E-QIP Community of Practice (CoP) Quality Improvement Plan (QIP) for submission to the CoP Friday April 1st, 2022

For new members and first time submissions to E-QIP: Please complete only the Narrative and Workplan sections. **For second submissions**: Please complete all the sections including the Narrative, Workplan and the Progress Report if you have submitted a QIP last year to E-QIP

Completing the Narrative: The Narrative is a brief executive summary of your QIP and sets the stage for the quality initiatives in your QIP. Please answer the questions #1 to 3 as they relate to your work on a few quality issues which can be easily understood by your staff, clients/tenants and community. Use it to engage in QI planning discussions and ensure it resonates with them. ***You can also include any diagnostic QI tools you may have used at the end of the narrative in the space (optional).***

Completing the Workplan: The workplan provides an opportunity to detail your plan to improve the quality of care you provide. You can choose any indicator based on data from standardised tools (eg. OPOC, OCAN, GAIN-SS) or you can use a custom indicator that is based on other data that you regularly collect.
What goes into the Workplan: Your chosen indicator, how you plan to measure and how you plan to implement the changes.

- **Measure**: Use this section to outline the measurement, population of focus, data source, reporting period and target performance for your quality project
- **Change**: Use this section to outline the planned improvement activities/change ideas and document any enabler/ barriers that might impact your intiative under the comments column *Example has been provided for reference only*

Completing the Progress Report: The Progress Report highlights to your team and community what impact your improvement efforts have had on the care provided at your agency over the last year. It requires you to reflect on the current performance compared with performance from the previous year (and compared to your target from last year), and the effectiveness of the change ideas you had planned last year and whether they led to measurable improvement. Your Progress Report links the last QIP with your current QIP and is a reflection of your agency's ongoing efforts over the past year.
The Progress Report should include information about your starting point for the previous year, the change ideas you selected, successes and challenges you experienced, and the progress made toward your targets. This information is a great starting point for determining priority areas for improvement, targets, and change ideas to include in your QIP for the coming year. **Note: The progress report is to be completed only if you have submitted a QIP to E-QIP CoP the previous year.**

What goes into the Progress Report: Taken from your last QIP, include last year's performance, last year's target and the current performance for indicators and target.

- **Comments**: Use this section to outline any challenges to meeting the targets you set:

— What are the root causes of your current performance?
— Reflect on whether you plan to work on the same aim/opportunity statement?
— Were the proposed change ideas adopted, amended, or abandoned? Why or why not?
— If implemented, have the changes helped your agency meet or exceed the target you set?
What change ideas were the most successful?
— If not implemented, what challenges did you face and what did you learn?
— What will your agency do in your next QIP to leverage these quality improvement activities and further improve on this indicator?

- **Lessons learned**: Describe your key learnings from your experience working on the change idea.

Include advice you would give to others attempting a similar change idea.
***Results** : Upload any results (e.g., a graphic or run chart) to illustrate your progress on the indicator (optional)*

Organization Name: Canadian Mental Health Association Thames Valley Addiction and Mental Health Services

Question #1: Tell us a bit about your organization. What is your focus of service? What is the population receiving care?

CMHA Thames Valley Addiction and Mental Health Services is a newly integrated mental health and addiction agency providing community-based supports and services to individuals aged 12 and up across Elgin, Middlesex, and Oxford Counties. The continuum of services includes crisis intervention and virtual supports, mobile crisis teams, police partnerships, case management, counseling, community wellness programs for both individuals and their families, housing supports and addiction medicine services. Treatment and service plans are developed based on standardized screening and assessment protocols and procedures.

CMHA TVAMHS's mission is to ignite hope and foster change by providing a continuum of mental health and addiction education, supports, and services. Our vision is: resilience for all through positive mental health and freedom from addiction. CMHA TVAMHS values inclusion, compassion, respect, choice, collaboration and accountability.

Question #2: In the coming fiscal year (2022/23), what do you hope to achieve by following your Quality Improvement Plan? How will you be engaging clients/tenants/service users?

