What does “quality” mean for Mainstay Housing?

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INTRODUCTION

The purpose of this paper is to foster a discussion at the Mainstay Board - with senior management – about how to understand “quality” at Mainstay. What does it mean to ensure or improve quality in a housing and support agency? In particular what does it mean at Mainstay, where the agency both owns the housing and also provides key support informed by harm reduction and recovery principles and community development? This is Mainstay’s primary reality, although the organization is also now beginning to administer rent supplements to people to live in housing not owned by Mainstay.

Quality improvement (QI) has become a priority for health and human services in recent years. The primary goal is to improve outcomes for people receiving services. A secondary goal has been to use resources more efficiently and effectively.

Mainstay’s 2012-2015 strategic plan includes a strategic direction to focus on quality. To operationalize this strategic direction, the board and senior management need to come to agreement on what quality means for Mainstay, decide what aspects of quality to focus on, and agree on the roles and responsibilities of the board and of senior management in addressing quality. To help with this discussion, this paper will describe what is reflected in the research and policy literature in the health care and supportive housing sectors about what quality means, the experience of others in how best to improve quality at an organizational level, and what has worked well in terms of the roles of the board and senior management. Throughout, the paper will offer some reflections on where Mainstay fits within the current housing and health care environment’s focus on quality.

THE ENVIRONMENT

Mainstay receives a roughly 2/3 of its total revenue from the Ministry of Health and Long-Term Care. Recently, the provincial government passed the Excellent Care for All Act that requires hospitals and other health care organizations to develop and implement quality improvement plans yearly. At this point, only hospitals are required to do so but the Act leaves open the possibility that in future other health care organizations will be included. The Act also requires Local Health Integration Networks (LHINs) to develop system level quality improvement plans. To do so, the LHINs will need to ask the health service organizations that make up the health system to support the LHIN plan with plans of their own. Given this context, it is timely that Mainstay begins to focus on quality in a systematic fashion.
Around the world, people are recognizing the importance of transforming the way mental health systems and services operate to make recovery the central focus. The language of recovery has begun to appear in quality improvement/accreditation documents for mental health services, although a recovery orientation is not yet central to most. While the best outcomes for people with mental illness are valued, there is a concern that services are implementing small changes but not making the transformation needed to really put recovery at the centre. A parallel in the physical health care is the growing importance of patient safety. Hospitals have always cared about patient safety, but their systems were not organized around the safest possible care; they were organized based on other priorities. Patient safety has become a priority in recent years and is now the central focus of quality frameworks and quality improvement plans for hospitals. Perhaps, like patient safety, a recovery orientation will become a central focus of quality frameworks and quality improvement plans for mental health services in future. Mainstay’s Outcome and Performance Measurement chart (see Appendix A), its approach and complexity models (see Appendix B) have a recovery orientation. This paper will present several recovery frameworks, how they reflect what Mainstay does, and ideas and questions they raise for Mainstay’s definition of quality.

DEFINING QUALITY

Defining Quality in Health Care

HEALTH QUALITY ONTARIO
Health Quality Ontario (HQO) defines quality as “doing the right thing, at the right time, in the right way, for the right person – and having the best possible results.”¹ HQO has identified nine attributes of a high quality health care system: accessible, effective, efficient, equitable, integrated, patient-centered, population health focused, safe and appropriately resourced. The provincial government has selected five of these (safety, effectiveness, accessibility, patient-centered, integrated) and requires hospitals to develop an annual quality improvement plan, with goals for improvement in each of these domains.

LHINs
The Local Health Integration Networks (LHIN) Collaborative’s LHIN Indicator Framework Guide, begins with three areas of focus: patient experience, organizational health, and system perspective. It then sets eight of HQO’s attributes of a quality health care system within each, and it adds its own dimensions.

What does “quality” mean for Mainstay Housing?

- Patient experience – accessible, safe, effective, patient-centered
- Organizational health – efficient, appropriately resourced, employee experience, governance
- System perspective – integration, e-health, community engagement

Equity is a crosscutting dimension that is to be addressed across all three.

