Access and Flow | Efficient | Custom Indicator

Indicator #1

Alternate Level of Care (ALC) Throughput. The ratio of the number of discharged ALC cases to the number of newly added ALC cases within a specific period of time (Waypoint Centre For Mental Health Care)

Last Year		This Year	
0.90	**1**	**1**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Decrease time spent searching for client housing

Process measure

- 1. Launch Housing resource toolkit 2. # staff oriented to the Resource Centre toolkit 3. # staff oriented to partner resource

Target for process measure

- Initiate by June 30

Lessons Learned

1) Resource Housing Toolkit.
Toolkit was launched.

2) Staff oriented to Toolkit
Receptively trained 15 Social workers, 6 Medical Directors and 48 Physicians, or 100% All new relevant staff will receive training.

3) Staff oriented to partner resource
LOFT Back to Home program in Penetanguishene has provided supportive housing. As at Feb 14,24 14 Waypoint patients have been admitted. 2 have been discharges. 12 residing at LOFT. (4 on Wait list)
Weber House occupancy started Dec 4th/2023 - As at Feb 14, 24 the building is full. 2 inpatients and 7 outpatients have moved into the building by Feb 1st.
This change idea has proven to be effective in establishing client housing options.

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

Implement ALC leading practices

Process measure

- % self-assessment gaps addressed

Target for process measure

- TBD once self-assessment complete

Lessons Learned

Self-Assessment Gaps
ALC Leading Practices have been partially implemented.
Six Leading Practices – Complete
Two Leading Practices – In Progress
One Leading Practice – Being Initiated
This change idea has been effective and we will continue to align with ALC Leading Practices in our 2024/25 QIP

Comment

Meeting target
ALC Throughput
Performance of 1.0 is Q3 YTD 23-24 as per Meditech (internally calculated)

Experience | Patient-centred | Custom Indicator

	Last Year		This Year	
Indicator #2 Percent positive response by Mental Health Inpatients to the OPOC survey question "I think the services provided here are of high quality" (Waypoint Centre For Mental Health Care)	**70** Performance (2023/24)	**75** Target (2023/24)	**73** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement Health Quality Ontario hospital quality standards for schizophrenia

Process measure

- 1) long-acting injectables offered and received 2) % clozapine offered and received 3) % patients screened as appropriate 4) % patients referred for Cognitive Behavioural Therapy for psychosis 5) # of Quality statements implemented

Target for process measure

- 1) 50th %'ile 2) 50th %'ile 3) 50th %'ile 4) 50th %'ile

Lessons Learned

Targets identified for 1) long-acting injectable offered and received and 2) % clozapine offered and received
1) & 2) the 50th percentile of the Ontario Hospital Association (OHA) dashboard. These targets were attained however the OHA Dashboard is no longer maintained. Targets were then established and accountability assigned to Medical Affairs for monitoring. For these two statements, we have achieved good performance for medications received. There is still a data entry issue for the percentage offered as this question is completed at the discharge in the RAI so not often captured in admission questions. We have started to measure actual medication orders to improve accuracy of results.

3) % of patients screened as appropriate and 4) % of patients referred for Cognitive Behavioural Therapy for Psychosis – Accountability of these statements was assigned to Clinical Services. After review targets were adjusted to the following 3) 70%

4) 60%, we have been in the yellow on this target (within 5-10%) since October 2023. Ongoing review and unit specific follow up have been initiated and work is progressing in this area and has improved significantly since August 2023.

5) # of Quality statements implemented- We are currently at 9 officially implemented with 1 very close to implementation (awaiting on update from Nursing Informatics Specialist and Recreation Therapy) and 3 others in test on the Schizophrenia in the Community BI Dashboard. The goal is to implement a total of 14 by March 31 2024.

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented**

Increase activities available to patients during their free time

Process measure

- 1. Number of after hours programming per week available to inpatient units 2. The number of weekend services offered

Target for process measure

- Collecting baseline

Lessons Learned

1. Low OPOC 2024 participation rates and poor survey usability call into question the validity of this as a success measure.

2. Rehab Services alone is not responsible for increasing the number of programs per week or the number of weekend services. Several other core programs and services are offered to clients across Waypoint that support recovery (Ex. Spiritual care, Psychotherapy, Nursing Psychoeducation, unit-based Rec. Therapy and other Allied Health Services).

3. Survey question # 33 “There were enough activities of interest to me during free time” improved to 78% in the 23/24 survey from 70% the prior year for Inpatients. Outpatients do not answer this question.

4. Survey question # 30 “The services I have received have helped me deal more effectively with my life’s challenges” improved to 80% in the 23/24 survey from 78% the prior year for Inpatients, for Outpatients the improvement was to 80% from 73%. This question has closer links to client recovery and perception of the overall experience at Waypoint.