This year, 2022/23, CMHA TVAMHS will focus further on our integration, in particular building and sustaining our infrastructure on the corporate side as well as services and supports. Our focus is on one year attainable goals, under the quality domains of efficiency and effectiveness, with the plan to work towards more continuous quality improvement initiatives after this first year. While programs will continue to support continuous quality improvement this years QIP focuses on entry into the organization at both the client and staff level. The plan is to have one suite of validated, standardized tools for screening and assessment for clients entering services and to have one, consistent, onboarding and training process for staff both new and existing.

Integration has led to a new org structure and there is a need to ensure the stucture is sustainable. This year our aim is to create a succession plan for senior leaders to ensure continued stability for CMHA TVAMHS.

In terms of performance measurement at the service level, CMHA TVAMHS will be working towards having one Electronic Health Record (EHR) or one EHR that bridges with Catalyst. This will support efficient and accurate (less duplication of unique individuals) access to data across the organization.

It is important to note that there are no safety aims on this years QIP. Safety for staff and clients remains a constant priority for CMHA TVAMHS and our health and safety focus this year is on development of an Enterprise Risk Management Framework and on a new Health and Safety Disabilities Management software. We continue to work towards decrease in incidents related to both clients and staff every year.

Question # 3: In previous quality improvement projects, what lessons learned will help your organization achieve these overarching goals?

Although it was expected that the pandemic would interfere with the work towards acheiving our goals we did learn that, although acting quickly is important, we should not lose sight of what we have been working on/measuring. The pandemic led to the implementation of a brief, select questions, Ontario Perception Of Care (OPOC) tool for CMHA Oxford and CMHA Elgin Middlesex (EM). The questions chosen by leadership at CMHA EM and Oxford were those that would measure what was important where services may also may be impacted by the pandemic. The OPOC questions being measured in both past and current quality improvment projects were not included which was an oversight. This made it difficult to measure client perception and improvement accurately for those QI projects.

The pandemic also impacted staff and we saw an increase as opposed to the aim of a decrease in reported incidents of psychological safety. It is believed that pandemic fatigue may be a factor where clients are demonstrating more behaviours and where staff tolerance, due to stress/fatigue, is lower leading to more reportable incidents. This is a hypothesis and has not been validated.

Change in the organizational structure, pandemic sick leaves and leader turnover, all in a short period of time, led to a lack of focus on certain aims within the legacy QIPS and these areas for improvement need to remain a focus even though they may not be on this years QIP i.e. counselling wait times for the Elgin program

It was expected that adding beds to the youth apartment program would decrease wait times and this was validated, however CMHA TVAMHS must continue to monitor wait times for the youth apartments once beds are at capacity even though this is not an aim on the QIP for 2022/2023.

Senior Leadership & Board Engagement (Optional Sign-off)

Leader's Name and Title: Chris Babcock, Director Quality Performance and Risk

Signature: 

Board Chair Name:

Signature:

Space for sharing any diagnostic tools, graphs (optional)