Toronto Central LHIN’s (TCLHIN) desired outcomes for quality improvement as of January 2011 were:

- To improve access to care by reducing avoidable time in hospital
- To improve the patient experience of care by improving wait times and transfer between providers
- To improve care for patients with complex needs.

LHIN level indicators for these outcomes are ones for which data all health service providers, can collect easily, so that a picture of what is happening across the LHIN can be created. For this reason the indicators developed at the LHIN level are quite limited. They address inpatient readmissions, repeat emergency department visits, response time for referrals, wait times for services, discharge and patient satisfaction. Not many of these are relevant to supportive housing. Response times and wait times are relevant for CASH (the Toronto Mental Health and Addictions Supportive Housing Networks Coordinated Access to Supportive Housing). Client or tenant satisfaction is relevant for Mainstay, but clearly in order to measure and improve quality in supportive housing, Mainstay has to develop others.

There are mental health service representatives on TCLHIN’s Quality committee. It seems then that the LHIN is interested in assessing quality in community-based services. Perhaps in future it will propose other indicators related to reducing avoidable time in hospital by people with mental illness, measures related to wait times for services and improved care for people with mental illness who have complex needs. Mainstay might want to look at its partnerships to see what can be measured in terms of the quality of care for tenants with complex needs, wait times for services needed by tenants and unnecessary hospitalization. These indicators will primarily be controlled by partner agencies but in looking at specific partnership processes, Mainstay may be able to identify potential quality improvement changes to try out.

ACCREDITATION PROGRAMS
Closely linked to the growing pressure to focus on quality, is the trend for health and social services agencies to undergo accreditation. Accreditation is a voluntary process that evaluates whether an organization meets a set of agreed-upon quality standards in the way
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it functions. The Canadian Mental Health Association Ontario and the Ontario Federation of Community Mental Health and Addictions Programs have created a toolkit of resources for community-based mental health and addiction services that is available on-line at www.ontario.cmha.ca. (See “Accreditation Capacity Building Toolkit.”) For a discussion of the various accreditation programs and their quality standards, see Appendix C.

Supportive Housing Quality Frameworks

A 2005 review of the literature on values and standards for supportive housing identified the following attributes of quality:

• Appropriateness and choice
  o Selects own housing; has information about options for housing and support; support for informed decisions; individual needs respected

• Access to resources
  o A range of housing and program models is available; clear access point for housing and support services; reasonable inclusion and exclusion criteria; fair and transparent intake process; person is involved in intake process

• Self-determination and voice
  o Right to make decisions; a range of flexible, responsive support providers to help to maintain housing, achieve goals and respond to crises; staff-tenant mutual trust and respect; tenants involved in developing/monitoring policies

• Accountability (All stakeholders are accountable to each other.)
  o Support to meet obligations as tenants; service plans developed collaboratively and followed; high quality services; agreements on sharing personal information; complaints process; regular evaluation of organization and publication/implementation of recommendations; best practice information routinely created/implemented

• Affordability
  o Rent should not exceed 1/3 of income; support to get income benefits

• Housing rights and legal security of tenure
  o Permanent housing; follows Tenant Protection Act; leases outline tenant rights and responsibilities; legal remedies available to address violation of housing rights/security of tenure.

• Quality
  o Physical – privacy, comforts, safety, cleanliness, density; social aspects – crowding, stress; location – safe, supportive neighbourhoods with access to shopping, public transit
What does “quality” mean for Mainstay Housing?

- Social support and integration
  - Housing resembles neighbourhood standards; treatment services are provided outside the home unless tenants choose otherwise; social activities and visitors in buildings; support to develop community relationships

The Corporation for Supportive Housing (CSH) in the United States has created the only existing quality framework for supportive housing providers that could be found in the literature. (See Appendix D.) Here are the domains and the standard for each domain:

1. Administration, management and coordination
   - All involved organizations follow standard and required administrative and management practices and coordinate their activities in order to ensure the best outcomes for tenants.

