

QI Project Report Back

Session 3 – June 23rd, 2022

Facilitators: Linda and Laura



Land Acknowledgement



Agenda

#1 Welcome & Opening Remarks

#2 Community Addiction Services of Niagara

#3 Mood Walks/CMHA Ontario/CMHA Grey Bruce

#4 CMHA Toronto

#5 Mission Services of Hamilton

#6 Providence Care – Seniors MHBSS

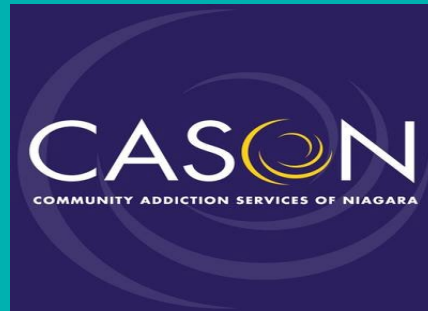
#7 Radius Child and Youth Services

#8 Next Steps and Staying Connected



Organization: Community Addiction Services of
Niagara
Project Title: Implementing OPOC surveys

Project Status as of: June 23rd, 2022



THE EXCELLENCE THROUGH QUALITY IMPROVEMENT PROJECT (E-QIP)
COHORT 6 REPORT BACK

PRESENTATION DATE: June 23, 2022



Project Story:

- Over the past few years we have found that the completion of Ontario Perception of Care (OPOC) surveys does not accurately represent the diversity of clients served.
- It is our mission to increase survey completion rate across programs at CASON and continue to include the voice of interested and affected parties
- We will achieve this by the creation and implementation of an “OPOC policy”, outlining how OPOC’s will be delivered and inputted.



Problem/Opportunity Statement

CASON has been conducting OPOC in person for several years, however this has been a challenge during the ongoing pandemic with virtual program delivery.

Lack of regular OPOC data representing all programs and clients served, gives us an opportunity to improve unlike previously done at end of the fiscal year.

CASON cannot improve programs without any strategy to implement and review OPOC data regularly as staff are uncertain without the information, leaving clients' needs unmet resulting in them leaving the program and hindering staff.

AIM Statement

- We plan to complete 10 % of OPOC every quarter with diverse CASON clients including Outreach, family, caregivers, children of loved ones who are at different points of their client journey by April 1, 2023.
- Additionally, we plan to draft policies & procedures for OPOC implementation at CASON by April 1, 2022.



Diagnostic Tools – The Vital Few.

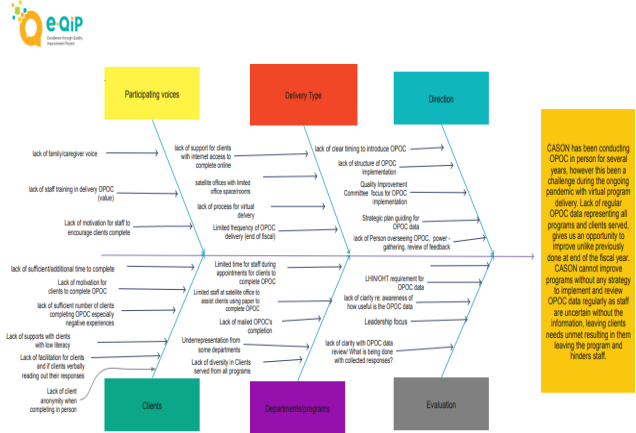
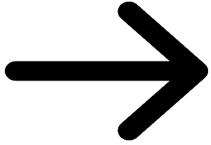
5W2H WORKSHEET

STEP 1: Answer the following 5W2H questions to better understand the problem/opportunity at your organization.

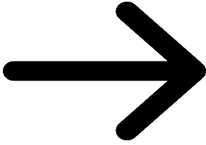
What is the problem/opportunity? Lack of OPOC data for all programs across CASON, lack of family engagement with OPOC	Why is it a problem/opportunity? not getting everybody's input, not representative of all clients served, gives us opportunity to improve, no ongoing strategy to implement and review OPOC
Where do you observe the problem/opportunity? Roll out to consistently get the feedback versus end of the year, not random selection of clients (only compliant, easy clients may be reached)	Who is impacted? Staff are impacted as we don't get the results (eg. comments section), we cannot improve programs if we don't know, no idea what to do with the information
When did you first observe the problem/opportunity? Since OPOC implementation but made worse with the pandemic	How does it affect clients/families/caregivers/staff? Client needs not met, finding out barriers why clients leave programs, program development is affected, staff feel frustrated for not able to support clients
How often does it occur? yearly, end of the fiscal year	

STEP 2: Use your answers from step 1 to draft a problem/opportunity statement.

CASON has been conducting OPOC in person for several years usually at the end of fiscal year. The pandemic has impacted this significantly with virtual shift of program delivery. There is lack of OPOC data representing all programs across CASON including family engagement and is not representative of all clients served thereby giving an opportunity to improve. There is no ongoing strategy to implement and review OPOC results, uncertainty with what to do with the information, impacting staff who may get frustrated for not able to fully support clients as they are not provided the results (eg. comments section). This also affects program development when we don't know this data (eg. client needs or barriers why clients leave programs).



CASON has been conducting OPOC in person for several years, however this has been a challenge during the ongoing pandemic with virtual program delivery. Lack of regular OPOC data representing all programs and clients served, gives us an opportunity to improve unlike previously done at end of the fiscal year. CASON cannot improve programs without any strategy to implement and review OPOC data regularly as staff are uncertain without the information, leaving clients needs unmet resulting in them leaving the program and hinder staff.



QI TOOLS + RESOURCES TEMPLATE

5 WHYS

Use the boxes on this worksheet to write down your answers to the question "Why is this happening?" until you arrive at a cause you can take action on. Write your five whys in the boxes below.

ROOT CAUSE/CONTRIBUTING FACTOR:
Limited agency staff & lack of designated staff support for OPOC

WHY?	Staff are tied with client care and this adds extra paper work and staff have limited understanding of value of use of the tool
WHY?	Staff are not explained about the tool, why it is being done besides getting the surveys completed
WHY?	It is not embedded in the policies besides the # of surveys completed, how the data is used by the agency to improve programs.
WHY?	lack of engagement from all parties (clients, staff, other partners)
WHY?	no priority from the leadership about allocation of resources, data management, sharing of results and follow up

eQIP QI tools and resources | Foundations to quality improvement



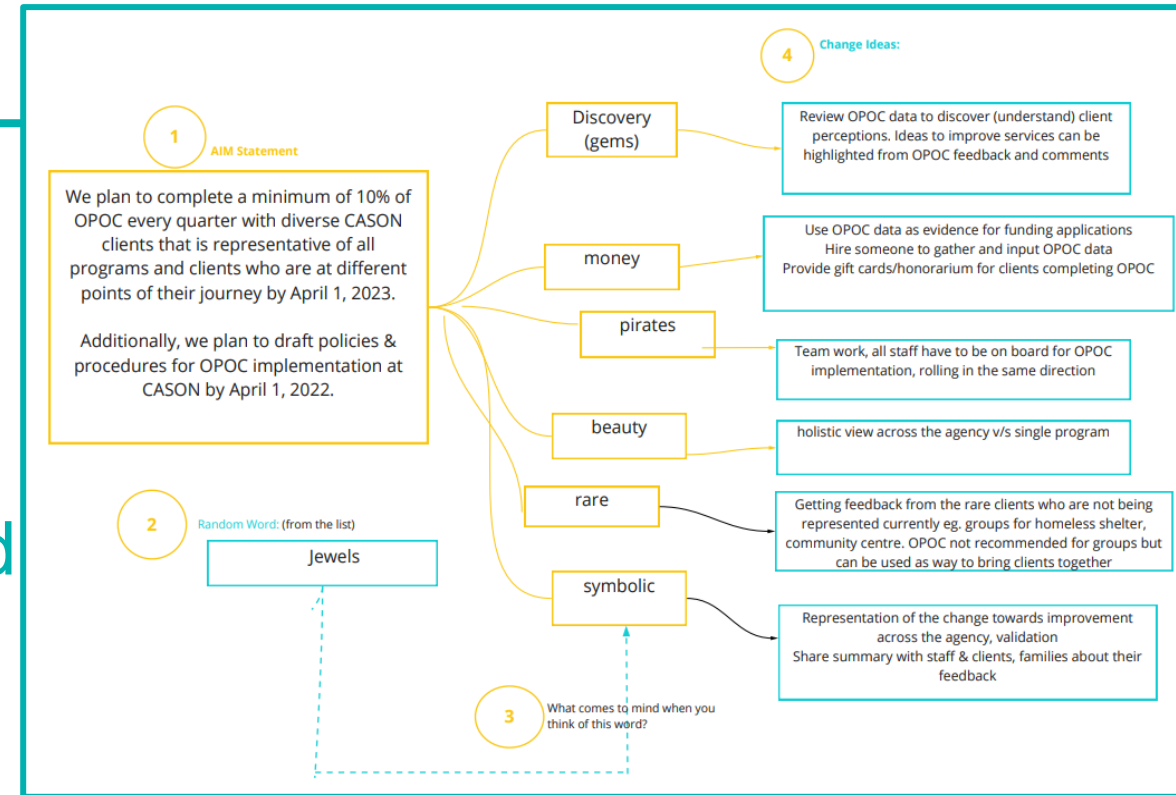
Frequency (# of Votes) % Cumulative Frequency