CMHA Thames Valley Addiction and Mental Health Services

Strategic Direction	Aim		Measure									Change				
	Issue (bold are priorities)	Quality Dimension	Chosen Indicator	Measure (statement of the indicator that tells you what is being measured)	Unit of Measurement	Population of Focus (which services)	Data source (where are you getting your data from?)	Reporting period	Current Performance (baseline numbers)	Target performance (desired state)	Target justification (how did you set the target?)	Planned improvement initatives (What are your change ideas)?	Methods (What will you do to make your planned changes happen?)	Process measures (what would tell you the changes are in progress?)	Target for process measures (what numbers will you monitor to show your changes are in progress?)	Comments (is there anything you think might be a barrier or enabler that leadership needs to know?)
1. Focus on ways to serve clients in an integrated way	**Due to integration CMHA TVAMHS is using multiple screening tools leading to inconsistent/incomplete information being collected and clients telling their story more than once**	***Efficient***	Implementation of one screening tool or suite of tools	Screening tools being used at all CMHA TVAMHS sites	# of screening tools being used (or suite of tools)	Intake and Access	Intake and Access leadership	April 1, 2022 - Sept. 30, 2022	multiple tools being used, at least 3	1, or a chosen suite of tools	internal for consistency and ability to measure improvement	1. Track tools currently being used 2. Review tools/analyze for evidence based practice, use by other MH&A agencies, fit with agency direction 3. Choose tool or suite of tools to be used at all sites	1. Request from legacies a list of tools being used 2. Intake and Access leadership and teams to review list of tools and research those tools 3. Recommend tool to VP Supports and Services 3b. Announce tool	1. list of tools 2. Research and Analysis is complete 3. Email/meeting with VP Supports and Services occurred with recommendation 3b. Screening tool is chosen (or suite of tools)	1. list of tools is 100% complete 2. Research and Analysis is 100% complete and documented 3. Recommendation is made and email is sent, or meeting held (minutes in place) 3b. Anncouncemnet in place for chosen screening too or suite of	
	Counselling wait times vary within each legacy and are long in the Elgin program	***Timely***	Wait Times for counselling programs	Wait time from referal to enrolment which may include referal to assessment plus assessment to enrolment	average days waited	Elgin Counselling program	Electronic Health Record EMHware	April 1, 2022-March 31, 2023	119 days (Elgin) April - Dec 2021	25 days	CIHI data (Ontario did not report) for average wait time in Canada (2019/2020)					This is a board priority and will be addressed through integration work and not within the QIP.
2. Foster staff wellness and nurture our unified culture	**Due to integration CMHA TVAMHS has inconsistent onboarding and internal training**	***Effectiveness***	One documented list in place to outline required training by role that is prioritized with a timeline and consitent across the org.	Completion of document listing required training	Document complete and in place	Full Agency	People and Culture	April 01, 2022 - September 30, 2022	3 different documented training programs	1 documented training program	Internal due to integration	1. Consolidate all legacy processes to inform the new onboarding and internal training process 2. Legacy HR staff from each org attend the various orientation sessions to determine new staff orientation that is consistent and reflective of integrated	1. Environmental scan of legacy processes 2. Schedule HR staff to attend each legacy oreintation session	Q1: Professional Development Strategy Draft is in place. Consultation with leaders has occurred. All HR staff did not "attend" each legacy's orientation, shared across team. Feedback from Org Effectiveness was requested and provided. We have created a new agency orientation presentation and it has been used for the last several sessions. We borrowed from ADSTV so a CEO greeting and land acknowledgement were added as well as current stats for both MH & Addictions were updated, updated programming info, waiting on policy updates in a number of areas and will include those as approved. Q2: A list of all available onboarding training topics from each legacy organization has been compiled. There are approx. 54 different topics some live facilitation and some are recorded training videos. A survey was created and sent out to leaders in July 2022 to get feedback from leaders about which topics they want their staff to complete based on the staff roles. Due to the pause in recruiting for the backfill of the Manager of Professional Practice work on this project was delayed until the	1. 100% completion of document consolidating legacy processes 2. 100% of HR staff have attended each legacy orientation	
3. Continue to stay connected to larger system and environmental context and be prepared to respond	**Due to integration there are duplicate representatives at various tables. These representatives may no longer be in a role that is appropriate for their previous participation at those tables/committees**	***Efficiency***	There is appropriate representation at community/regional/provincial tables that is not duplicated with leaders	Document listing tables/committees and the leader representing CMHA TVAMHS	Document Complete and in place	Leadership	Leadership/ SmartSheet	April 01, 2022 - September 30, 2022	There is duplication at tables	100% completion of document listing appropriate leader at each table/committee	internal due to efficiencies	1. Collect via SmartSheet, a list of all committees tables and who is representing CMHA TVAMHS and legacies 2. Review list and assign appropriate leader	1. create form in SmartSheet and send out to Leaders to complete 2. CEO and VPs to review and assign appropriate leader 3. CEO's communicate to all leaders the finalized list and expectation for some to disengage form previous committee/table	1. Creation of SmartSheet 1b. Form emailed to leaders 2. CEO review list 3. Email sent to leaders or meeting minutes re: discussion of leaders representation	1. SmartSheet created 1b. Form created and shared with leaders 2. CEO sent list of participation 3. Email sent to leaders of finalized list of CMHA TVAMHS participant at tables/committees	
4. Build and strengthen an integrated infrastructure	**Inability to gather data that is valid and duplication (There are currently 3 main electronic health records due to integration)**	***Efficiency***	Implementation of one Electronic Health Record	the Electronic Health Record	One Electronic Health Record and process to bridge with Catalyst	all CMHA TVAMHS	Corporate Services	April 01, 2022 - September 30, 2022	3 EHRs	1 main EHR or one that bridges with Catalyst	internal/other AMH agencies	1. Provide Demo's on CRMS, EMHware and Catalyst 2. Make a recommendation to SLT 3. Prepare for and implement transition to chosen EHR(s)	1. Develop a working group of various legacy, direct service and leadership to review and recommend the HER 2. Create a decision guide for support in decision making 3. Make a recommendation to SLT formally with the decision guide	1. Working Group Meeting Minutes 2. EHR demos are scheduled 3. EHR Decision Guide in place	1. Working group is in place and has met at least once 2. All Demos are scheduled and there is 50% attendance 3. EHR Decision Guide is created and completed and there are meeting minutes demonstrating the discussion	
5. Prepare and implement our Succession Plan for Key Leaders	With integration there is a new structure in place with VP's and co-CEOs. There is no plan at present for succession planning	***Effectiveness***	Succession plan	The succession plan document	The succession plan document	Senior Leadership	CEO and People and Culture	April 01, 2022 - September 30, 2022	no document/plan in place	Documented Succession Plan is in place and approved by the board	internal	Understand the plans of each senior leader, as well as strengths and gaps of the team; establish a mechanism to measure progress and communicate plans	1. Create a document to outline measurable milestones demonstrating organizational stability 2. Use the above document to predict timelines and report to the Board	1.Development of document with timelines and thresholds identified and measured quarterly 2. Monthly projected timelines for Board of Directors on processes in place to create and maintain stability in the organization.	1. Succession Plan document is in place 2. Board has received at lease 4 reports	The not for profit salaries are funded lower than other health care institution leadership salaries, potential barrier to recruiting qualified individuals. The broader public sector executive compensation act, 2014 has frozen wages for those designated as executive positions, may be a barrier to recruiting qualified senior leaders. Protecting a sustainable pulic sector for future generations act, 2019, has 3 year moderation period, our 3 year time period ends March 14 2024, potential barrier to recruiting qualified individuals.