2. Physical environment
   - The design, construction, appearance, physical integrity, and maintenance of the housing units provide an environment that is attractive, sustainable, functional, appropriate for the surrounding community, and conducive to tenants’ stability.

3. Access to housing and services
   - Unnecessary criteria, rules, services requirements, or other barriers do not restrict initial and continued access to the housing opportunities and supportive services.

4. Supportive services design and delivery
   - The design and delivery of supportive services facilitate access to a comprehensive array of services, are tenant-focused, effectively address tenants’ needs, and foster tenants’ housing stability and independence.

5. Property management and asset management
   - Property management activities support the mission and goals of the housing and foster tenants’ housing stability and independence, and appropriate asset management strategies sustain the physical and financial viability of the housing asset.

6. Tenant rights, input and leadership
   - Tenant rights are protected within consistently enforced policies and procedures, tenants are provided with meaningful input and leadership opportunities, and staff-tenant relationships are characterized by respect and trust.

7. Data, documentation and evaluation
   - All involved organizations reliably capture accurate and meaningful data regarding the effectiveness, efficiency, and outcomes of their activities, and
use this data to facilitate, and improve, the performance of those activities on an ongoing basis.

Defining Quality at Mainstay

Mainstay’s strategic focus on quality provides an opportunity for the organization to explore what it thinks are the most important characteristics of a high quality supportive housing organization. It is important not to narrow it down to only what Mainstay can provide but to look at what it and its partners can provide, even though Mainstay cannot control aspects of quality that depend on its partners. It can, however, influence them. Mainstay’s housing first approach can in fact help partners to be more effective. The focus on keeping tenants housed whatever crises or challenges they are going through, means that Mainstay works with tenants to reach out to agencies when they need help to address issues that can undermine housing stability.

In its analysis of 2011 hospital quality improvement plans, HQO suggests that hospitals not be afraid to set targets over which they do not have full control, because other organizations influence the outcome. (For example, hospitals can’t reach their targets for discharging people who don’t need to be in hospital if nursing home beds are not available or home care can’t provide care at home.) Like financial variances, Mainstay can explain variances and develop mitigation strategies to deal with a failure to meet a target that has not been reached due to partners.

HQO recommends that Boards ensure that the quality of services is embedded in the mission, vision and values and the strategic plan. However, Mainstay’s promise to tenants and Outcome and Performance Measures Chart are clearly focused on quality so the discussion will begin there.

Mainstay promises its tenants that they will become successful tenants not only within Mainstay but anywhere else; that they will have access to community and a sense of belonging that makes sense for them; that their own goals for a better life will be supported; and that they will be supported to make a contribution to their community, however they define it. They will also know how to stay safe and be healthy. In Mainstay’s performance framework these elements of success are summarized as two outcomes: successful tenancy and community/belonging. These could be the two domains of quality:

- Building tenant capacity to say housed (possibly measured by housing stability)
- Creating a sense of belonging/community.
Creating a sense of belonging/community could be broken down as follows:

- Involves tenants in the organization and the community and supports tenants to build/maintain a social network of their choice within and beyond Mainstay
- Supports self-determination (choice, voice, decision-making power, setting own goals and realizing them)
- Promotes tenant health and safety

These characteristics can be put in terms of statements or standards (an agreed-up way of doing something):

**Building tenant capacity to stay housed**
- Tenants are supported to meet their obligations as tenants, maintain their housing (cleanliness, bugs, hoarding), and maintain good relationships with other tenants.

**Tenant safety**
- Staff interact with tenants in a way in which supports tenants to feel safe, including avoiding practices people may experience as traumatic.
- Tenants are supported to learn how to create a safe environment and how to take care of themselves if they feel threatened.

**Supporting self-determination**
- Tenants have the right to make decisions about and have control over their housing and support services.
- Staff are supported to work well with informed risk-taking as part of promoting people’s choice and self-determination
- Tenants can work with a range of coordinated, flexible, responsive support providers to help them maintain housing, achieve goals and respond to crises.
- Mainstay and support agency staff strive to develop and maintain relationships with tenants that emphasize mutual trust and respect
- Tenants can play active roles in developing and monitoring policies.