Change Ideas

- Random Word Generator: →
- A change idea being implemented

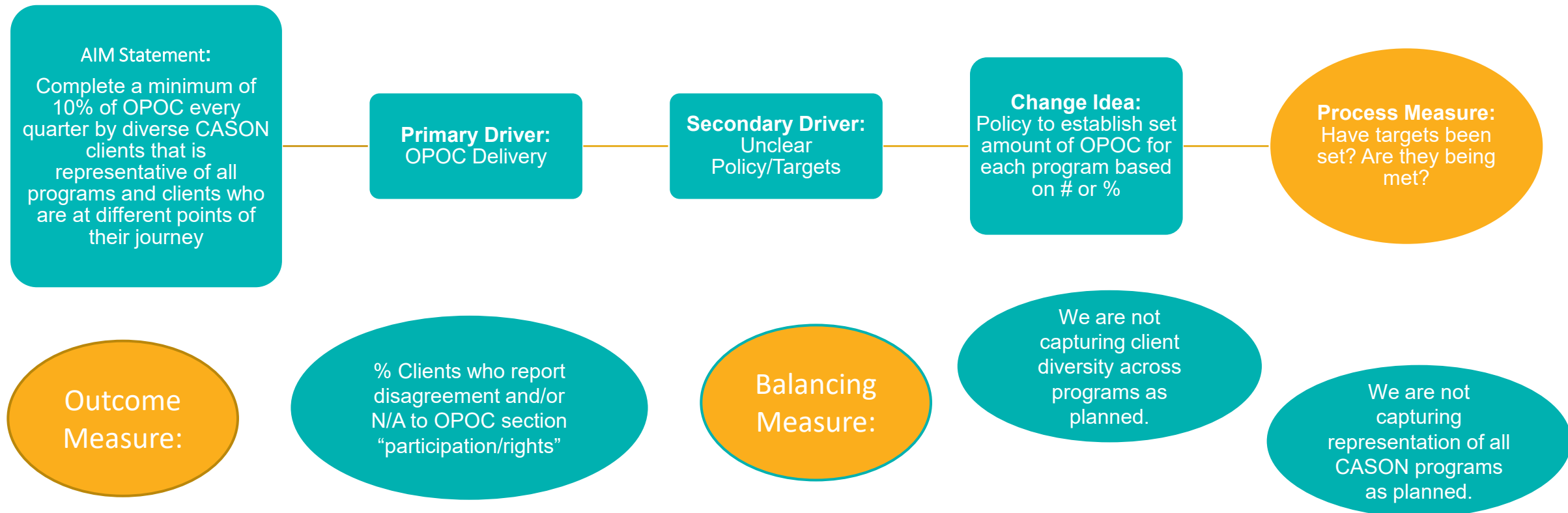
Information/Training sessions for staff



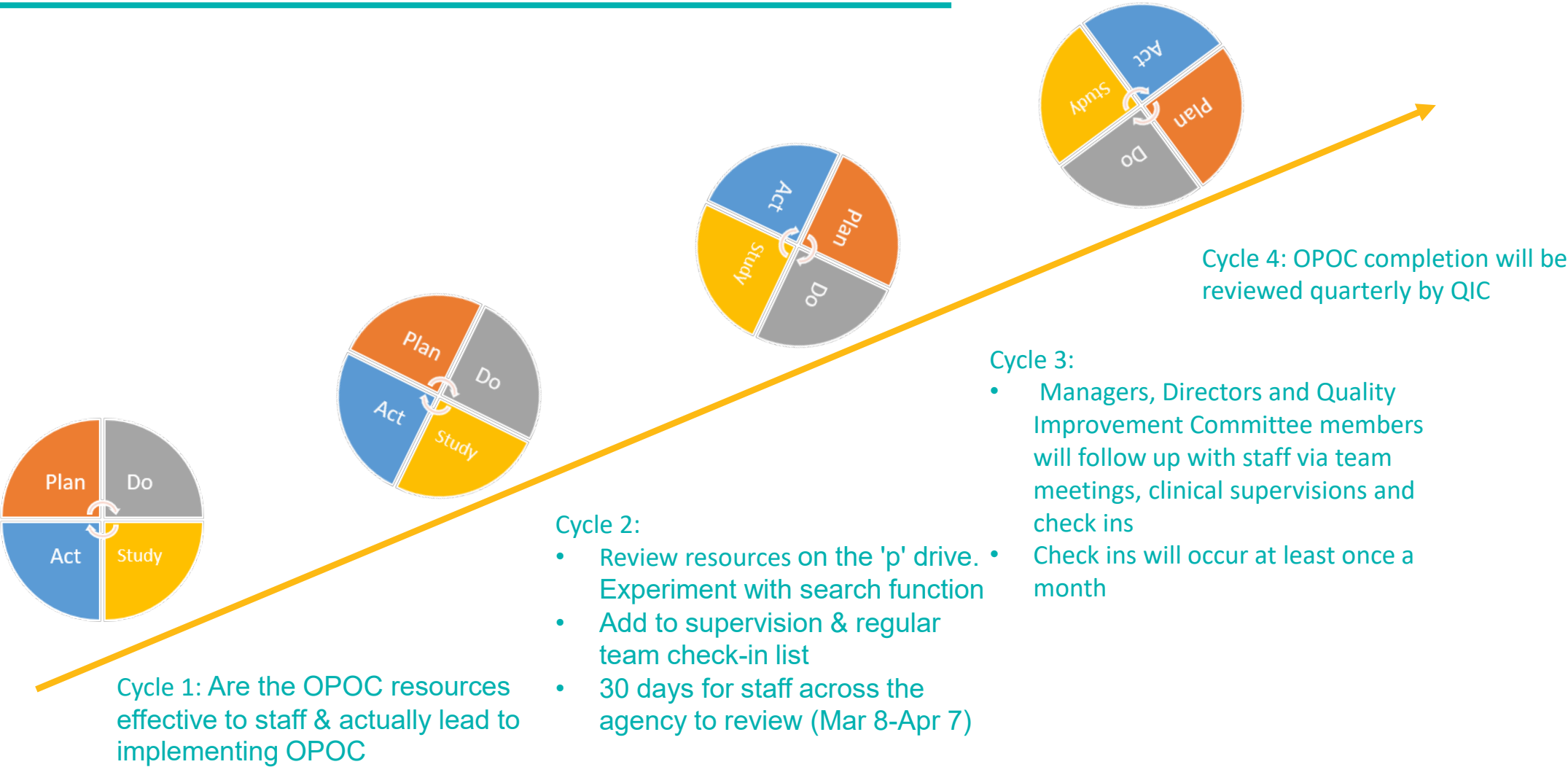
- How we will know that this is working:

OPOC will increase, staff will feel more educated about the evaluation tools used in the agency

Driver Diagram (mini)



PDSA Planning : Share OPOC Training Resources



What have we measured so far?

- Outcome Measure:

Under the targeted section of “participation/ rights” we had a 97% completion rate and did not receive any feedback indicating “disagree” or “strongly disagree”

Process Measure:

Targets have been set to complete OPOC surveys with a minimum of 10% of clients in each program across the agency.

Data is still being collected for this quarter.



Lessons Learned / Ah-ha Moments

- *The most significant learning moment was:*
 - The “TRIZ” exercise; acknowledging how the problem could be made worse, and then generating change ideas to correct possible problems in advance.
- *How will you know when your project is at the point of 'sustainability'?*
- *Quality Improvement Committee will review completion % quarterly. We can assume that project is at the point of sustainability if targets have been met by the end of the 2022-2023 fiscal year*

Project Title: Mood Walks program for youth ages 12 -29

Project Organizations:

- The City of Hamilton
- The Town of Innisfil
- CMHA Grey Bruce
- CMHA Ontario
- London Intercommunity Health Centre



THE EXCELLENCE THROUGH QUALITY IMPROVEMENT PROJECT (E-QIP)
COHORT 6 REPORT BACK

PRESENTATION DATE: June 23, 2022



Project Story:

Mood Walks has a long history of getting people outside; weekly walks into nature in small groups, participants notice a positive change in their overall wellbeing.

Our QI group was tasked with researching the possibility of using this already proven program to improve and support youth's overall wellbeing.

In the CMHA National "Mental Health Impact of COVID-19" survey results, stats showed that 2 of the top 4 most negatively affected populations during the pandemic were youth ages 18-24 and students.

We hope that Mood Walks will become a go-to Tier 1 program that anyone can implement in their community to support youth mental health.



Problem/Opportunity Statement

Development of a Mood Walks model/program tailored for youth ages 12-29 to support optimal physical and mental well-being through engagement with nature both physically and socially by walking outdoor in groups. The group-based program offers knowledge, empowerment, leadership and skill building activities while minimizing negative impacts such as inactivity, loneliness, social isolation, accessing resources and long wait lists.

AIM Statement

Develop the core components of a Mood Walks program for youth aged 12 - 29 years, by March 31, 2022, and at least 4 partner organizations will deliver, test and evaluate the program by August 31, 2022. By October 31, 2022, the final model and toolkit of the Mood Walks program will be released and promoted throughout the province.



Diagnostic Tools – The Vital Few

Impact - Effort Grid Decision Making Matrix

High ↑
Impact

- Clearly articulate in the manual which components are necessary in order to
- Ensure all mood walks leaders have the "Hike Leader" training from Hike Ontario
- Mood Walk leaders have the tools and resources to meet the challenges participants
- Ensure all mood walks leaders have access to a hike safety pack and other necessary
- Ensure all mood walks programs have access to the necessary equipment
- Have the program available and accessible during times that are good for the youth
- Offer open and closed group options
- Access local green space, and then find trails - build on group input

Quick Wins

- Involve youth from diverse backgrounds in the development of the program
- Link ongoing COP members with E-QIP QI team for continuous improvement
- Be open to feedback from youth and leaders and be ready to change and adapt as needed
- Hire youth as MW leaders or adults that have experience working with youth
- Offer groups with varying difficulty so there is a suitable group for all abilities
- Funds and/or gifts in kind to mitigate barriers

Major Projects

- Raising awareness of the social determinants of health (SDH) impacts on mental health
- Partner with organizations to make the program more accessible to their
- approach like programs to manage recruitment and distinguish fit for youth in communities

Schedule

Rethink

Change Ideas

We had several change ideas, and they were narrowed down by the Impact/Effort grid. Following are examples of key change ideas:

- Tools, training, and resources for hikers and hike leaders
- Outcomes evaluations and contributions for quality improvements
- Continuously engaging youths in designing a Mood Walks model by evidence
- Locations and accessing green space

Driver Diagram (mini)

AIM Statement:

Develop the core components of a Mood Walks program for youth aged 12 - 29 years, by March 31, 2022, and at least 4 partner organizations will deliver, test and evaluate the program by August 31, 2022. By October 31, 2022, the final model and toolkit of the Mood Walks program will be released and promoted throughout the province.

Primary driver:

To co-develop the curriculum through a cohesive and effective team

Secondary driver:

To be continuously engaging with youth to co-design a Mood Walks model of excellence

Change Idea:

To involve youth from all backgrounds in the development of the program

Process Measure:

Number of youth that participate in the co-design process

Outcome Measure:

Number of organizations that collaborate to develop, test and evaluate the youth-friendly MW program

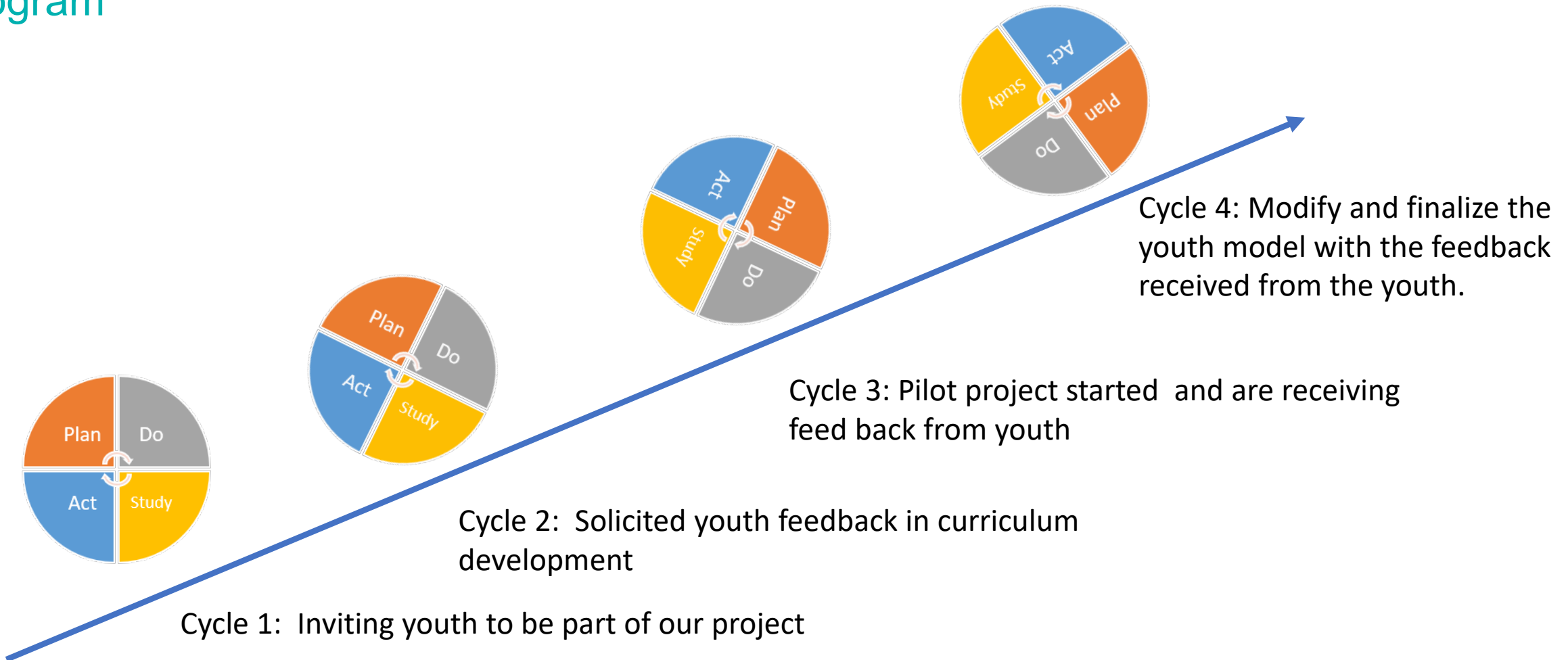
Balancing Measure:

OPOC Question #32 – if another youth was in need of similar help I would recommend this program



