This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.
Overview

In January 2015, Mount Sinai Hospital, Bridgepoint Active Health Care, and the Lunenfeld – Tanenbaum Research Institute, along with our home care partner Circle of Care, came together to form Sinai Health System (SHS). In our first year after amalgamating, Sinai Health System has undertaken the journey from operating as separate organizations to becoming one and has introduced a corporate direction through its Vision, Mission and Values. Our vision is to be Canada’s leading integrated health system, pushing the boundaries to realize the best health and care from healthy beginnings to healthy aging for people with specialized and complex care needs. Our mission is to deliver exceptional care in hospital, community and home focusing on the health conditions with the greatest impact on the overall health of the population. We discover and translate scientific breakthroughs, develop practical health solutions, educate future clinical and scientific leaders, and lead efforts to eliminate health inequities. Our six core values include person centred, excellence, accountability, collaboration, equity and innovation. Sinai Health System’s mission, vision and core values are at the heart of our newly developed organization wide Quality Aims.

Our Quality Aims were established by the leadership team at SHS in collaboration with the Board Patient Safety and Quality Committee and ultimately approved through the SHS Board. The Aims were informed by patient and family feedback and a comprehensive review of internal and external information (Figure 1). The Aims were further refined through frontline content expert engagement. These aims articulate Sinai Health System’s priorities for improving quality of service delivery over the next three years.

Sinai Health System’s Aims are as follows with a comprehensive list of SHS’s sub-aims found at the end of the Narrative:

1. Make care safer by eliminating preventable harm or death caused in the delivery of care.
2. Provide effective and reliable care in the implementation of clinical processes to detect and manage both pain and dementia with agitation and aggression for populations with complex and specialized care needs.
3. Provide timely access to acute, rehabilitative, complex continuing and community care for populations with complex and specialized care needs by being a top 10% operational and best practice performer in achieving length of stay and wait time targets for complex orthopedic and medicine populations.
4. Be a top 10% performer in engaging and informing patients and their families in the design and delivery of care and care transitions.
Finally, as a leader in eliminating health inequities, key Quality Aim indicators related to equity of care will be systematically measured and monitored through stratification using socio-demographic data. A data driven understanding of disparities in health, in combination with the unique stories of our patients, will allow SHS to further drive improvement in health equity.

**QI Achievements From the Past Year**

All sites of SHS have been active in quality improvement activity in the past year to achieve the QIP 2015/16 targets. Two QI initiatives will be highlighted here. At the Bridgepoint site, the Patient Oriented Discharge Summary (PODS) was implemented on the Acquired Brain Injury (ABI) unit. At Mount Sinai, improvement opportunities in hand hygiene adherence before and after patient contact to reduce hospital acquired infections were implemented including the wireless hand rub dispenser monitoring (e Monitoring) project.

Bridgepoint became an early adopter of the TCLHIN and OpenLab PODS initiative which is a discharge tool based on best practices in information and graphic design and patient education (plain language). It includes five essential elements including information on medications, follow up appointments, normal expected symptoms and what to do with arising symptoms, lifestyle changes and resources post discharge. Corporate Bridgepoint NRC Picker Patient Satisfaction results related to continuity and transition, at the end of fiscal 2014/15, were at 75.7% with the 90th percentile peer performers at 83%. The objective of PODS implementation on the ABI unit was to improve patient satisfaction in information provided and engagement at discharge. The project team included...
clinicians from the ABI team, two former patients and project co-leads. The team customized the OpenLab prototype tool to the ABI population and workflows were designed to allow for delivery of PODS through an inter-professional team two days prior to discharge. The delivery of PODS includes a comprehensive discussion with patients and their families around the five essential elements. More than 150 patients have received PODS on discharge on the ABI unit as of February 2016. An e-PODS tool connected to the EMR has been developed to replace the original paper tool and further support workflow efficiency. A full plan to spread PODS throughout the Rehab units at Bridgepoint has been established for 2016/17 and is listed as a change idea in this year’s QIP 2016/17 along with an opportunity to explore its spread at Mount Sinai. After implementing PODS, ABI satisfaction levels have reached 89% by February 2016. One patient’s wife noted, “as part of the PODS process, both the Pharmacist and Physician made sure that my husband’s local care team in Huntsville had the information they needed and that the local pharmacy would be able to meet his needs. It really felt like a team. That’s what I felt was most impressive!”