**Involving tenants in the community**
- Support is provided for tenants to develop community relationships and participate in the supportive housing community and other communities of their choice.

Definitions of quality should be aligned with the organization’s strategic goals and objectives. The strategic plan suggests other characteristics of quality for supportive housing:

- Embraces innovation and best practice in program design and delivery
- Documents and shares emerging practice to encourage system change
What does “quality” mean for Mainstay Housing?

- Values tenant\(^2\), staff and board voice, involvement and leadership in the organization
- Develops, maintains and strengthens partnerships to provide integrated services to tenants
- Collects meaningful data on effectiveness of its programs and services and uses it to improve performance
- Manages assets to sustain their financial and physical viability

Other features of quality are the housing itself and access to it,
- Provides good quality housing (physical buildings, neighbourhood, location, social conditions – not all shared rooms, no crowding, etc.)
- Provides equitable access to supportive housing

Tenant success may be affected by some factors beyond tenant control such as the ease with which various systems can be navigated, continuity of supports across systems, and attitudes (discrimination), practices (putting people with mental illness in prison) and social conditions (a lack of affordable housing). Mainstay alludes to the question of a just society in its promise to tenants and some of these factors are recognized in Mainstay’s Complexity Model. Mainstay’s leadership in the Homecoming Community Choice Coalition, its contributions to integrated and collaborative housing and mental health systems (leadership on TC LHIN committees, in the Ontario non profit housing association, the Ontario Federation of Community Mental Health and Addiction Programs, CHRA, Connex Ontario, City of Toronto homelessness committees, etc.) address system and social issues.

The characteristics of quality might include:
- Takes initiative to improve communication, collaboration, integration and advocacy across the housing and mental health systems.
- Takes action to address the social conditions and policies that promote recovery

These are the quality characteristics that are evident from a review of Mainstay’s literature and discussion with the Executive Director. The next section explores other quality-related frameworks to identify other potential characteristics of quality.

\(^2\) This differs from involving tenants in the organization. One is from the perspective of what Mainstay is doing for tenants. The other is from the perspective of what tenants do for Mainstay. It is a recognition of reciprocity, that when tenants are involved it not only benefits them, but it makes Mainstay a better organization.
RECOVERY AND QUALITY

SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States has a comprehensive set of principles for recovery. Here are the principles and excerpts from SAMHSA’s description of each one with reflections on how each might fit for Mainstay’s definition of quality:

Recovery emerges from hope:
Hope is the catalyst of the recovery process. Hope is internalized and can be fostered by peers, families, providers, allies, and others.

Mainstay’s approach to clients is one that fosters hope. In the Framework for Recovery-Oriented Practice from Victoria, Australia, this is framed as follows
- Fosters a culture of high expectations of recovery and hope

Victoria’s framework suggests that putting it into practice includes
- Provide avenues for people to share stories of recovery
- Celebrate rights of passage and achievements
- Recognize when a person has developed effective coping strategies for stressful situations
- Support tenants to become advocates or peer support workers, where appropriate
- Share promising practice and evidence of effectiveness on recovery-related outcomes
- Ensure support plans involve routine conversations about people’s aspirations and hopes.

This seems to be in alignment with the direction Mainstay is going in its approach.

Recovery is person-driven:
People define their own life goals and design their unique path(s) towards those goals; have choice over the services and supports; get what they need to make informed decisions; build on their strengths; and gain or regain control over their lives.

Mainstay incorporates this principle and it has been identified as a characteristic of quality earlier in the paper.
Recovery occurs via many pathways:

*It is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Creating a supportive environment can also enable recovery pathways.*

At Mainstay, individualized support allows for a variety of pathways to recovery. Mainstay’s eviction prevention strategy recognizes there will be setbacks and that problems are opportunities to engage the tenant in problem-solving, capacity and confidence building and taking pride in being responsible for finding the solution the individual desires. Mainstay may wish to draw attention to these ways of working in its explanation of how it supports people’s self-determination and realizing of their goals. Creating a supportive environment is a clear priority for Mainstay and is included in the characteristics of quality already identified.