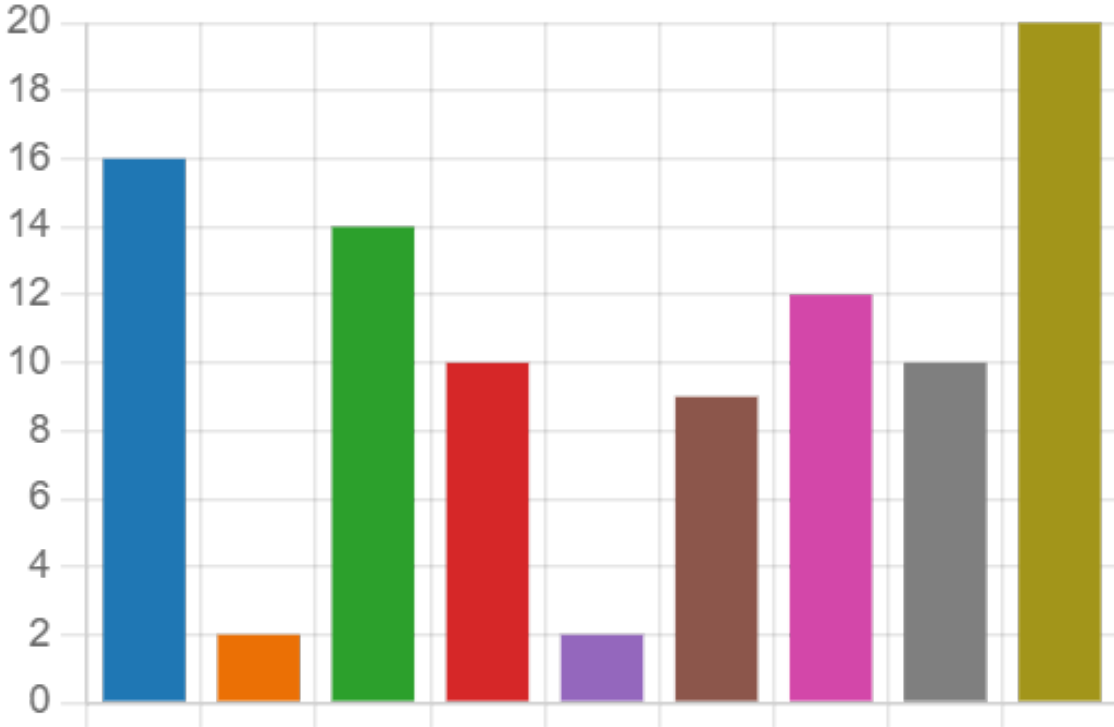
PDSA Planning – Mood Walks

Change Idea: Involve youth from diverse backgrounds in the development of the program

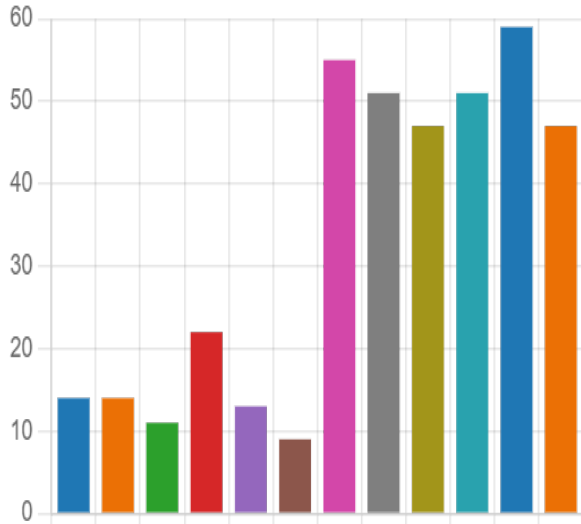


What Motivated you to participate in Mood Walks

● I hope to learn new skills for co...	16
● I want opportunities to meet ne...	2
● I like to learn new things	14
● I have friends who are taking th...	10
● I have heard good things about ...	2
● I want to learn more about outd...	9
● I would like to increase my phys...	12
● I am curious about the program	10
● Other	20



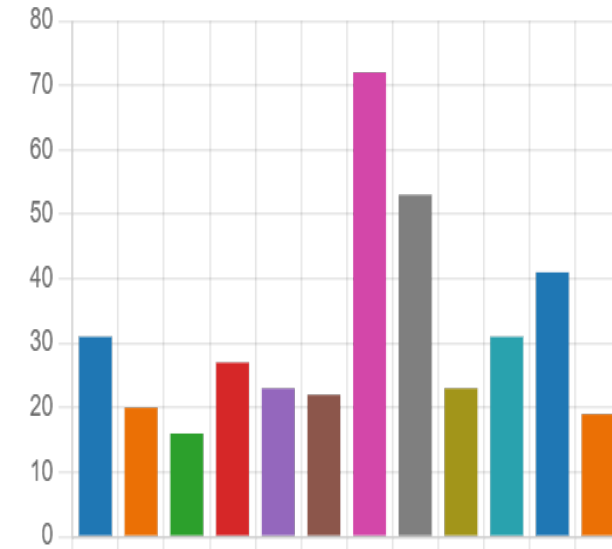
Before the walk



Stressed 😞	47
Sad 😞	29
Sick 😞	24
Annoyed 😞	40
Grouchy 😞	33
Gloomy 😞	28
Tired 😞	111
Neutral 😞	90
Energetic 😊	34
Happy 😞	50
Calm 😞	66
Content 😊	32

Stressed 😞	21
Sad 😞	18
Sick 😞	15
Annoyed 😞	25
Grouchy 😞	16
Gloomy 😞	14
Tired 😞	71
Neutral 😞	64
Energetic 😊	59
Happy 😞	65
Calm 😞	75
Content 😊	56

After the walk



Run Chart(s) for Process Measures via emojis
(before n=220 and after the walk n=202)

Lessons Learned / Ah-ha Moments

- One of the biggest Ah-ha moments for our project group is hearing the updated list each week of the rising numbers of CMHA branches and other community groups that want to offer this Tier 1 support for the youth in their community and the NUMBERS of youth already signed up to participate in those pilot groups! It has been way more than we anticipated!
- Another very significant learning that needs to be recognized and stated was seeing first-hand the truth in the 4th and final round of the CMHA National research project - "Running on empty" that found that the pandemic had greatly strained the already-overstretched community mental health sector and its workforce. This was very much felt within our small but mighty group. The co-chairs of the Mood Walks QI project would like to take this opportunity to thank ALL of our group members that always had 100 other things that needed to be done and were experiencing the over-stretching of themselves but gave up a weekly slot of their time (PLUS!) to be part of the QI project. We HEAR you! We SEE you! We appreciate you! We are humans first, a QI project second!
- Next time, we would be more gentle on ourselves with the timeline. We set out a very ambitious plan, generated by our first-hand understanding of the incredible needs of those aged 12-29 in our communities even when we didn't have baseline data
- We are continuing to have incredible work on the model, developing themed ideas, self-care tools, and mindful meditation techniques for youth to participate, learn and practice as we are starting to see the changes via emojis.

Testimonials

Facilitator's testimonials:

- ❖ “Not only has there been mood changes, but participants are motivated to explore and hike different trails”
- ❖ “Participants are enjoying the group, and in we have seen growth in participants and how they interact”
- ❖ “They want the hikes each week.”

Words from participants

Relaxing
Easy Comfy
Joyful
Welcoming Calming Fun
Amazing
I like it Engaging Energetic
Inclusive Enjoyable



Organization: CMHA Toronto Branch Project Title: FSHP Transitional Plan

Project Status as of: June 1st, 2022



**Canadian Mental
Health Association**
Toronto

THE EXCELLENCE THROUGH QUALITY IMPROVEMENT PROJECT (E-QIP)
COHORT 6 REPORT BACK

PRESENTATION DATE: June 23rd, 2022



Project Story:

- The FSH receives referrals from the client's primary case manager in the TRHP 1&2 programs.
- The client is deemed 'ready' for independent housing, however they may experience a relapse in the transition process. Therefore the application is considered premature as the client may require additional skills and support to live more independently.
- The FSH program will work collaboratively with the referring worker and client in developing a Transition Plan that may create direction for providing better outcomes.
- The Transition Plan will be included in the referral package as a practice



Problem/Opportunity Statement

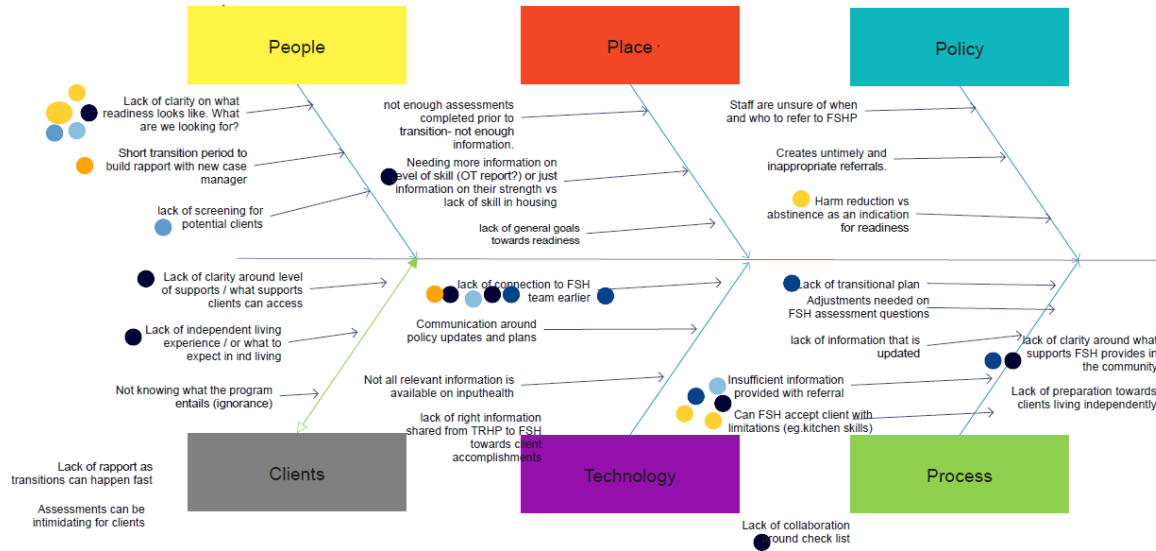
- The FSH program have received premature referrals from the TRHPs programs.
- How can the programs assess the client's "readiness" within a recovery framework?

AIM Statement

- CMHA Toronto FSH team aims to develop & complete transition plans for 100% of new referrals to the program by June 2022, as to determine the service user's readiness for independent living.

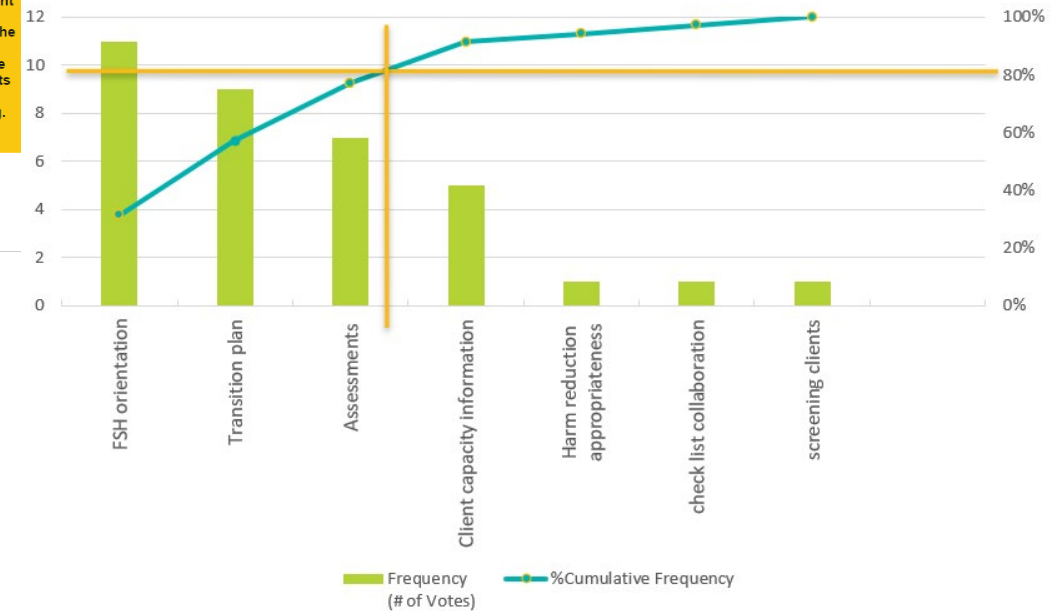


Diagnostic Tools – The Vital Few



Since the start of the pandemic, staff & clients at Transitional Housing program (TRHP) are not clear when client is ready for transition to Forensic Supportive Housing (FSH) program & when clients need to be referred to FSH. This happens at each referral with duplicate assessments thereby impacting clients as they move from supportive housing to independent living and causes stress for clients/family & staff because of the risks like missing medications, appointments without any onsite staff to remind. As a result, clients feel isolated and impacts their readiness for independent living.

