Central West **LHIN**

2017
CENTRAL WEST LHIN
INAUGURAL
QUALITY AWARDS

Tuesday, January 31, 2017
Millennium Gardens Banquet Centre
Brampton, Ontario

Healthy Change:
Making It Happen

PROGRAMME

Ontario
Local Health Integration Network

WELCOME

Welcome to the Central West Local Health Integration Network's (LHIN) inaugural Quality Awards.

Healthy Change: Making It Happen denotes a shared sense of responsibility. It reflects an understanding and acceptance that by working together as a collaborative team of health service providers (HSPs), community partners and the LHIN organization, we can do so much more to bring about "healthy change" across the local health care system.

Placing a spotlight on quality and excellence, these awards celebrate the achievements of local teams as they relate to strategic directions and initiatives outlined in the LHIN's 2016-2019 Integrated Health Service Plan (IHSP). They represent a desire to showcase and recognize the important transformative work taking place throughout the Central West LHIN; work that is focused on ensuring LHIN residents and patients remain at the centre of their local health care system.

The LHIN is committed to the implementation of a local quality framework and agenda that places patients first, enhancing their experience with the local health care system while enabling improved outcomes. A proven methodology for improving the provision of high-quality, patient-centred care, these awards are a catalyst for sharing information which leads to stronger outcomes and better health care experiences.

The Central West LHIN is fortunate to work with HSPs and community partners that are actively engaged in helping to bring about healthy change across the local health care system. Take the time to familiarise yourself with their efforts and the exciting work underway in the Central West LHIN. Meet new people, reacquaint with colleagues and share ideas. Discuss opportunities and perhaps most of all… take the time to celebrate your achievements!

Thank you for coming.

Maria Britto – *Chair, Central West LHIN Board of Directors*

Scott McLeod – *CEO, Central West LHIN*

3:00pm	**Registration / Showcase Preview / Networking** *A selection of cheese and crackers, charcuterie platters, a dessert station and fresh fruit will be available for your enjoyment along with infused waters, tea and coffee.*
3:30pm	**Welcome Remarks** **Maria Britto** Chair, Central West LHIN Board of Directors
3:40pm	**Keynote Address –** Hearing the Patient Voice **Judith John** *Former hospital communications executive, cancer survivor, and caregiver*
4:10pm	**Break –** Showcase Preview / Networking
4:40pm	**Provincial Quality Improvement Update** **Jennie Pickard** R.N., MScN *Director, Strategic Partnerships, Health Quality Ontario*
4:55pm	**Award Presentations**
5:55pm	**Closing Remarks** **The Hon. John McDermid**, P.C.

SPEAKERS

JUDITH JOHN

Former Communications Executive,
Cancer Survivor, and Caregiver

Judith John served as Vice President of Communications, Marketing and Public Affairs at United Way Toronto, Mount Sinai Hospital and Foundation, and the Hospital for Sick Children. Facing long-term health care issues, she turned her focus on strengthening relationships between clinicians and patients to advance the quality and delivery of care.

Judith volunteers widely with organizations that include University Health Network, Princess Margaret Cancer Centre, SickKids and Mount Sinai, concentrating on the patient experience, partnerships and communications. She is a trained Patient Partner, writer, consultant, facilitator and coach.

As a patient advocate, public relations, ethics and marketing instructor and lecturer, Judith has taught at universities and colleges across Ontario and has been a guest speaker for institutions worldwide, including England's National Health Service. She sits on several arts boards, literacy organizations, the Advisory Board for the Ryerson City Building Institute, as well as The V Generation, which promotes meaningful volunteerism for retirees and senior citizens.

Judith chairs and is an active member of several inter-institutional and government committees and panels, as they work to improve healthcare in Canada.

JENNIE PICKARD R.N., MSCN

Director, Strategic partnerships, Health Quality Ontario

In her role at Health Quality Ontario, Jennie works with partners from all sectors of the health care system to align efforts for collective impact and system improvements.

Previously, Jennie has held senior leadership roles in the community and mental health sectors as well as leading several large scale initiatives to improve the integration of care.