Hand hygiene is a critically important practice for the prevention of hospital acquired infections. Until recently, adherence to hand hygiene has been measured in acute care facilities using direct observation on in-patient units. This method is costly, results in a very small proportion of practice being monitored, and is strongly affected by observational bias (health care workers change their behaviour when observed). Consequently, observational auditing is limited in its capacity such that hand hygiene adherence appears to be 100% in observational auditing when it is in fact much less in routine practice. An important change to address this came about when Mount Sinai Hospital became the first hospital in Canada to pilot an electronic monitoring system for measuring hand hygiene adherence. This system counts all soap and alcohol hand rub dispensed on an in-patient unit. It then uploads that information to the internet, where it is merged with data on how many patients are present in the unit and the data on the number of hand hygiene opportunities needed per hour when caring for a patient on that type of unit. This results in measured hand hygiene adherence for all patient care on the unit. In the summer of 2015, a trial of the system was implemented on the medical/surgical unit (14 South). Hand hygiene adherence has improved by 9%.

Integration & Continuity of Care
A central element of SHS’s strategy is to integrate care across the continuum, by bringing together acute care, continuing care, rehabilitative care, primary and community care, to focus on the needs of the most complex patients. We begin with a strong foundation; Sinai Health System is already deeply integrated with the community in many of our programs and services. These include the Temmy Latner Centre for Palliative Care, the GTA’s largest and most advanced palliative care program, the Assess and Restore initiative at our Bridgepoint site, which has enabled admissions directly from the community and the Mount Sinai emergency department without an acute stay, the Acute Care for the Elders (ACE) strategy, and our leadership role in the House Calls initiative.
As a System we have worked to drive better, more coordinated care for our patients by developing innovative, evidence-based models of care and integrating care pathways. For example, SHS has developed and launched an integrated orthopedic pathway from acute care to rehabilitative care and community care, developing seamless handovers across the continuum. In palliative care, Sinai Health System is redefining the model of care, with a primary focus on expanding community access and avoiding unnecessary admissions to acute hospitals. In our daily clinical operations Mount Sinai and Bridgepoint collaborate with community partners including Health Links, CCACs, local service providers such as WoodGreen Community Services, and Circle of Care and other home care partners, to ensure that supportive discharges are in place for high risk and difficult cases.

Sinai Health System’s partnership with UHN, Toronto Central Community Care Access Centre (CCAC), Mid-west Toronto Health Link and Women’s College Hospital for the Hospital at Home initiative exemplifies a collaborative approach to meeting the needs of some of Toronto’s most complex patients. This program aims to deliver safer and higher quality acute level patient care in the home setting of our patients after a short acute stay. Through this program, we will improve access to care and the overall patient experience across the continuum, while making acute facilities and infrastructure available for the patients who need them most.

In primary care, Sinai Health System’s Family Health Teams service more than 27,000 patients on three sites. We are continually working to deepen our integration with primary care and system partners, and look forward to playing a significant role in driving and supporting the integration of LHIN sub-regions, particularly in Mid-west Toronto.

Health system integration and continuity of care are critical to Sinai Health System because they are critical to quality and safety, especially for the complex patients who are our disproportionate focus. Both within our own system, and with other health sector and social service partners, we will continue to work to build integrated, evidence-based models of care, and to achieve seamless transitions, for the benefit of our shared patients.

Engagement of Leadership, Clinicians and Staff

The SHS Quality Aims are the foundation of the QIP 2016/17. Change ideas to achieve the Quality Aims were developed through numerous frontline content experts and clinical teams. These ideas were refined through various stakeholder groups including the SHS Senior Management Team, Medical Advisory Committee, Nursing Advisory Committee, Health Disciplines Advisory Committee, Centre of Excellence and Program Committees. An understanding of what quality means to patients and families through numerous stories and solicited patient and family feedback grounded the work of the Quality Aims and the QIP. Oversight of the development of Quality Aims and QIP was through the SHS Quality, Patient Safety and Risk Committee with final approval and adoption provided through the SHS Executive, Patient Safety and Quality Board Committee and overall SHS Board.

Patient/Resident/Client Engagement
A core value for SHS is person centred care and we understand this value as one that makes clear that patients and families are our partners. At SHS, there is a strong history of working with patients and families whether through our long standing Declaration of Patient Values, the NICU Family Advisory Council, work with Patients and Family Advisors on initiatives this past year including use of Experience Based Co-Design on Orthopedic Rehab, Patient and Family Advisors supporting the accessibility and usability of the Bridgepoint front entrance, the review of the SHS patient relations processes, review of the Patient Fund criteria and redesign of space in the Women’s and Infants program. Building on the strong Service with Heart model at Mount Sinai adopted from the Cleveland Clinic, plans are underway to trial this approach at Bridgepoint in the coming year.

At SHS, partnering with patients and families organizationally and at the bedside has been energized by the commitment of Accreditation Canada, HQO and the Minister of Health. In response, a robust strategy to support improvement in patient experience in care areas and to actively partner with patients and families across all corporate quality initiatives will be articulated. A Quality Aim to ensure patients and families are "engaged and informed" has been set such that a target of 80% of all corporate quality initiatives, by 2019, will include meaningful patient and family engagement. It begins this year with a roadmap and establishing foundational infrastructure to drive culture change across the organization.