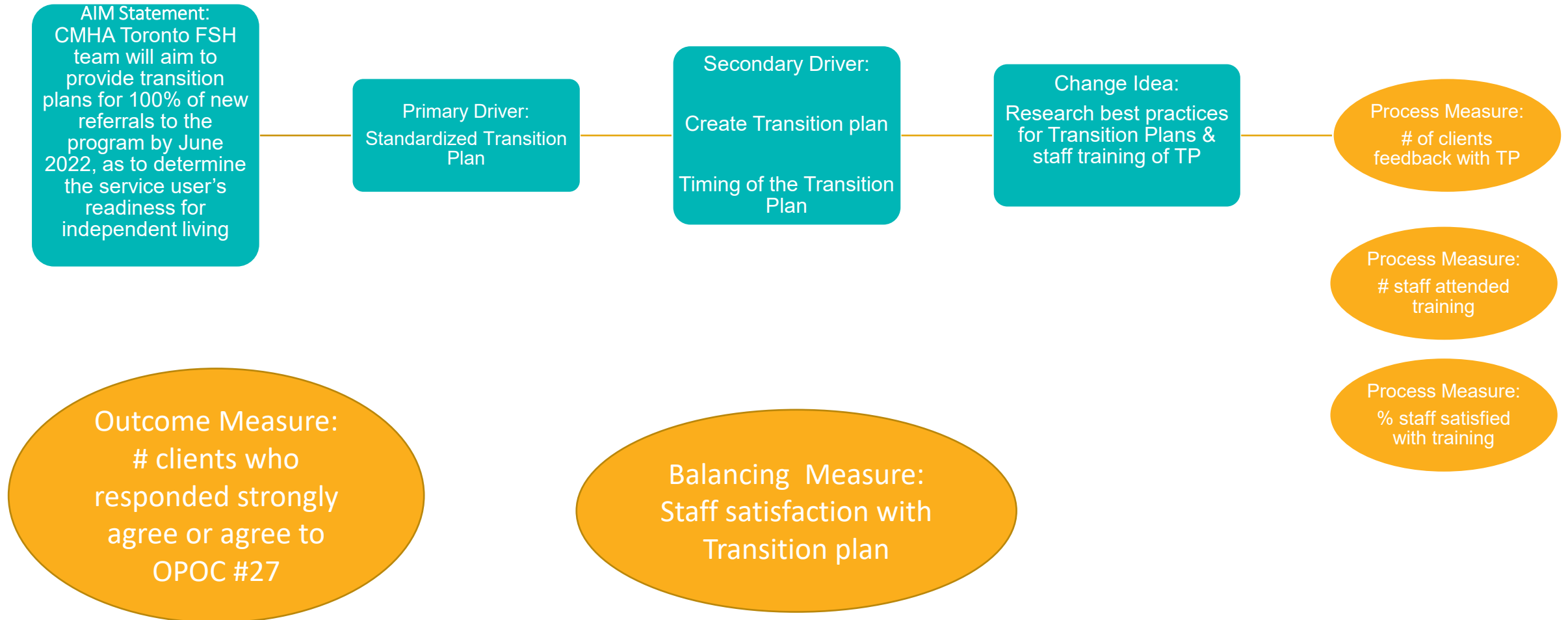
Pareto Chart



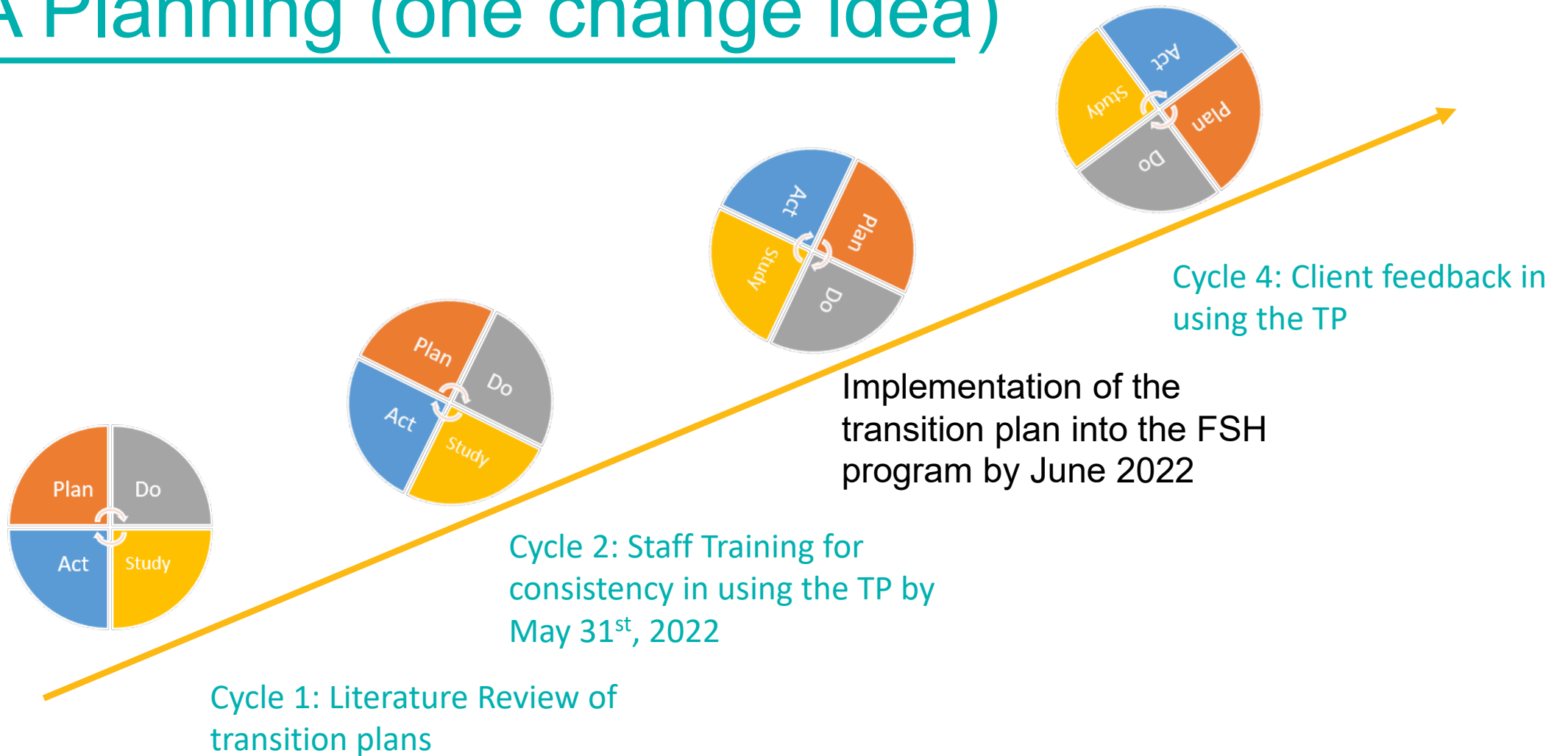
Change Ideas

- The Ontario perception of Care Tool for Mental Health and Addictions (OPOC) – client feedback through peer interviews and anonymous mail in responses.
- Developed a transition plan, testing with clinician and upload into EMR
- Feedback from clients on their experience in using the plan.

Driver Diagram (mini)



PDSA Planning (one change idea)



OPOC Survey conducted by Peer with Clients

Items	Strongly Agree 4		Agree 3		Disagree 2		Strongly Disagree 1		(1+2+3+4) 100%	Not Applicable n	Total N
	n	%	n	%	n	%	n	%			
Selected Question #1											
7. I had a good understanding of my treatment services and support plan.	0	0.0%	3	100.0%	0	0.0%	0	0.0%	3	0	3
Selected Question #2											
27. Staff helped me develop a plan for when I finish the program/treatment.	0	0.0%	3	100.0%	0	0.0%	0	0.0%	3	0	3
Selected Question #3											
28. I have a plan that will meet my needs after I finish the program/treatment.	2	66.7%	1	33.3%	0	0.0%	0	0.0%	3	0	3
Selected Question #4											
29. Staff helped me identify where to get support after I finish the program/treatment.	1	33.3%	2	66.7%	0	0.0%	0	0.0%	3	0	3

Lessons Learned / Ah-ha Moments

- *What were you / are you most excited about?*

We're excited with using a new approach in assisting the forensic population as they move into independent living into the community.

- *How will you know when your project is at the point of 'sustainability'?*

The program will receive less premature referral application. In addition, the clients may experience improved outcomes as they work collaboratively with the transition plan.

Mission Service's of Hamilton Tackling Hamilton's Opioid Crisis “Developing a Harm Reduction Team”



Project Team: Valerie Sadler, Greg Croft, Victor Cyr, Michelle Noiles, Kristen Drury

Project Story:

Over the past two years, Mission Service's has seen an increase in on-site overdoses. This can result in death or long term health impacts in our service users and has revealed a need for intervention.

During this time we have seen an increase in mental health struggles with our clients directly related to substance use and gaps in services (lack of ability to connect clients with community sites).

We recognized a lack of staffing and resources to diffuse situations (mobile response support vs. police intervention). We wanted to build staff capacity to handle these complex situations, raise awareness of substance use risks, enhance client safety and build more awareness around street drug supply.

We wanted to find an innovative way to both support staff and clients in our sites while positively impacting the opioid crisis in our community.



Opportunity Statement

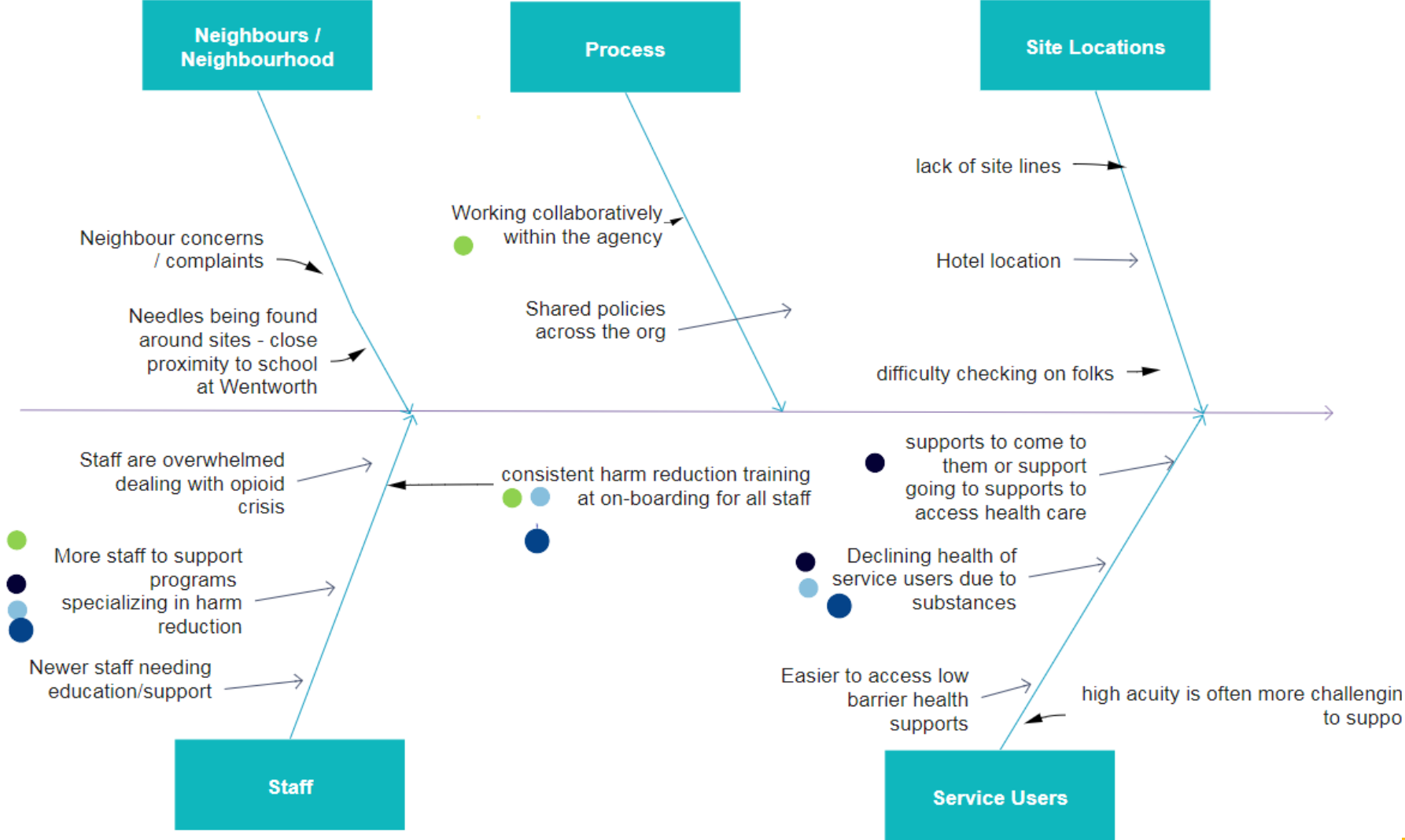
Since 2019 we are seeing a decline in the health of service users, an increase in overdoses/serious occurrences at our sites and an increased need to support neighbours as a result of the opioid crisis in Hamilton. A Harm Reduction team will improve health outcomes, reduce overdoses, build staff capacity and provide education/resources for our service users.