Interprofessional and cross sector collaborations has been an area of focus for Jennie as evidenced in such provincial initiatives as Behavioral Supports Ontario, End-of-Life and Palliative Care, and Improving and Driving Excellence Across Sectors(IDEAS).

AWARDS

The Central West LHIN Quality Awards
An Overview

A celebration of quality and excellence, the Central West Local Health Integration Network (LHIN is excited to present its inaugural Quality Awards. Placing a spotlight on quality and excellence, these awards celebrate the achievements of local teams as they relate to strategic directions and initiatives outlined in the LHIN's 2016-2019 Integrated Health Service Plan.

Within its quality framework, the Central West LHIN has adopted attributes associated with Health Quality Ontario's definition of a high-quality health system – a health system that delivers world-leading safe, effective, patient-centered services, efficiently and in a timely fashion, resulting in optimal health status for all communities.

In addition to demonstrating results within the context of these attributes, submissions must demonstrate the following:

- the use of quality improvement principles
- the use of change management principles
- the use of partnerships to achieve outcomes (at least one of the partners must be funded by the Central West LHIN)
- measureable change in health outcomes and/or experiences for patients/clients, and;
- focused on the timeframe of 2015/16 fiscal to the present time.

AETONIX COMMUNICATION SYSTEM

Participating Organization(s)
Peel Cheshire Homes Inc

IHSP Strategic Imperative/Initiative
Drive Quality & Value

Peel Cheshire Homes Brampton installed the Aetonix Communications System in its residential facility for the purpose of giving residents increased independence, dignity and respect, control over their own lives, and as an added safety feature for both residents and staff.

The Aetonix System is a technology based tool. Each resident wears a bracelet which is connected to a tablet in their room, and both of these items are connected to two staff mobiles on site. The resident can push a button on the bracelet when they require staff support. In addition, the system will detect if a resident experiences a fall or has wandered from the building, sending an immediate alert to staff. Staff can also use the system to communicate with other staff in the building or with an offsite On-Call Manager in the event of an emergency. Since installing Aetonix Peel Cheshire Homes Brampton has already averted several possible emergency situations.

In addition, a goal for the Aetonix system was to enhance the quality of residents' lives by connecting them virtually to family and friends. Residents can connect with family and friends anywhere in the world with a simple touch of a picture on the tablet screen. One resident has reconnected with his niece in England, who he hadn't seen in 15 years. Another, with her mother whom she had not seen in 10 years. The joy and excitement they experience after every call is contagious, and impacts not only their happiness but that of all the other residents and staff alike.

CLIENT AND FAMILY ENGAGEMENT TO IMPROVE QUALITY AND PERFORMANCE

Participating Organization(s)
CANES Community Care

IHSP Strategic Imperative/Initiative
Drive Quality & Value

CANES Community Care's mission is to provide excellent support services for seniors, enabling them them to remain at home in their community safely and with dignity.

As an organization, CANES has embraced an initiative to 'Drive Quality and Value' where the focus is on 'Clients & Family First'. With a strong emphasis on the Client and Family Centered Care approach, CANES' initiative encourages clients, family members and caregivers to participate throughout the entire continuum of a client's care. Annual Community Forums, Client Focus Groups, Health Quality Council, and ongoing innovative technological developments support the implementation of this initiative.

Quality and value is a continually evolving dynamic embedded in CANES' every day organizational culture. CANES' vision is to significantly heighten the positive client experience and satisfaction.

CANES has achieved a positive impact by leveraging the Client and Family Centered Care approach, attested to by the results of CANES' Client Satisfaction Surveys. 99.71% of respondents stated that they are treated with courtesy and respect, 93.06% stated that CANES staff listens to their needs before the service begins, and 99.66% stated that their cultural values and religious beliefs are being honoured by CANES staff.

At CANES, we are bringing Quality Care Home.

EXPANSION OF PHARMACY SERVICES

Participating Organization(s)
William Osler Health System

IHSP Strategic Imperative/Initiative
Drive Quality & Value

William Osler Health System's Pharmacy Program found efficiencies in its day-to-day operations that enabled re-allocation of existing resources to provide an expansion of services to 24 hours per day, 7 days a week.