Organization name: ADSTV, Canadian Mental Health Association (CMHA) Elgin Middlesex, CMHA Oxford

Chosen Indicator - CMHA Elgin Middlesex	Last Year Performance	Last Year Target	This Year (21/22) Performance	This Year (21/22) Target	Comments
1. Occupancy rate of Crisis Stabilization Space	73%		75%	80%	small improvement, did not achieve target - continue work
2. Wait time from referral to program enrolment (Transitional Youth Apartments)	106 days		59 days	75 days	Achieved - beat target of 75 days - monitor as new beds reach capacity
3. Wait time from referral to program enrolment (Elgin Counselling)	98 days		156.8	35 days	integration and turnover interfered and no further action was taken
4. Identified Individuals admitted to Crisis Stabilization Space as an ED Diversion	67%		75%	80%	good improvement, just missed target of 80% (by 5%)
5. Employee incidents related to workplace violence	22		10	0	good improvement, 55% improvement
6. Employee incidents related to psychological safety	15		27	0	Possible Covid fatigue leading to increased frustration in clients and less tolerance in staff?
7. OPOC #11. I was referred or had access to other services when needed, including alternative approaches (e.g., exercise, meditation, culturally appropriate approaches).	weighted average 3.26		weighted average 3.36	weighted average 3.36	Target was achieved (integration work?)
8. OPOC #19 (Standard) #14 (Crisis) #22 (Supportive Housing) Staff were sensitive to my cultural needs (e.g., religion, language, ethnic background, race)	Strongly Agree 52%		Strongly Agree 61%	Strongly Agree 55%	beat target of 55% by 6% - cannot clearly state this was due to training/education as this was not accurately measured
9. Feedback from Community Partners is received	no existing survey		No survey was implemented	survey is implemented	other integration priorites interfered
10. Annual Employee Engagement Survey. Q13.CMHA Elgin Middlesex offers services or benefits that adequately address my psychological and mental health.	Strongly Disagree and Disagree 16.97%		Survey was not implemented	Strongly Disagree and Disagree 15% or less	Although work was completed and some change ideas implemented - no engagemen survey was admisistered so we cannot see if effective.
11. Annual Employee Engagement Survey. Q25 Leadership in my workplace is effective (target-relief)	Strongly Disagree and Disagree 23%		Survey was not implemented	Strongly Disagree and Disagree 15% or less	Although work was completed and some change ideas implemented - no engagemen survey was admisistered so we cannot see if effective.