AIM Statement

By Dec 31, 2022, we will develop a Harm Reduction Program that will provide 1000 interactions to individuals using services at Four Points Hotel and Men's Shelter.



Diagnostic Tools – Fishbone Diagram



Diagnostic Tools –5 Whys

WHY?

seeing increase in overdoses could result in death or long term health impacts and shows need for intervention

WHY?

opioid crisis
long-term use
alcohol use and crystal meth use are prevalent across the board (interactions between mixing)
i/v drug use - including increased risk of communicable diseases

WHY?

reluctance to talk about because of stigma and fear of being restricted from services
overwhelmed by system
normalized use and unsure where to start
belief that abstinence is the only solution

WHY?

lack of individualized plans including usage and health challenges
referrals to other resources
safe needles
communication to other staff
plans would be developed in partnership with the client, speaks to commitment from client,
empower clients toward their own wellness



Change Ideas

Through staff training (training modules) staff will feel more confident when there is an overdose.

We will know the change is making an improvement when staff report higher confidence in offering assistance during the event.

Problem Statement or Root Cause: Since 2019, we are seeing a decline in health of service users, an increase in overdoses/serious occurrences at our sites, and an increased need to support neighbours as a result of the opioid crisis in Hamilton. A Harm Reduction team will improve health outcomes, build staff capacity, and provide education/resources for our service users .

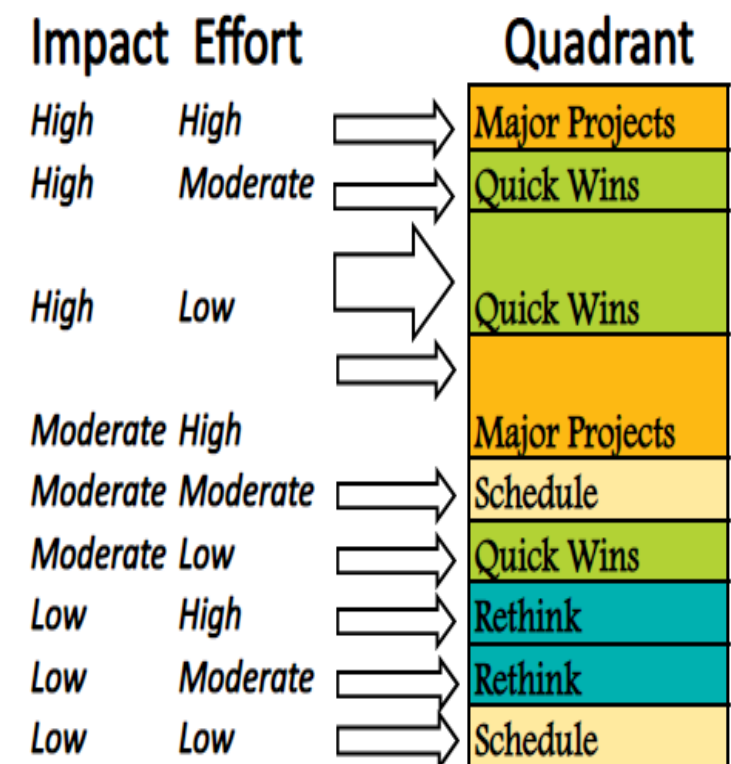
How could you and your team make the problem worse?	Reversed Ideas (Positive)
staff continues to be overwhelmed, uncomfortable / reluctant when there is an overdose	build staff capacity (training for current staff) training (new staff) one-to-one staff shadowing opportunities informal, on shift debriefing available harm reduction team acts as a resource and support to front line staff
client issues not being addressed	develop harm reduction plan and processes to support developing these plans with clients resources (bring in or go to) to help access other services provide clients the opportunity for overdose awareness and education (conversations & lectures) provide clients opportunity for support and education regarding substance use (1:1 and group settings, linkages to other services) signs and awareness of dangerous use patterns (written, verbal and follow-up resources)
not monitoring (overdoses and post care)	Harm reduction team to provide follow up post over-dose. communication with staff - shift change forms, informal check in, HRT staff are looped into teams channel - already happening! client follow up - monitoring (covered in previous section)

Impact Effort Grid

F G H I K L M N O

Improvement Project
Community-focused. Data-driven.

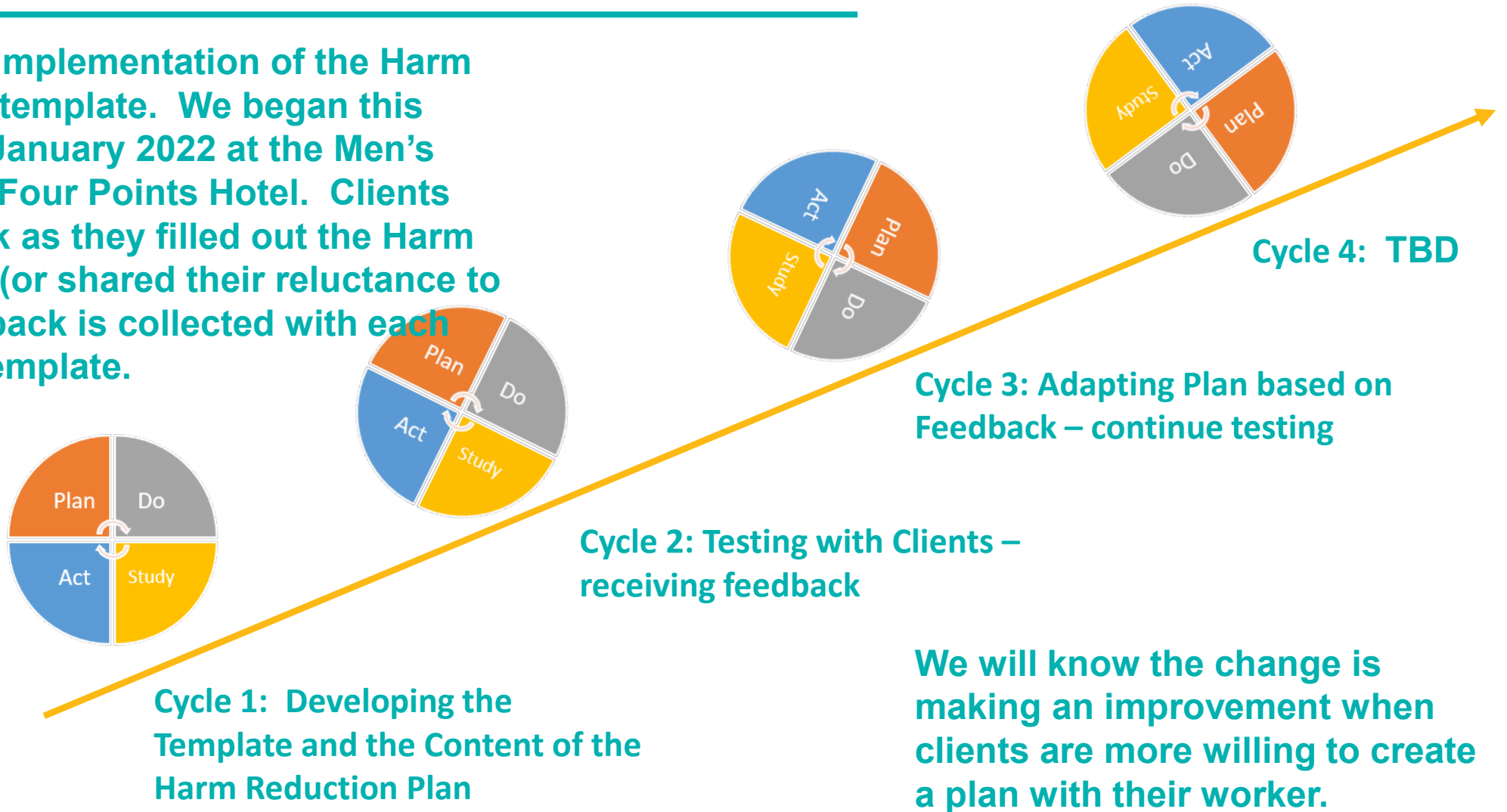
List The Change Ideas	Impact	Effort
develop harm reduction plan template	High	Moderate
resources (bring in or go to) to help access other services	Moderate	Moderate
develop process to identify and become aware of signs and dangerous use patterns (written, verbal and follow-up resources)	High	Low
provide training and assistance to staff and clients on how to use harm reduction supplies	High	Moderate
	Select	Select
Consistent harm reduction training at on-boarding	High	High
training for current staff	High	High
	Select	Select
invite neighbours to harm reduction training / overdose support	Moderate	Moderate



Read Me Data Visual +

PDSA Planning (one change idea)

We studied the implementation of the Harm Reduction Plan template. We began this change idea in January 2022 at the Men's Shelter and the Four Points Hotel. Clients shared feedback as they filled out the Harm Reduction Plan (or shared their reluctance to sign-off). Feedback is collected with each version of the template.



Lessons Learned / Ah-ha Moments

- *The project has reached more people than anticipated and has had a positive effect on both staff and clients; we thought this project would be a “tough sell” to clients but this has not been the case*
- *This project can be spread throughout the organization as the Harm Reduction Team grows*
- *Learning about QI and the impact of data analysis has prompted Mission Services to spread QI circles throughout the organization and develop an organizational QI Plan*



Providence Care Seniors Mental Health Behavioural Support Services

Improving Care Partner Engagement in Care Plans

Project Status as of: June 23, 2022

THE EXCELLENCE THROUGH QUALITY IMPROVEMENT PROJECT (E-QIP)
COHORT 6 REPORT BACK

PRESENTATION DATE: June, 2022



Project Story:

Seniors Mental Health Behavioural Support Services has gathered OPOC data since 2017. We have continuously monitored OPOC data, making various improvements to this process to improve data quality.

In early 2021 we were ready to use OPOC data as an outcome measure for quality improvement projects, so we applied for and were successful in joining the EQIP Cohort 6 to formulate our thoughts on a problem and to use OPOC data as an outcome measure.

Along the way, we realized OPOC had changed over time too. There are now two possible surveys that we can send to our clients and/or their care partners. We need to change how we send OPOC surveys before we can use the data to evaluate a change idea.