5. “Change Idea” phrasing. The assumption that patients' free time was in the evenings and weekends has exposed a bias. Inpatients at Waypoint have expressed having time to participate in activities throughout all hours of the day and no matter which day of the week. Many clients have expressed preferring to simply relax free from structured programming on evenings and weekends.
The change idea was effective in making improvements.

Comment

Performance:
21-22 70%
22-23 72% (Previously, erroneously reported as 70%)
23-24 73% (Preliminary)

Indicator #3

Percent positive response by Mental Health Outpatients to the OPOC survey question "I think the services provided here are of high quality" (Waypoint Centre For Mental Health Care)

Last Year		This Year	
98	**98**	**82**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement Health Quality Ontario hospital quality standards for schizophrenia

Process measure

- 1) long-acting injectables offered and received 2) % clozapine offered and received 3) % patients screened as appropriate 4) % patients referred for Cognitive Behavioural Therapy for psychosis 5) # of Quality statements implemented

Target for process measure

- 1) 50th %'ile 2) 50th %'ile 3) 50th %'ile 4) 50th %'ile

Lessons Learned

Targets identified for 1) long-acting injectable offered and received and 2) % clozapine offered and received

1) & 2) - the 50th percentile of the Ontario Hospital Association (OHA) dashboard. These targets were attained however the OHA Dashboard is no longer maintained. Targets were then established and accountability assigned to Medical Affairs for monitoring. For these two statements, we have achieved good performance for medications received. There is still a data entry issue for the percentage offered as this question is completed at the discharge in the RAI so not often captured in admission questions. We have started to measure actual medication orders to improve accuracy of results.

3) % of patients screened as appropriate and 4) % of patients referred for Cognitive Behavioural Therapy for Psychosis – Accountability of these statements was assigned to Clinical Services. After review targets were adjusted to the following 3) 70% 4) 60%, we have been in the yellow on this target (within 5-10%) since October 2023. Ongoing review and unit specific follow up have been initiated and work is progressing in this area and has improved significantly since August 2023.

5) # of Quality statements implemented- We are currently at 9 officially implemented with 1 very close to implementation (awaiting on update from Nursing Informatics Specialist and Recreation Therapy) and 3 others in test on the Schizophrenia in the Community BI Dashboard. The goal is to implement a total of 14 by March 31 2024.

Change Idea #2 ☑ Implemented ☐ Not Implemented

2)Increase activities available to patients during their free time

Process measure

- (1) Number of after hours programming per week available to inpatient units (2)The number of weekend services offered

Target for process measure

- Collecting baseline

Lessons Learned

1. Low OPOC 2024 participation rates and poor survey usability call into question the validity of this as a success measure.

2. Rehab Services alone is not responsible for increasing the number of programs per week or the number of weekend services. Several other core programs and services are offered to clients across Waypoint that support recovery (Ex. Spiritual care, Psychotherapy, Nursing Psychoeducation, unit-based Rec. Therapy and other Allied Health Services).

3. Survey question # 33 “There were enough activities of interest to me during free time” improved to 78% in the 23/24 survey from 70% the prior year for Inpatients. Outpatients do not answer this question.

4. Survey question # 30 “The services I have received have helped me deal more effectively with my life’s challenges” improved to 80% in the 23/24 survey from 78% the prior year for Inpatients, for Outpatients the improvement was to 80% from 73%. This question has closer links to client recovery and perception of the overall experience at Waypoint.

5. “Change Idea” phrasing. The assumption that patients' free time was in the evenings and weekends has exposed a bias. Inpatients at Waypoint have expressed having time to participate in activities throughout all hours of the day and no matter which day of the week. Many clients have expressed preferring to simply relax free from structured programming on evenings and weekends.
The change idea was effective in making improvements.

Comment

Performance:
21-22 98%
22-23 82% (Previously erroneously reported as 98%)
23-24 82% (Preliminary)

Safety | Effective | Custom Indicator

	Last Year		This Year	
Indicator #4 Total Margin: Total Operating Surplus (Deficit) with amortization added back divided by Revenue (expressed as a %) (Waypoint Centre For Mental Health Care)	**2.99** **Performance (2023/24)**	**0** **Target (2023/24)**	**-3.38** **Performance (2024/25)**	**NA** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Decrease staffing costs.

Process measure

- Improve % of staff on an Attendance Support Program (ASP) contracts

Target for process measure

- Target for this process measure = 100%

Lessons Learned

Attendance Support Program
A new Absence Dashboard went live in Fall 2023, and has been helpful in benchmarking indicator performance across the Hospital so that targeted interventions can be put in place
Focused attention on this indicator, and resulting follow-up, has been effective in reducing this category of absences vs prior years
This change idea was effective but not enough to enable us to meet target

Change Idea #2 ☑ Implemented ☐ Not Implemented

Decrease staffing costs.