Chosen Indicator - CMHA Oxford	Last Year Performance	Last Year Target	This Year (21/22) Performance	This Year (21/22) Target	Comments
1. Provide a safe and welcoming atmosphere in all of CMHA's physical spaces					
I felt safe in the facility at all times. OPOC Q. 25	Strongly Disagree and Disagree - 0.0%		NA	Strongly Disagree and Disagree - <30%	This question was not on the mini OPOC (used during pandemic)
Overall, I found the facility welcoming, non-discriminating, and comfortable (e.g., entrance, waiting room, décor, posters, my room if applicable). OPOC Q 22	Strongly Disagree and Disagree - 0.0%		NA	Strongly Disagree and Disagree - <35%	This question was not on the mini OPOC (used during pandemic)
Crisis Intervention: #/% of staff with up-to-date crisis/safety training (e.g., NVCI) to reduce harm to staff	100%		**100%**	100%	performance was maintained and goal achieved

2. Improve access to service and experience for those waiting for service					
Wait Times: Percent of Active Employees receiving clinical support and active supervision quarterly	90%		**100%**	100%	Performance was maintained and goal achieved
The wait time for services was reasonable for me. OPOC Q 1.	Strongly Disagree and Disagree - 0.0%		NA	Strongly Disagree and Disagree - <15%	This question was not on the mini OPOC (used during pandemic)
The program accommodated my needs related to mobility, hearing, vision, and learning, etc. OPOC Q 26	Strongly Agree and Agree - 90%		**84%**	Strongly Agree and Agree - >65%	A slight decline in client perception but target was exceeded
3. Increase client satisfaction					
Client Satisfaction: % Clients Strongly Agreeing with OPOC Survey Q 32 - If a friend were in need of similar help I would recommend this service	Strongly Agree and Agree - 100%		NA	Strongly Agree and Agree - >75%	This question was not on the mini OPOC (used during pandemic)
Client Satisfaction: % Clients Agreeing with OPOC Overall Experience statement Q30 & Q31 : Overall, I am satisfied with the services I have received	Strongly Disagree and Disagree - 0.0%		**6%**	Strongly Disagree and Disagree - <20%	slight decrease in client perception but target was exceeded

Chosen Indicator - CMHA ADSTV	**Last Year Performance**	**Last Year Target**	**This Year (21/22) Performance**	**This Year (21/22) Target**	**Comments**
#27: Staff helped me develop a plan for when I finish the program/ treatment.	Weighted Average - 3.77			Weighted Average - 3.82	