With a want to provide the same level of care to patients regardless of time of day, and a desire to provide safer, higher quality services by decreasing discrepancies and opportunities for errors that previously existed during the overnight hours, the Pharmacy Program is committed to putting the needs of patients first.

Patients at Osler sites now benefit from having pharmacy services available 24 hours per day, 7 days a week. This expansion of pharmacy services has resulted in a safer, higher quality drug distribution system, and has allowed for a real time clinical review of new medication orders. In addition, Headwaters Healthcare Centre (HHCC) now has access to an on-call pharmacist for clinical questions, with the ability to procure urgent medications from Osler after-hours (24-hours a day).

FOUR PILLARS OF SUPPORTIVE AND PALLIATIVE CARE

Participating Organization(s)
William Osler Health System

IHSP Strategic Imperative/Initiative
Build Integrated Networks of Care

Osler's Four Pillars of Supportive and Palliative Care initiative was designed to address some of the complexities in delivering Palliative Care to the Central West LHIN community. The Four Pillars include Outpatient Clinics, Community, Acute Palliative Care and Consultative Services.

Osler's Outpatient Clinic is a multidisciplinary team that serves early palliative care patients and families. In collaboration with Community Care Access Centre (CCAC) services, Osler's physicians see patients in the home when they are no longer are able to attend the clinic. Meanwhile, the Acute Palliative Care Clinic accepts direct admissions from the community for pain and symptom management. Our consultative team is comprised of a physician and nurse that consult and assess patients in other hospital areas such as medicine, surgery and critical care.

Osler's vision is to create patient-inspired healthcare without boundaries. Through surveying the community, we know that more people would prefer to die at home rather than the hospital. This has been one of the inspirations to create the four-pillar approach that extends beyond traditional hospital-based palliative care, and removes the boundaries of care delivery. This multi-system approach has allowed palliative care to reach beyond cancer diagnosis to all patients with incurable illness, such as renal disease, cardiac and other chronic diseases.

The impact of this initiative has been to increase access to Palliative Care despite patients' location. Patients receive supportive and palliative care sooner, reducing pain and suffering, and increasing quality of life for patients and their families.

HEALTHY COMMUNITIES INITIATIVE

Participating Organization(s)
Central West LHIN, City of Brampton, Region of Peel and William Osler Health System

IHSP Strategic Imperative/Initiative
Demonstrate System Leadership

Together in 2016 the Central West Local Health Integration Network (LHIN), City of Brampton, Region of Peel and William Osler Health System (Osler) launched a Healthy Communities Initiative. The initiative seeks to mobilize the entire community to address diabetes, by empowering residents to make healthier eating decisions and active lifestyle changes.

In order to create an environment that will support this change, partners formed a community alliance with local businesses, school boards, health service providers and community partners to integrate a mandate of healthy eating and active living.

Among their achievements to date, organizations have been encouraging healthy options at congregation meals, implementing menu labeling, enhancing physical infrastructure and play areas, developing community gardens, establishing active transportation infrastructure (e.g. bike racks), and collaborating with community organizations to deliver active programming.

As a call to action, the prescription for change is 5-2-1-0; Enjoying 5 or more servings of vegetables and fruit… Powering down – no more than 2 hours of screen time a day… Being active – at least 1 hour a day… and, Choosing healthy – 0 sugar-sweetened drinks.

The Healthy Communities Initiative, Working together to get more PEOPLE... more ACTIVE... more OFTEN.

HOSPITAL 2 HOME (H2H)

Participating Organization(s)
Central West CCAC, Headwaters Health Care Centre and William Osler Health System

IHSP Strategic Imperative/Initiative
Building Integrated Networks of Care

The Central West Integrated Care Model was selected by the Ministry of Health and Long-Term Care (MOHLTC) to pilot an integrated funding model. Hospital 2 Home (H2H) is a collaboration between the Central West CCAC, Headwaters Health Care Centre and William Osler Health System, working with the Ontario Telemedicine Network and supported by the Central West LHIN. The model was created with and inspired by patients.

H2H supports patients requiring short-term nursing interventions, initially targeting those diagnosed with cellulitis and/or urinary tract infections. The model consists of directly-hired nurses who are integrated into the acute care and community teams, equally accountable to all three health service providers and allowing for seamless access to hospital and community health records. Patients experience a smoother transition as there is no need to transfer care to a third party service provider upon hospital discharge, significantly reducing breakdowns in communication and potential medication errors.

