution made by a **team or individual** to the CQI commitment.

Team members may include volunteers.

An individual effort may be recognized when the improvement initiative meets the criteria.

Any staff or volunteer can nominate an improvement team, an individual or self nominate for this award.

Note: Supporting documentation demonstrating how the initiative meets the criteria and that the goals of the initiative have been met must be included in the application.

Use this application to identify a project or an idea developed and implemented by a team or a department that results in (note: definitions of each quality domain are on the last page of this application):

- | | |
|-------------------|---------------------|
| 1. Accessibility | 5. Continuity |
| 2. Client Centred | 6. Population Focus |
| 3. Safety | 7. Effectiveness |
| 4. Worklife | 8. Efficiency |

Name of Improvement Project:

Quality Domain:

Team Leader or Individual :

Team Members:

Brief Description of the Quality Initiative:

Specify the Improvement Achieved (Measurable Outcome):

Signature: _____

Date:

Quality Award Process:

- Managers are responsible for communicating/supporting the nomination process.
- Submission to Quality Lead by May 31st annually.
- Adjudication by an all staff voting process through Survey Monkey.
- First place in each quality domain is honoured with a Quality Award.
- One overall award will be selected and the project and team added to the Quality Plaque.
- All nominees receive recognition.
- The Award Ceremony is at the next general staff meeting (and also presented at the Annual General Meeting)

Definitions of Quality Domains:

- Accessibility: Providing available, timely and equitable services. The ease with which services can be accessed in a timely manner and deals fairly with all concerned. Ability of people to obtain services at the right place and right time based on needs.
- Client Centred: Putting clients and families first. The degree to which the system actually functions by placing the client at the centre of its delivery of services. Increasingly measured as the client's experience of care with the emphasis on caring. The degree of conformity to the wishes and expectations of the users and their families. Services provided meet expectations of service users, community, providers and government.
- Safety: Keeping people safe. The system has the right structures, renders service and attains results in ways that prevent harm to the users, providers and environment.
- Worklife: Supporting wellness in the work environment.
- Continuity of Service: Experiencing coordinated and seamless services over time. Measured by the client's perspective. The system is sustainable, comprehensive, and has the capacity to provide seamless and coordinated services across programs, practitioners, organizations, and levels of service, in accordance with individual need.
- Population Focus: Working with the communities to anticipate and meet needs.
- Effectiveness: Doing the right thing to achieve best possible results. The degree to which an activity or initiative is successful in achieving a specific goal.
- Efficiency: Making the best use of resources. Ensuring the resources are used to yield maximum benefits or results. Services provided are relevant to service users' needs and based on established standards.

APPENDIX H (vii)

QUALITY PROGRAM EVALUATION TOOL

Please provide feedback to the Quality Council by completing this survey. Your feedback will help the agency to communicate, identify strengths and areas of improvement and to continuously implement improvement processes.

1. Rate your overall knowledge of the Quality Program at the agency.

Understand and Limited Contribute to it understanding	Good understanding of the program	Some understanding	Have heard about it
--	--------------------------------------	-----------------------	------------------------

2. Are you aware of the performance indicators being monitored by your program?

Yes No

3. Have you seen a program scorecard or sample organization scorecard?

Yes No

4. Have you seen any trending or variance reports related to the indicators?

Yes No

5. Has anything changed as a result of monitoring trends or variances in your program?

Yes No

Comments:

Effective Date: 2008

Date Revised: January 2010, December 2010, March 2012, February 2015

Date of Next Review: 2018

Related Documents:

1)Talent Management Plan

2)Change Management Plan

Effective Date: 2008

Date Revised: January 2010, December 2010, March 2012, February 2015

Date of Next Review: 2018