Problem/Opportunity Statement

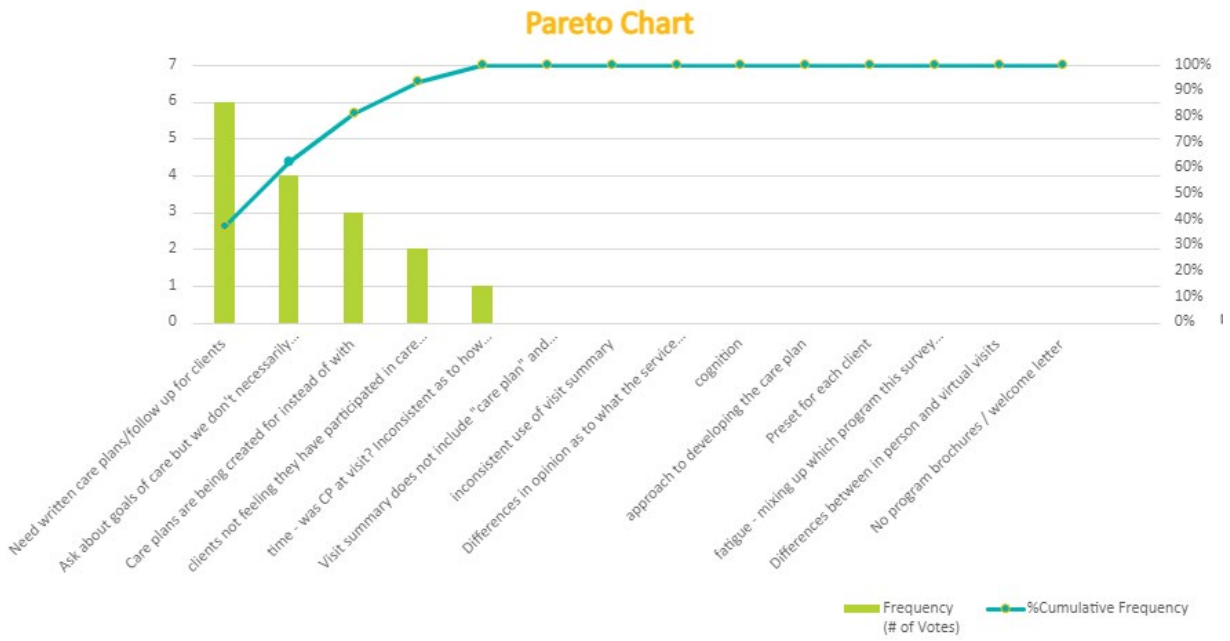
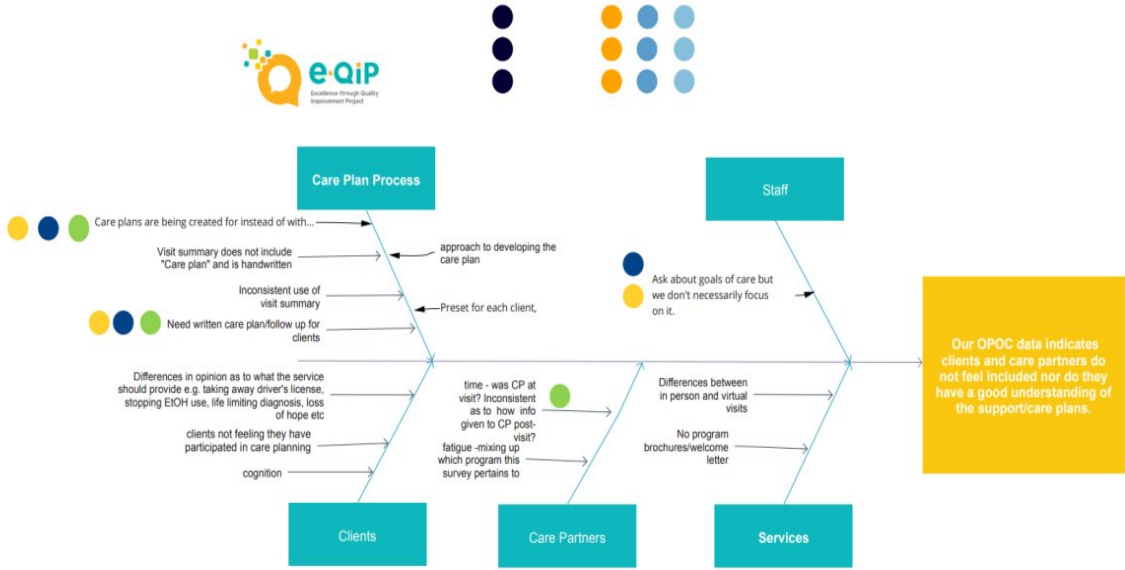
- Our OPOC data indicate clients and care partners do not feel included nor do they have a good understanding of the support/care plan.

AIM Statement

- By March 31, 2023, the response to OPOC caregiver survey question 12 will be agree or strongly agree 75% of the time.




Diagnostic Tools – The Vital Few.



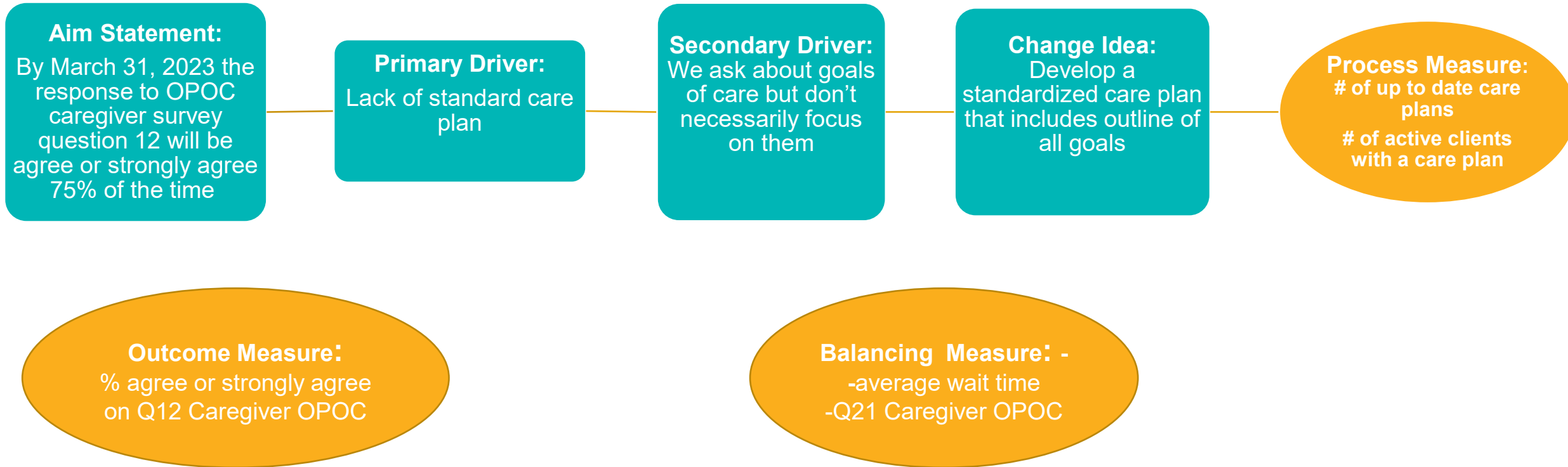
Change Ideas

We are currently testing the idea of distributing the right survey to the right person at the right time. This includes re-establishing staff awareness of the survey, thinking about the variety of ways we can communicate with clients about the survey, and sharing OPOC results every 6 months with staff to keep it top of mind.

We will know a change is making an improvement by monitoring the number of surveys sent out/returned, and staff feedback on the new process.

 TRIZ Exercise	
Problem Statement or Root Cause: Our OPOC data indicates clients and care partners do not feel included nor do they have a good understanding of the support/care plans.	
How could you and your team make the problem worse?	Reversed Ideas (Positive)
Don't ask people about their goals	ask people about their goals ask people repeatedly about their goals discussion about their goals (inclusive conversation) people = client and caregiver reason for referral - primary care provider goals every week of goals → identified approach to asking about goals → follow-up to goals → re-evaluation (review and update) goals embracing person-centered care philosophy goals (all) outlined on care plan alignment of goals
No writing a care plan	develop a standardized care plan education around the plan (how to write, implement and share it) develop a plan for reviewing and with whom establish an integrated team approach to writing the plan (with not for approach) care plan versus summary → summary still important but not addressing the needs of care partners and professional support staff to care for the client → care plan language needs to be simple and easy to understand → provide client / caregiver with a copy of the plan
Don't include clients and / or care partners in developing the plan	establish an integrated team approach to writing the plan care plan language needs to be person-centered with plain language we don't want people to be surprised by what's in the plan (no surprises) → dedicating time to include the client and care partner(s) → getting view to prioritising writing the plan and including the client and care partners → need to include the clients and / or care partners in developing the plan
No follow up with the care plan	including / scheduling routine review of goals (review, reset, etc) use process (standardized) standard check points that follow up it being done →
No distributing OPOC surveys (caregiver or registered)	sending the right survey to the right person at the right time (survey version awareness) introduce / reintroduce OPOC to staff how to communicate the survey to client re-establish awareness and importance of using the OPOC → trickle down OPOC results to staff more frequently → ongoing one and post campaign information → news, changes and feedback - broader efforts of communication of OPOC → collect anecdotal / qualitative feedback from staff (pre & post project) (short staff survey)
No case managers service provided (worst case scenario)	everyone receives case management service →

Driver Diagram (mini)



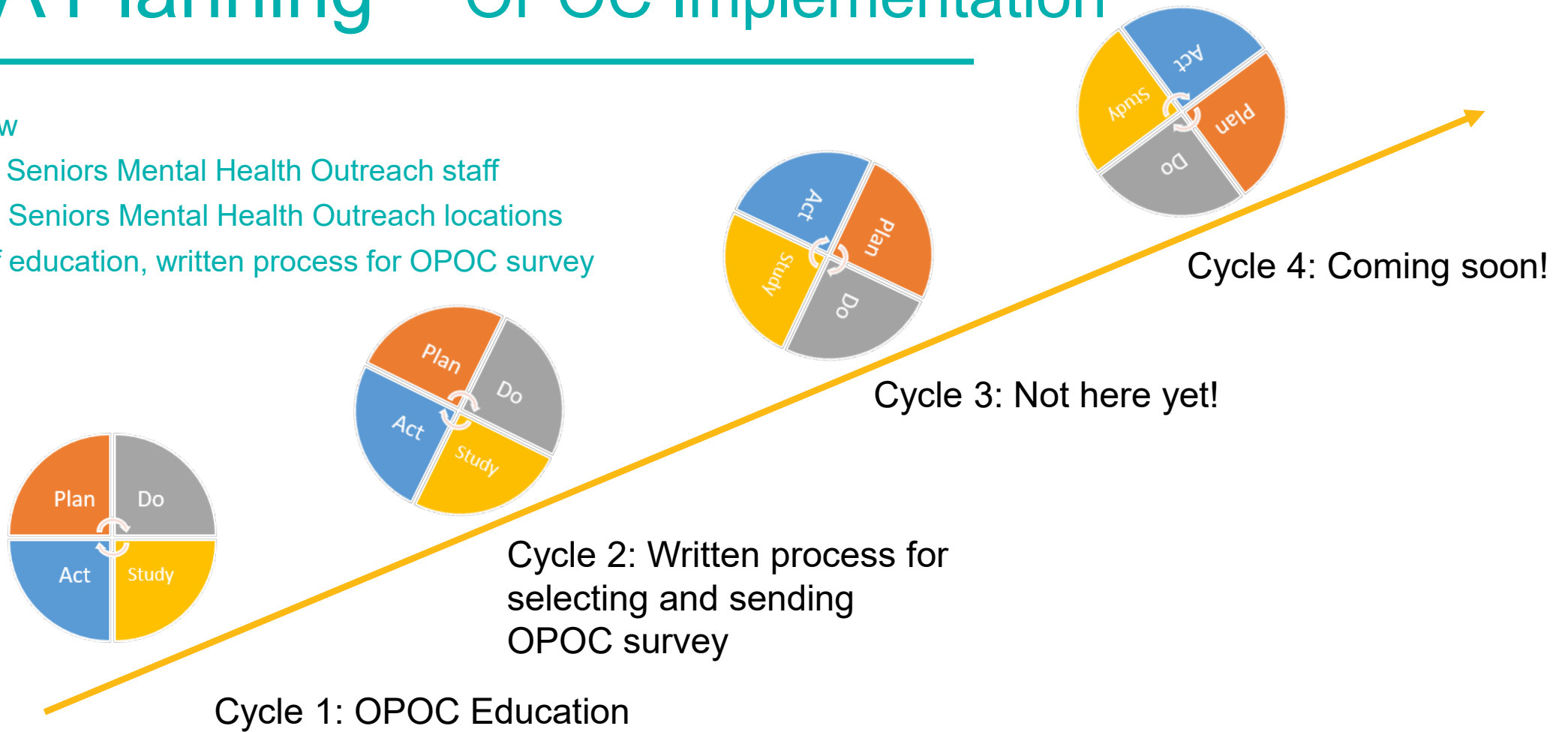
PDSA Planning – OPOC Implementation

When: Now

Whom: All Seniors Mental Health Outreach staff

Where: All Seniors Mental Health Outreach locations

How: Staff education, written process for OPOC survey selection



Lessons Learned / Ah-ha Moments

Our “Ah-Ha!” Moment:

The realization that a new version of the OPOC had been released since we began using the OPOC, and this version was potentially valuable to many of our clients.