Process measure

- Decrease unapproved leave of absence.

Target for process measure

- Target for this process measure = 100%

Lessons Learned

Unapproved Leave of Absence
A new Absence Dashboard went live in Fall 2023, and has been helpful in benchmarking indicator performance across the Hospital so that targeted interventions can be put in place
Focused attention on this indicator, and resulting follow-up, has been effective in reducing this category of absences vs prior years
This change idea was effective but not enough to enable us to meet target

Comment

Not meeting target
22-23 2.99%
Q3 YTD 23-24 -3.38%

Safety | Safe | Custom Indicator

Indicator #5

Workplace Violence Frequency (Lost time claims per 100 full time equivalents) (Waypoint Centre For Mental Health Care)

Last Year		This Year	
2.80	**1.50**	**3.90**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Improve the execution of planned room entries.

Process measure

- (1) Number of staff and patient injuries (2) Number of planned room entrance interventions (3) Adherence to standard work (4) Safewards and 6 core strategies are being implemented to decrease patient and staff injuries.

Target for process measure

- To Be Determined (TBD)

Lessons Learned

1) Staff & Patient injuries
A new Health & Safety dashboard went live in Fall 2023, and has been helpful in benchmarking indicator performance across the Hospital so that targeted QI interventions can be put in place.
Leading programs have developed Violence Reduction A3's, which are tracked for success and reported to JHSC
Trending analytics (see example for Bayview below) are effective in measuring success of Violence Reduction QI Plans

2) Planned room entrance (PRE) interventions
As at January 31, 24 we are on track to perform approximately 120 PREs this fiscal. A similar number as were performed in 20/21 while significantly more PREs were performed in some other years. Over the past few years the number of PREs per year has fluctuated based on bed flow, and the number of Court Ordered Treatment Orders and COVID 19 measures.

3) Adherence to Standard work around PRE's
Ongoing data collection and analysis are contributing efforts at the program level to direct focused improvements. For example, the Managers Checklist has been revised to include a severity scale. The severity scale enables us to track the level of intervention required in each PRE (full resistance to full cooperation, and now, PRE PPE ordered but not donned)

4) Safewards & 6 Core Strategies
As of Nov 2023 Safewards has been implemented on three inpatient programs.
Focus has been on Leadership training on 6 Core Strategies. The 6 Core Strategies project has been merged with our Model of Care project.

This change idea has not been effective in improving our performance for this indicator.

Comment

Not meeting target
22 - 23 2.8
23 - 24 Q3 YTD 3.9

	Last Year		This Year	
Indicator #6 Workplace Violence Severity (Lost time claim days per 100 full time equivalents) (Waypoint Centre For Mental Health Care)	**19.20** Performance (2023/24)	**25** Target (2023/24)	**59.20** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Improve the execution of planned room entries.

Process measure

- (1) Number of staff and patient injuries (2) Number of planned room entrance interventions (3) Adherence to standard work (4) Safewards and 6 core strategies are being implemented to decrease patient and staff injuries.

Target for process measure

- To Be Determined (TBD)

Lessons Learned

1) Staff & Patient injuries
A new Health & Safety dashboard went live in Fall 2023, and has been helpful in benchmarking indicator performance across the Hospital so that targeted QI interventions can be put in place.
Leading programs have developed Violence Reduction A3's, which are tracked for success and reported to JHSC
Trending analytics (see example for Bayview below) are effective in measuring success of Violence Reduction QI Plans
This change idea has not been effective in improving our performance for this indicator.

2) Planned room entrance (PRE) interventions
As at January 31, 24 we are on track to perform approximately 120 PREs this fiscal. A similar number as were performed in 20/21 while significantly more PREs were performed in some other years. Over the past few years the number of PREs per year has fluctuated based on bed flow, and the number of Court Ordered Treatment Orders and COVID 19 measures.

3) Adherence to Standard work around PRE's
Ongoing data collection and analysis are contributing efforts at the program level to direct focused improvements. For example, the Managers Checklist has been revised to include a severity scale. The severity scale enables us to track the level of intervention required in each PRE (full resistance to full cooperation, and now, PRE PPE ordered but not donned)

4) Safewards and 6 Core Strategies
As of Nov 2023 Safewards has been implemented on three inpatient programs.
Focus has been on Leadership training on 6 Core Strategies. The 6 Core Strategies project has been merged with our Model of Care project.

Comment

Not meeting target
22 - 23 19.2
23 - 24 Q3 YTD 59.2