Since launching in January 2016, over 750 patients have received 6,500 in-home nursing visits. H2H is a patient-centred example of health care partners working together to prevent unnecessary hospital admissions and re-admissions (reduced by 36% and 13% respectively), to shorten the acute length of stay (reduced by 33%), to provide greater continuity of care and to ultimately, enhance the experience for patients and families.

MULTI-LINGUAL COMMUNICATION CARDS

Participating Organization(s)
Punjabi Community Health Centre

IHSP Strategic Imperative/Initiative
Drive Quality & Value

Difficulties with communication can be upsetting and frustrating for residents in Long-Term Care (LTC) and their care providers, particularly when English is not a first language. To bridge this gap, the Punjabi Community Health Centre (PCHC) has developed multi-lingual communication cue cards for adults who may not be able to communicate their needs due to language barriers, speech or cognitive loss due to stroke, traumatic brain injury, dementia, and/or other development disabilities.

Developed in 10 different languages – English, Punjabi, Hindi, Portuguese, Polish, Simplified Chinese, French, Tagalog, Italian and Spanish – these cards depict a variety of activities of daily living and situations, and can be used to prompt discussions, assist with directions and clarify client needs.

With these cards, residents are able to communicate their needs and wants to the health care professional, resulting in improved outcomes for adults who have difficulty speaking or understanding. The cards have proved particularly valuable for clients experiencing dementia, supplementing verbal communication when loss of language skills presents.

PALLIATIVE PATIENT EARLY IDENTIFICATION

Participating Organization(s)

Central West CCAC and Central West Palliative Care Network

IHSP Strategic Imperative/Initiative

Drive Quality & Value

Research shows that if patients were identified earlier in their illness they would benefit from well-coordinated, high quality palliative care, improving both their quality and length of life. By September 30th 2016, the Central West CCAC increased its identification of patients with palliative care needs from 5.2% to 10%, enabling access to optimal palliative care and improve quality of life.

Project work was informed by work of the South West LHIN Early Palliative Identification Project, Gold Standards Framework, and Supportive and Palliative Care Indicators Tool (SPICT). The project team included a cohort of clinicians and partners, all of whom had completed the QI Advanced IDEAS program.

Early identification education and supporting processes were rolled out between March and October 2016 results include:

- 40% reduction in acute care readmissions/admissions
- Increase percentage of patients dying at home (54%) for patients identified as palliative under the project, as compared to patients not identified as palliative where only 35% died at home
- Patient families stated that their experience at end of life was improved, and that they had less anxiety through better planning and earlier conversations with their loved ones.

The valuable work of improving the early identification of patients who would benefit from a hospice palliative care approach is challenging, and resource intensive as it requires engagement with all elements of the health care system. Utilizing a QI framework, organizational and leadership support and a committed project team, the Central West CCAC and Central West Palliative Care Network have made great strides in improving the overall experience for palliative patients and their loved ones.

PHYSICIAN INITIAL ASSESSMENT & EMERGENCY DEPARTMENT LENGTH OF STAY

Participating Organization(s)

William Osler Health System – Etobicoke General Hospital

IHSP Strategic Imperative/Initiative

Drive Quality & Value

Time to Physician Initial Assessment (PIA) and Emergency Department Length of Stay (EDLOS) are major quality indicators in emergency medicine. In March 2015, Etobicoke General Hospital's (EGH) performance on these indicators was 90th percentile Time to PIA = 2.6 hours (P4R rank = 20/74 hospitals), and 90th percentile EDLOS CTAS 4-5 = 3.9 hours (P4R rank = 32/74 hospitals). Meanwhile, EGH's Patient Satisfaction score remained at 68.9%.

For the year 2015-2016, Osler sought to achieve 3 goals at its EGH site:

- Decrease our 90th percentile Time to PIA
- Decrease our 90th percentile EDLOS CTAS 4-5
- Increase our Patient Satisfaction Scores.