*Recovery is holistic:*

*Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.*

Mainstay and its partners address all aspects of the person’s life. This may be something that could be identified as a quality characteristic.

- Services and supports to address the whole person are made available, including mind, body, spirit, and community.

*Recovery is supported by peers and allies:*

*Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self.*

Mainstay may have peer support programs, encourage people to become peer supporters, and/or encourage informal peer support through its community development programs. Mainstay could aspire to have paid peer support workers. Given the growing recognition of the role of peers in recovery, this could be recognized as a characteristic of quality.
Facilitate and support peer support processes and ensure peer support workers have adequate resources.

*Recovery is supported through relationship and social networks:*

An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

A primary focus for Mainstay is the importance of community to recovery. This is included in the characteristics already identified. An interesting aspect of this principle is the particular value of relationships with people who believe that the individual can and will recover. There may be a role Mainstay does or could play in educating and supporting family, friends and others around the person about recovery.

*Recovery is culturally-based and influenced:*

Culture and cultural background in all of its diverse representations including values, traditions, and beliefs are keys in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual’s unique needs.

Cultural safety and cultural competence were not addressed above. Mainstay may wish to include something about this in its quality framework,

- Is culturally competent and creates cultural safety

*Recovery is supported by addressing trauma:*

The experience of is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Mainstay recognizes trauma as one of the factors in the complexity of the lives of people who are chronically homeless. The role of trauma in mental illness is a growing area of interest in the mental health field. Is this an important aspect of quality for Mainstay? It could be framed as a staff competency.
Recovery is based on respect:
Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one’s self are particularly important.

This principle has been incorporated into characteristics suggested earlier in the paper.

Recovery involves individual, family, and community strengths and responsibility:
Individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Mainstay recognizes that tenants have both rights and responsibilities and supports tenants to fulfill their responsibilities as tenants. Is there a role for Mainstay in speaking out on or supporting individuals, families and communities to take on the other responsibilities described here and is this a particular characteristic of quality?

Canada’s Mental Health Strategy

Changing Directions, Changing Lives: The Mental Health Strategy for Canada suggests priorities for action that support recovery, particularly in strategic direction 2. Translating the ones relevant to supportive housing, some quality characteristics could be:

- Trains staff in recovery-oriented approaches
- Offers tenants the opportunity to provide advance directives indicating what the individual would like to be done if they are deemed incapable of making decisions
- Communicates with, supports and involves tenants’ families, where tenants agree
- Employs people with mental illness within the organization

The Scottish Recovery Indicators (SRI 2)

Scotland has a set of ten indicators of recovery-oriented services (see Appendix E):
What does “quality” mean for Mainstay Housing?

- Basic needs are identified and addressed
- Goals are identified and addressed
- Personalized services are provided
- Service is strengths based
- Service promotes and acts on service user involvement
- Informal careers (family and friends) are involved
- Service encourages advance planning and self-management
- Staff are supported and valued

The list is missing many elements already described in Mainstay's practice and in other frameworks. However, the indicators that are here have been worked with extensively. They have been evaluated and revised (hence, the name SRI 2). An on-line self-assessment process is available for Scottish organizations to use that includes data collection tools and guidance on gathering the evidence needed. ³

Victoria’s Recovery Framework

The Framework for Recovery-Oriented Practice from Victoria, Australia, identifies nine domains of recovery; core principles for each domain; core capabilities for providers for each domain; and good practices for both staff and leaders. This paper will not lay out the domains and principles because they are similar to the SAMHSA principles. What might be useful to Mainstay, however, are the leadership practices in each domain. These are promising organizational practices in recovery-oriented high quality services. The ideas are very concrete and practical, and many reflect practices Mainstay is or may be already engaged in. There might be some new ideas.