Change Idea - CMHA Elgin Middlesex	**Lessons Learned**
General	We were to ambitious during a time of Pandemic and integration having 11 Issues to address in the QIP. Next year we will focus on 5 (half)
1. Use multiple ways to review declines to the program ensuring appropriateness of referrals	The idea to review and assess declines through education, and supervisions was only partially successful. CSS program should continue to work towards improvement with a possible feedback loop to community partners.
2. Improve capacity by expanding to a larger building for Youth Program (Adelaide)	This was very successful. It will be important to continue to monitor wait times as beds fill and capacity is reached. With more beds added it was natural that wait times decreased.
3. Restructuring counsellor/case manager positions to allow 2 staff more copacity for counselling	Although this change idea was implemented, change in leadership, changes in integration interfered with further focus on this indicator and there was actually an increase in wait times. This should continue to be a focus and new change ideas developed whether on nextyears QIP or not.
4. Change the source of info regarding ED diversion to the referral source from staff and capture at intake if a client referred bay be on an ED diversion whin identified as "not" ED diversion by referral source.	Adjusting the target from previous years and having the source of information i.e. ED diversion, has supported improvement in this area. We are meausuring the right thing now. Indicator improved greatly however did not reach target. Continue to monitor without further change
5. Policy review annually, a complete 30 point criteria matrix, complete workplace violence, harrassment and risk assessments at all programs leading to action plans for mitigation of risk	Our target is zero (0) because we believe there is no acceptable number of physical assaults. This target was not achieved however we must recognize there was a 55% improvement leading us to believe our actions had a positive impact and should continue. It is important to acknowledge the pandemics impact with fewer face to face contacts this year but also the fatigue it has caused which could lead to behavioural responses. The need to continue this work is essential for staff safety but it can be removed from the QIP and prioritized by the Enterprise Risk Management team.
6. Complete an assessment of psychological injury as a component of the WV Program Risk Assessment initiative and Implement appropriate controls to decrease risk of psychological safety	Our change ideas were successfully implemented on all new programs. The Pandemic led to an inability to complete on current programs. As above, face to face contacts were decreased and as we reopened they did increase again. Pandemic fatigue could have played a role in both client behavioural responses leading to psychological injury of staff and also staff fatigue leading to a greater inability to tolerate behaviours. The need to continue this work is essential for staff safety but it can be removed from the QIP and prioritized by the Enterprise Risk Management team.
7. Integration may lead to improvement due to a larger array of internal referrals to a broader	With greater awareness of the integrated agencies programs and the ability to internally refer, eliminating some barriers, there was improvement to clients perception that they were made aware of and referred to other community resources. The need to continue to work towards an integrated access to services is important to continue however does not need to be on the QIP.
8. Explore and provide anti-racism training to CMHA EM employees similar to the Indigenous	The method of monthly training and focussed training was implemented however a follow up survey was not implemented. Although the client perception of cultural sensitivity of staff improved and met the target, it cannot be proven it was due to education and training. We will continue to offer this method of training and will implement a survey. This does not need to be on next years
9. This fiscal 2021/2022 the focus will be on integration. Create a feedback mechanism for community stakeholders	Other integration priorities were higher this year. This was not formally completed. Conversations, informal, continue at various community tables. This should be a focus next year, but not a priority on the QIP. As stated initially, due to the pandemic and integration there were too many issues listed in the QIP making it challenging to prioritze and find the time to work on them.

10. and 11. Create QI Team and facilitate Root Cause Analysis Create Change Ideas and plan implementation Implement change ideas	Although 2/3 of the process measures were fully completed on both QI projects, and some change ideas were implemented, there was an inability to measure improvement. An employee engagement survey was not conducted this year due to other integration priorities. It will be important to ask these same questions in order to meausre improvement in these area. There should be a focus on the QI project work moving forward to see if these align with the integrated agency and not just legacy CMHA Elgin Middlesex.
Change Idea - CMHA Oxford	**Lessons Learned**
General	Using the brief/mini OPOC was effective during the pandemic to not overwhelm staff or clients however, quality improvement initiatives requiring the responses to OPOC questions that were not on the mini OPOC were negatively impacted in terms of ability to measure improvement. This was also experienced by CMHA Elgin Middlesex
Change Idea - ADSTV	**Lessons Learned**
1. Implement the PODS form	
2. Improve education / teach back	

Results (space for sharing any data, graphs) (optional)