To achieve these goals, Osler implemented the following initiatives:

- Mandatory use of Pulsecheck - a real-time dashboard for tracking patients in the ED, their Time to PIA and EDLOS
- Redesigned principles of Flow of patients in the Ambulatory Treatment Centre (ATC) and Fast Track areas of our ED
- the Physician in Triage Collaborative Process (with Nurse Practitioners)
- ED Physician Navigators
- Numerous no cost intangible cultural changes.

Combined, these initiatives have transformed the EGH ED into a top-performing ED in Ontario. Despite a 20% increase in patient volumes, 90th percentile Time to PIA = 1.1 hrs - a 58% decrease (1st in the province); 90th percentile EDLOS CTAS 4-5 = 3.0 hrs - a 23% decrease (3rd in the province); and, EGH's patient satisfaction score has increased by 12% to 77%.

PREVENTION OF ERROR-BASED TRANSFERS

Participating Organization(s)
William Osler Health System

IHSP Strategic Imperative/Initiative
Building Integrated Networks of Care

Many transfers to hospital are the result of errors related to consent, capacity, and substitute decision making. These errors profoundly affect not only treatment prior to death (from being made to undergo unwanted amputations just prior to death, to being tube fed despite wishes to forgo artificial nutrition), but also the location of death (for example, dying in an ambulance or ED instead of in one's own bed). The Prevention of Error-based Transfers (PoET) Project was designed to reduce error-based transfers between Long-Term Care (LTC) to hospital.

To achieve the change William Osler Health System (Osler) collaborated with residents, staff and physicians in LTC Homes across the Central West LHIN to co-design and develop the "Individualized Summary" tool, replacing the Level of Care form that drives error-based transfers.

PoET's objective is to prevent these error-based transfers by aligning the culture of decision-making with the wishes, values and beliefs of residents and the laws of Ontario. This approach helps to achieve basic ethical obligations when providing residents with wanted and beneficial treatment, and to refrain from imposing unwanted and potentially harmful treatment.

Aligning with these obligations improves quality of care for the resident, and promotes responsible stewardship of the system. Data has revealed that since Q1 of 2015-2016 there has been a shift in the number of LTC residents who die in hospital after repeated transfers, and a 56% reduction in the number of these transfers over 2012-2013.

RAPID DIAGNOSTIC AND BREAST SUPPORT CLINIC

Participating Organization(s)
William Osler Health System

IHSP Strategic Imperative/Initiative
Drive Quality & Value

Patients in Ontario with abnormal mammograms wait an average of 64 days from abnormal mammogram to date of surgery. This contributes to delayed systemic treatment, possible disease progression, and increased anxiety and patient dissatisfaction. At William Osler Health System (Osler), collaboration between Diagnostic Imaging, Pathology, Oncology and Surgery was initiated 2 years ago to systematically improve surgical and systemic wait times related to breast cancer.

The Rapid Diagnostic and Breast Support Clinic creates a patient-centered pathway identical for all patients requiring a biopsy related to an abnormal mammogram. Every breast biopsy is referred within a week by a nurse navigator, to the Breast Support Clinic where they are seen by a General Surgeon, a Medical Oncologist and a Radiation Oncologist (in person or virtually). This encounter represents a mini Tumour Board a week after biopsy that allows immediate initiation of appropriate surgical or systemic treatment. Also, within 7-10 days of that visit, urgent breast cancer operating room time is available for any patients requiring surgery.

Since launch in March, 2016, Osler has been successful in reducing the wait time for abnormal mammogram to an average of 25 days (compared to the 64 day Ontario average). Patient experience and satisfaction through this new clinical pathway has been quantified at 100%.

REDUCING INAPPROPRIATE USE OF ANTIPSYCHOTICS

Participating Organization(s)
Avalon Retirement Centre

IHSP Strategic Imperative/Initiative
Demonstrate System Leadership

Antipsychotic medications have serious side effects, including increased risk for falls and reducing quality of life.