What Our Data Told Us:

We thought we were providing adequate information to clients and care partners about their plan of care; however, our OPOC data revealed we were not.

Impact on Our Organization:

Our organization recently developed corporate indicators in relation to engaging the people we serve in our annual plan. This project sets us up for success in terms of attaining our own goals, as well as those of our organization.

Organization: Radius Child and Youth Services

Project Title: Demystifying the Complaints Process

Project Status as of: June 21, 2022



Radius Child & Youth Services
PREVENTION • INTERVENTION • RESEARCH

THE EXCELLENCE THROUGH QUALITY IMPROVEMENT PROJECT (E-QIP)
COHORT 6 REPORT BACK

PRESENTATION DATE: June, 2022



Project Story:

In August 2021, data from Radius' Client Experience Survey showed that only 44% of clients know how to make a complaint. This low endorsement is concerning, as Radius prides itself on being child/youth and family centered. If clients don't know how to make a complaint, we may miss valuable information on ways we can better attend to the needs of those we serve. This project sought to improve clients' awareness of Radius' complaints procedure by reducing barriers in clients' access to this information through the development of a client-facing instructional document. By April 1, 2023, we aim to increase the proportion of clients and caregivers who report being informed how to make a complaint at Radius to 70%.



Problem/Opportunity Statement

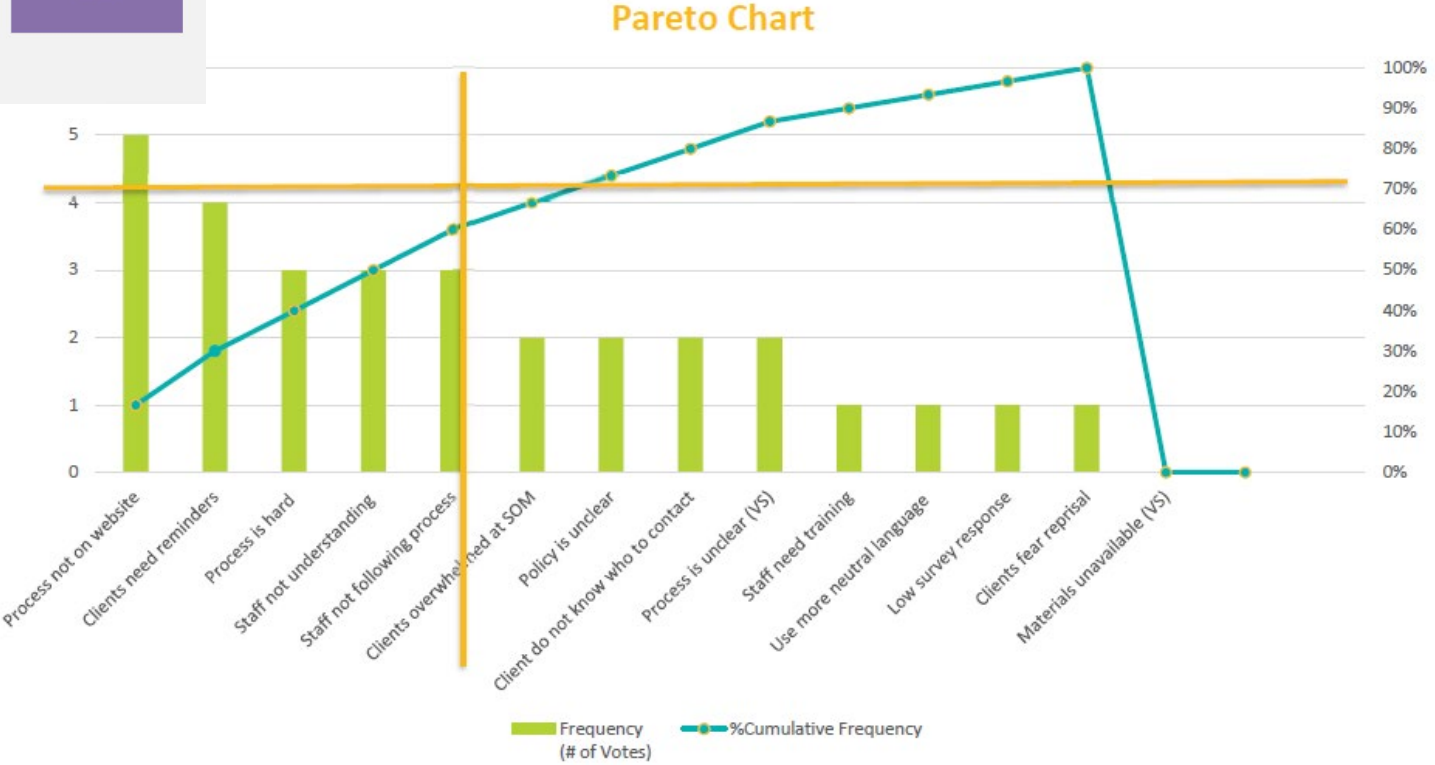
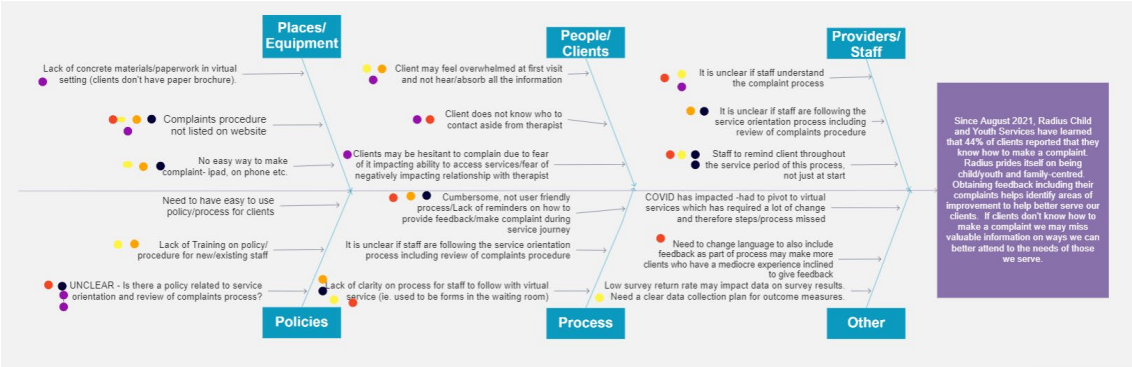
- Only 44% of Radius' clients reported knowing how to make a complaint. If clients don't know how to make a complaint, we may miss valuable information on ways we can better attend to the needs of those we serve.

AIM Statement

- In August 2021, we learned that only 44% of clients reported that they know how to make a complaint. By April 1, 2023, we aim to increase the proportion of clients and caregivers who report being informed how to make a complaint at Radius to 70%. This proportion will be measured as the number of survey respondents who respond "Agree" to the statement "Radius Staff explained how to make a complaint at Radius" (numerator) divided by the total number of respondents who complete Radius' Client Experience Survey (denominator).



Diagnostic Tools – The Vital Few.



Change Ideas

1. Reduce Barriers for Clients

- Develop Client-facing Document that Summarizes Complaint Process
 - Shared at case assignment (welcome package)
 - Reviewed at initial service orientation meeting
 - Number of clients who receive this document

TRIZ EXERCISE

STEP 1: Start by writing down either your Problem Statement or a Root Cause identified through the diagnostic phase of your project in the box at the top of your worksheet

STEP 2: Ask yourself, "how could we make this problem worse?" and write down your ideas in the left side column of the TRIZ Exercise Worksheet

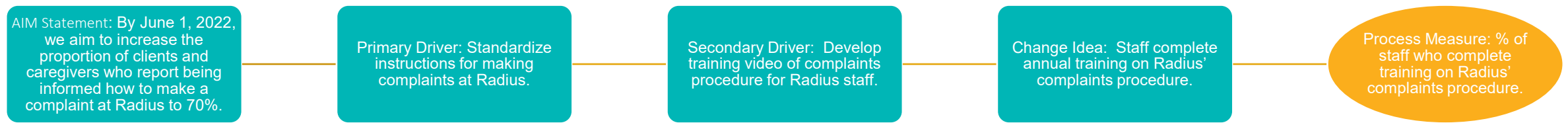
STEP 3: Reverse your ideas from Step 2 into the positive to create either a list of Change Concepts or Change Ideas you can use to address your problem. Record these Change Concepts or Change Ideas in the right-side column of the TRIZ Exercise Worksheet.

PROBLEM STATEMENT OR ROOT CAUSE	HOW COULD YOU AND YOUR TEAM MAKE THE PROBLEM WORSE?	REVERSED IDEAS (POSITIVE)
Roughly half of our clients have reported that they DO NOT KNOW or are unsure about how to make a complaint at Radius. How might we make this issue WORSE?	Do not provide the "Have Your Say" brochure at the Service Orientation Meeting (SOM).	Provide the "Have Your Say" brochure at the SOM.
	Never explain the procedure. Do not tell them about the complaint process.	Explain / remind clients of the procedure (or where to find documentation) at multiple points in service.
	Make the complaint procedure extra complicated.	Simplify the procedure (e.g., "Give them a button!"), with clear instructions, few steps, and pictures.
	Do not provide staff with a process for how/when to give this info to clients.	Provide training and clear instructions to clinicians. Ensure all staff provide the same information to clients. Provide updates on necessary changes/modifications.
	Overwhelm clients with information at SOM!	Have Intake team review rights and responsibilities with clients, including complaints procedure, BEFORE the SOM. Review again at Assessment feedback session.