In grounding the creation of the SHS QIP 2016/17, aggregate patient feedback and individual patient and family stories were used to understand what good care at SHS looks like and where current gaps exist. To reflect the aggregate patient feedback that included hundreds of statements, the SHS poet in residence was asked to create a poem to reflect the good and bad experience of care of our patients. It is entitled “Discharge Summary” and was written from a patient’s perspective – see end attachment.

**Performance Based Compensation [part of Accountability Mgmt]**

Hospital leadership is held accountable for achieving targets set out in the QIP through performance-based compensation, which has been a standard practice to promote accountability and continuous improvement in quality of care. This year executives will have up to 6% of performance based compensation tied to a portion of the indicators outlined in the 16/17 QIP. The selected QIP indicators will be derived from the complement of indicators that are outlined in the QIP Improvement Targets and Initiative spreadsheet including: eliminating preventable harm related to high risk medications and improving access to care for complex medical patients through the development of an integrated pathway of care.
Quality Aims and Sub-Aims

1. Make care safer by eliminating preventable harm or death caused in the delivery of care through the achievement of:
   a. Zero falls with serious injury or death
   b. Zero incidence of nosocomial cases of C. Difficile infection (CDI)
   c. Zero incidence of hospital acquired stage II or greater pressure ulcers including the neonatal population
   d. Zero serious harm or death associated with high risk medications (opioid administration)

2. Provide effective and reliable care in the implementation of clinical processes to detect and manage both pain and dementia with agitation and aggression for populations with complex and specialized care needs by:
   a. Being a top 10% performer in pain management for post-partum, complex medicine and orthopedic populations including continuity for discharged high risk populations with chronic pain issues.
   b. Being an early adopter of the HQO Quality Standards in the management of responsive behaviours (agitation and aggression) associated with dementia through the implementation of 100% of appropriate HQO Quality Standards

3. Provide timely access to acute, rehabilitative, complex continuing and community care for populations with specialized and complex care needs by being a top 10% operational and best practice performer in achieving length of stay and wait time targets for complex orthopedic and medicine populations by:
   a. Achieving top 10% QBP performance benchmarked against peers for access to care and average length of stay in Orthopedics
   b. Decreasing conservable days to become a top 10% performer for complex medicine patients at MSH and sustaining LOS reductions at BH
   c. Decreasing the overall percentage of ALC days for Medicine and Complex Continuing Care to less than 20%
   d. Be a system leader in Emergency Medicine by ensuring a top 10 standing in "Performance Rank" in the Ontario P4R ranking system for access and flow
   e. Ensuring 90% of Obstetrical Triage Acuity Scale (OTAS) priority 1-3 patients meet best practice times for assessment and LOS to disposition

4. Be a top 10% performer in engaging and informing patients and their families in the design and delivery of care and care transitions as measured by:
   a. Achieving 90% in patient overall patient experience
   b. Achieving 85% in patient experience for Continuity and Transitions.
   c. Achieving 85% in patient experience for "Informed"
   d. Ensuring 80% of all corporate quality initiatives will have patient and family engagement
Poem

Ronna Bloom, 2016, Poet in Residence, Sinai Health System

My first meeting with the doctor came after I died.

Until then the care was excellent,

Forgive me, my humour is of the few things left now that

I can't type or speak, but somehow I know you hear me.

So apologies for the tone, take it with a grain of salt.

The wound that dropped in while I was there hurt so much I wanted to scream.

We were not a team, as you are, but sometimes circumstances bond.

I know all your patients are not me.

Some complain so much even I would look away,

but in the service of frankness, let me speak for those I met.

We just don't go there, do we? I thought I knew history, but... the service of frankness.

Some of the grief, you know, is getting to me.

Me, I got sweet potato every day and loved it.

though my grandchildren wondered. The view is beautiful.

Let me tell you, all the drugs this side of the border

could not rival the comfort offered by the gentle hands

of the one who changed my sheets.

You know the shame that comes with this — whether I was in my life, grand or low, it doesn't matter — I wanted more than to end

it. I learned a solid bed and unable to move,

inside my eyes I knew what was happening. Time was coming for a change.

I only wish I'd met the doctor sooner

and they'd not put a balm in my wound.

To those who could stand it, I'm especially grateful.

I'm grateful and hesitant in my boldness.

I never understood a word the lovely nurse said.

I know those who were impatient were tired.

Like me, we've had a long day.

My first meeting with the doctor came after I died.
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

________________________________________
Jay Hennick
Board Chair

________________________________________
Paula Blacksten-Hirsch
Quality Committee Co-Chair

________________________________________
Mark Wiseman
Quality Committee Co-Chair

________________________________________
Joseph Mapa
Chief Executive Officer

Insert Organization Name
Insert Organization Address