A review of Health Quality Ontario's (HQO) data for antipsychotics without diagnosis of psychosis, determined Avalon was higher than the provincial average. Avalon's Responsive Behaviour Committee – a multidisciplinary committee comprised of managers from various departments, Registered Staff, PSWs, BSO PSW, Physicians, Nurse Practitioner, Pharmacist, and community resources that include a local Psychogeriatric Resource Consultant (PRC) – was tasked to re-evaluate current practices, with an eye to the implementation of new strategies designed to reduce residents receiving antipsychotics without diagnosis.

In response, the team completed holistic assessments of residents currently receiving, and now completes similar assessments of residents prior to receiving. These assessments are designed to determine if other alternative interventions can be implemented. The team then develops comprehensive plans of care to minimize responsive behaviours.

Coupled with the training of staff on the DementiAbility Program, this initiative has improved the care and quality of life for Avalon residents. In November 2016, reported responsive behaviours in the home had been reduced by 45% since January of the same year. Antipsychotic use, without a diagnosis of psychosis, has been reduced by 48% since inception of this approach.

REDUCING WAIT TIMES FOR PATIENTS WHO PRESENT WITH MENTAL HEALTH / ADDICTIONS CONCERNS

Participating Organization(s)
William Osler Health System – Etobicoke General Hospital

IHSP Strategic Imperative/Initiative
Drive Quality & Value

The Emergency Department (ED) team at William Osler Health System's Etobicoke General Hospital (EGH) is striving to achieve Physician Initial Assessment (PIA) and excellent service for delivery of care, to patients that present in the ED with mental health or addictions concerns.

With a vision to provide "Patient Inspired Health Care Without Boundaries" and eliminate stigmas attached to patients requiring mental health and/or addictions care in the ED, specialized training for ED front line staff is crucial for positive patient outcomes. Engaging internal/external resources to support diversion of re-admission for patients that could be followed within the community, enables a focus on patients that are acute and require more supports. Response to timely hand-over between EMS/Police is important for decreasing injuries and allowing our external partners to be out in the communities… not in hospitals.

This work has positively impacted patients, their families/caregivers, front-line staff, and ED Physicians. Ensuring quicker hand over has improved patient trust that staff are there to support them, resulting in improved patient outcomes.

Relationships between the hospital and its external partners have also strengthened, reducing wait times and allowing EMS/Police to get back out into the communities they serve.

REFINING QUALITY-BASED PERFORMANCE MANAGEMENT IN HOME CARE

Participating Organization(s)
Central West CCAC

IHSP Strategic Imperative/Initiative
Drive Quality & Value

In 2011, the Central West CCAC, in collaboration with local Service Provider Organizations (SPOs), developed and implemented a quality-based performance management strategy to embed quality into its purchased service contract management and procurement processes. Since that time, as the drive for high-quality care continues to evolve in the province, the Central West CCAC has responded in collaboration with its SPO partners, by refining its approach to quality-based performance management with a broader set of quality indicators.

Building on the success of incorporating the "voice of the patient" into its performance management framework, the Central West CCAC has pursued the inclusion of additional quality indicators to assess SPO performance to drive quality on a variety of dimensions: patient experience; clinical; safety; operational and system-level.

With the addition of multiple quality indicators, an increased focus on quality and accountability can be successfully sustained and expanded through collaborative partnership in contract management leading to improved patient satisfaction, a more meaningful relationship with SPOs, and a more accountable health system.

SINGLE SERVER PROJECT FOR THE DUFFERIN FAMILY HEALTH TEAM

Participating Organization(s)
Headwaters Health Care Centre and Dufferin Area Family Health Team

IHSP Strategic Imperative/Initiative
Build Integrated Networks of Care

The goal of this project, was to collate databases comprising over 50,000 patient charts from five different sites of the Dufferin Area Family Health Team (FHT), into one data-base on one server housed by the Headwaters Health Care Centre (HHCC) IT system. Separate from the hospital system, the server would receive the same protection, backup systems and disaster recovery protection of the hospital's Electronic Medical Record (EMR).

The main goal of the initiative was to provide access to all patient charts regardless of location, enabling a more standard process for after-hours clinics, easier access to EMRs by the Allied Health staff, potential access to the EMR by physicians in the Emergency Department (ED), and more consistent documentation practices. In addition, the FHT would be able to pull more accurate and consistent information around the health of their patient population, allowing for better population health planning.