2. Increase Procedural Clarity for Staff

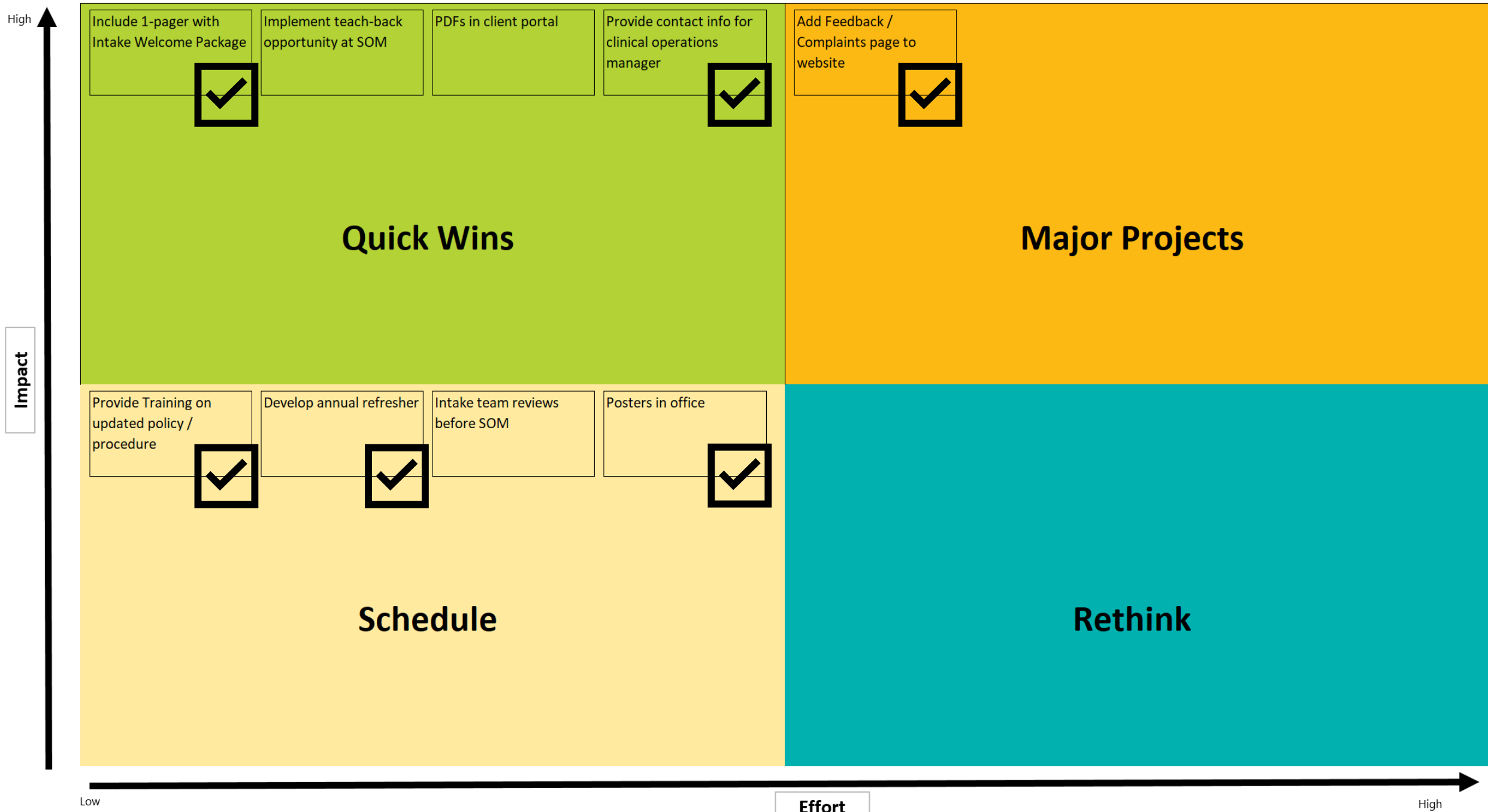
- Provide Standardized Training re: Complaints
 - Develop brief training video
 - Staff complete training at orientation (and annually)
 - Responses to pre/post training survey

Driver Diagram

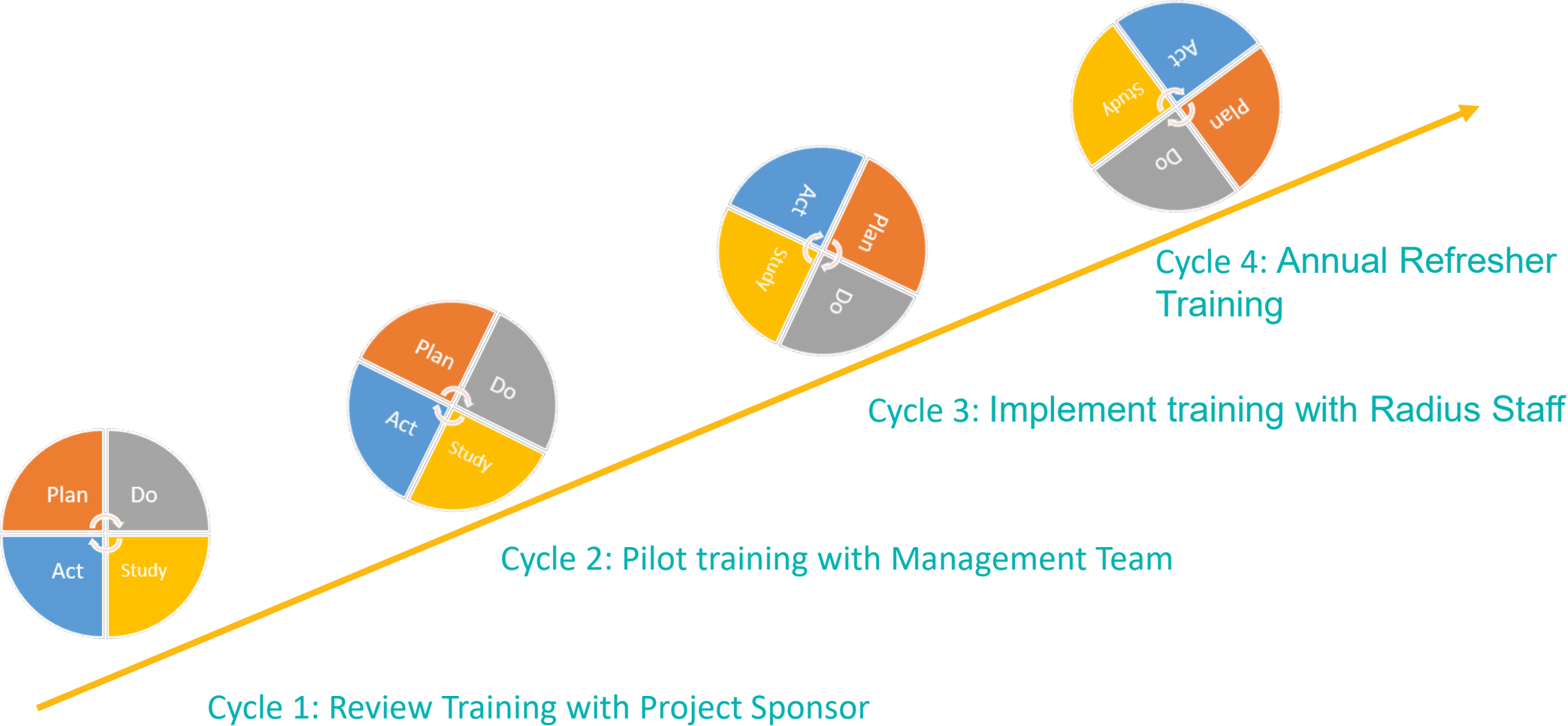


Outcome Measure: ## of survey respondents who agree that staff explained how to make a complaint (numerator) / ## completed surveys (denominator).

Balancing Measure: Staff Workload (Indirect hours).

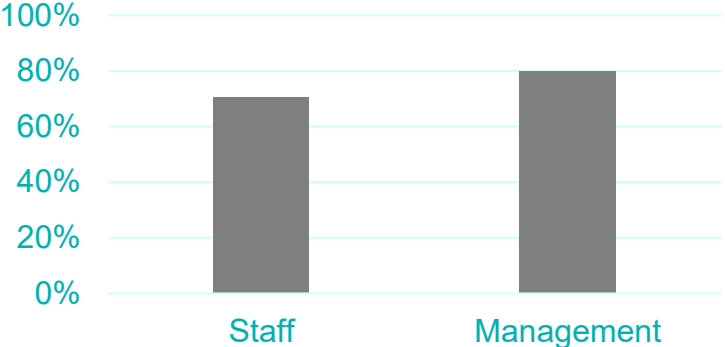


PDSA Planning: Provide Training to Staff

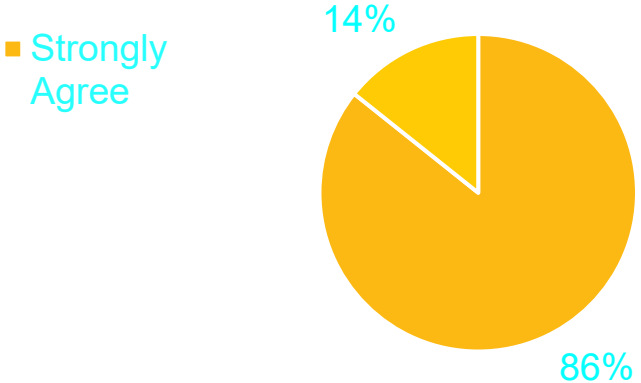


PDSA Cycle 3: Implement Training with Staff

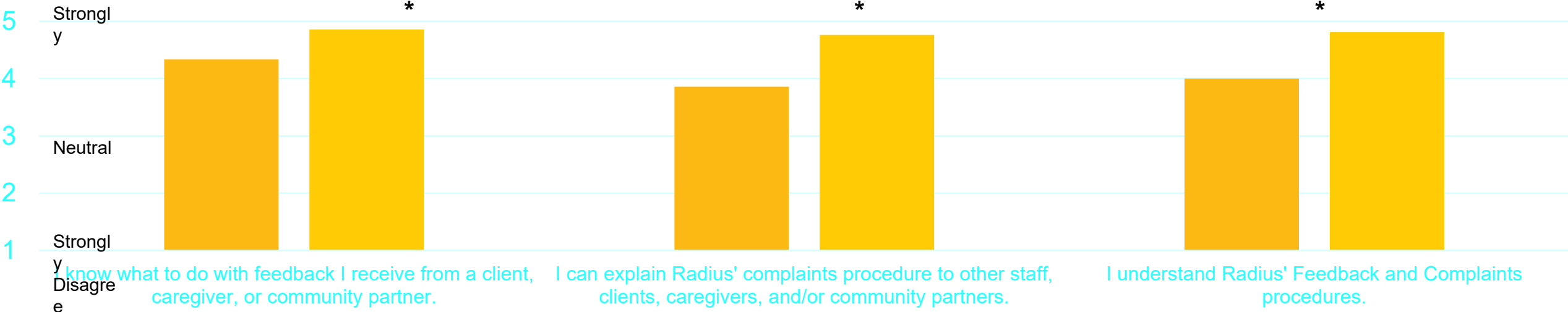
Training Completion



The training video helped me better understand Radius' Feedback and Complaints procedures.



Time 1 Time 2



Lessons Learned / Ah-ha Moments

- *The most valuable learning moment from this project was the incredible value of “low hanging fruit.” By focusing on a couple quick wins from our Impact-Effort grid, we were able to gain considerable momentum for the project and buy-in from the team, making larger change ideas more manageable.*
- *Sustainability will be achieved once the newly developed feedback/complaints document is regularly distributed to incoming clients by our Intake team. Once 100% of incoming clients have this document, we expect that a higher proportion of clients will report knowing how to make a complaint.*

Final Evaluation Survey



Questions and Curiosities



What is summertime all about?

- Continue to monitor your Change Ideas (collect the data now)
- Consider your threshold for Sustainability. When will you know you've reached sustained improvement?
- What will you continue to monitor past August 31st? Is this a multi-year project?
- Who else might benefit from hearing about your project?



A person in a dark jacket and pants stands on a rocky mountain peak, looking out over a vast mountain range at sunrise. The sun is low on the horizon, creating a bright glow and lens flare effects. The sky is a mix of blue and orange.

Take your QI activities one step further...

-
- Is this QI project part of your Quality Improvement Plan? If not, is there an opportunity to add it?
 - Consider joining E-QIP's Community of Practice.
 - Do you have new board members or new senior leaders? Consider Governance and Leadership training
 - Do you have others in your organization who have an interest in learning more about QI? Consider signing up for Foundations to QI (IDEAS) e-Course



e-QiP

Excellence through Quality
Improvement Project

Community-focused. Data-driven.

[CLICK
HERE TO
APPLY!](#)

COHORT 7

QI project coaching
APPLY NOW!

Applications Due June 17th!



THERE ARE MANY WAYS TO ENGAGE WITH E-QIP!

CONNECT AND IMPROVE

LEARN

- QI cycle and data literacy webinar series
- IDEAS - QI Foundations course (e-learning course)
- Agency specific governance and leadership training (customized based on need)

BE INFORMED

- E-QIP newsletter
- @EQIP_ON on Twitter
- E-QIP website

- Coaching consultations on quality improvement activities
- E-QIP Cohorts for QI and data coaching (6 to 7 months dedicated coaching for projects)
- Community of Practice (bi-weekly, 1-hour meetings)

-  e-qip.ca
-  @EQIP_ON
-  quality@e-qip.ca



Follow us @ EQIP_ON



E-Mail: quality@e-qip.ca



www.e-qip.ca

Foundations to QI(IDEAS) e-Course - REGISTER HERE!