The newly merged data-base has met all of these expectations. This improved and more consistent access to the patient records will allow for better patient care.

STANDARDIZED CLINICAL ORDER SETS

Participating Organization(s)
Bethell Hospice

IHSP Strategic Imperative/Initiative
Drive Quality & Value

The purpose of the standardized order set for residents at Bethell hospice (which includes pain management, dyspnea, constipation, delirium, anxiety, insomnia and catastrophic events) is to allow for timely treatment of anticipated symptoms without always having to contact a physician prior to administering medications.

A valuable tool, the order set empowers staff – in particular nurses – to increase their knowledge, education, and trust in their clinical judgement.

Since inception of the order set, enhanced nursing support has notably improved communication between doctors and nurses. Nurses are frequently making recommendations to community physicians via telephone and physicians, through the use of a predictable, recognized order set, are now increasingly engaged in providing care to patients in hospice.

THE ADMINISTRATIVE AUDIT TOOL

Participating Organization(s)
Canadian Mental Health Association Peel-Dufferin

IHSP Strategic Imperative/Initiative
Drive Quality & Value

The purpose of this project was to streamline client audit processes and tools, and to ensure audits can be completed for all programs regardless of varying documentation requirements. Specific outcomes included the want to:

- reduce the length of time required to complete both qualitative and quantitative aspects of client audits
- reduce the work effort required for quantitative audit through generation of an automated Client Record Management System (CRMS) report.

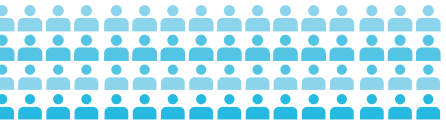
The result has been a powerful tool not only for auditing client files, but in its ability to pull large amounts of data in an organized fashion not previously available.

Providing improved information for the analysis of client information, the tool has subsequently been used in areas related to health equity, Ontario Common Assessment of Need (OCAN), CMHA Peel-Dufferin's current Quality Improvement Plan (QIP), and analysis of postal code demographics. With its ability to present real time client data, the tool has helped CMHA Peel-Dufferin to better understand client needs, improve the quality of client services offered, build better supports, and improve the overall client experience.

Central West **LHIN**

BY THE NUMBERS

920,000+
People 7% of Ontario's total population*



Population Growth By 2025
Between 2010 and 2025*

29%

Residents

Over 50%
VISIBLE MINORITIES
Source: Canadian Census

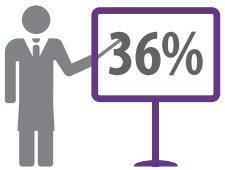
SENIORS GROWTH
62%
BY 2025 Age 65+*

86% URBAN

7% SUBURBAN
(urban/rural)

7% RURAL

Source: Canadian Census



OF POPULATION HAS ONE OR MORE CHRONIC CONDITION

Source: LHIN Environmental Scan 2012
*Source: Ministry of Finance, Estimates and Projections 2012

Health Service Providers

23
LONG-TERM CARE HOMES (LTC)
Over 750,000 Resident Days/Year

15
COMMUNITY SUPPORT SERVICES (CSS)
Over 40,000 clients/year

8
MENTAL HEALTH & ADDICTIONS AGENCIES
Over 20,000 interactions/year

2
HOSPITAL CORPORATIONS ACROSS 4 SITES
Over 70,000 admissions and 240,000 Emergency Department visits/year

2
COMMUNITY HEALTH CENTERS (CHC) ACROSS 5 LOCATIONS
Over 25,000 primary care visits/year

1
COMMUNITY CARE ACCESS CENTRE (CCAC)
Serving 32,500 clients/year

Plus 500 primary care physicians, including 6 Family Health Teams, funded by the Ministry of Health and Long-Term Care.

COMMITTEES

With thanks to...

Quality Event Steering Committee

Geraldine Cabral, *Founder, Shake It Up Events*

Hali Harry-Paul, *Administrative Assistant, Central West LHIN*

Mayo Hawco, *Executive Director, WellFort, Bramalea Community Health Centre*

Brock Hovey, *Senior Director Health System Performance, Central West LHIN*

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Christine Sevigny, *Executive Director, Caledon Meals On Wheels*

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