It may also be of interest that simple Mainstay processes intended to benefit clients are broken down to point out how they do or can maximize a recovery orientation. For example, having a complaints process for tenants is broken down as follows:

- Make it easy to provide feedback and make complaints (for example, provide open access for families and clients make complaints in multiple forms).
- Include consumer and carer (family) members in the feedback and complaints process (such as on panels or review teams).
- View feedback and complaints as opportunities for service improvement and set up systems to ensure that feedback and complaints are translated into service changes and that these are communicated to staff and clients.

The leadership practices listed in this framework could spark ideas for small changes to improve the quality/recovery orientation of specific programs and processes.

What does “quality” mean for Mainstay Housing?

QUALITY IMPROVEMENT IN HEALTH CARE

Health Quality Ontario’s *Quality Improvement Guide* provides clear guidance on how to plan and implement change that is effective in improving outcomes. It describes the “Model for Improvement,” an evidence-based change process. It has two parts: a set of three questions and a cycle for learning and improvement. The three questions are:

- What are we trying to accomplish? (the aim)
- How will we know if a change is an improvement? (the measures)
- What changes can we make that will result in improvement? (change ideas)

The cycle for learning and improvement is called the plan-do-study-act (PDSA) cycle. PDSA cycles involve planning the change (P); testing it (D); immediate data collection and analysis (S); deciding what changes to make to the change and then testing it out again (A).

**AIMS**

Aims should include a target and a deadline and define the scope, boundaries and constraints for the initiative. For example, to address the quality dimension “successful tenancy”, Mainstay could aim to reduce the number of evictions of tenants in x program over the next year by y percent.

**MEASURES**

The literature on quality improvement measures varies in the way measures are approached. On the one hand, the quality improvement plans developed by the LHINs and the hospitals are intended be used to assess performance and executive compensation is tied to performance. On the other hand, the research-based literature emphasizes that QI measures are different from performance measures. Learning measures are used to improve the system, not to assess performance against a standard. Data is not compared to standards but to historical performance and relationship with other variables. Measurement for learning also requires more comfort with variations than performance measures do. Finally performance measures follow the rule “If it can’t be measured, it can’t be managed” whereas in measurement for learning it is accepted that often the most important things are unknown and unknowable, so one can’t always get the perfect measure or perfect data but can get a sense of whether changes are heading in the right direction.

The literature is consistent in stating that three types of measures should be taken:

4 A better question may be what changes do we think will result in improvement, since we don’t know until we try it out.
• Outcome measures – Are the changes leading to the achievement of the aim? For example, if three changes are introduced to reduce evictions, are these changes taken together, actually doing so? It is not possible to measure the impact on the outcome of one small change, such as changing how staff address hoarding, but the outcome of several changes should add up to a reduction in evictions.

• Process measures – Is a particular a specific change is having its intended effect? For example, is the new hoarding protocol reducing the incidence of hoarding problems?

• Balancing measures – These measure the impact of changes on the rest of the system, in order to ensure that a change does not cause other unintended problems. For example, if a proposed change will increase the SHW workload, something else might need to be dropped.

DATA
Data collection for performance measures is often detailed and takes weeks or months to get, for example quarterly financial reports. In testing QI changes, data must be both easy and quick to obtain. Short time periods between testing a change and getting data on how it is affecting the situation are necessary. Some ways to do this include:

• Get immediate feedback from those testing the change
• Plot data over time (e.g. daily) to see trends
• Sampling - such as monitoring impact on a small number of people instead of the whole population of tenants or staff
• Integrating simple data collection into the daily routine (e.g. using simple manual data collection forms that are part of someone’s job or modifying existing forms and systems instead of developing something new).
• Getting qualitative data and confirming with quantitative later (e.g. ask staff and tenants their perceptions of the impact of a change and more objective data can be gathered over the longer term to see if the impressions and practice jive). Quantitative data is often easier and faster to get.
• The data doesn’t have to be perfect, just useful.

DEVELOPING CHANGE IDEAS
Each QI initiative should be developed and carried out by a team that includes three types of expertise: the front-line people who work with the process that is being improved; people with the technical expertise who understand the topic, how to design and test changes, facilitate meetings, collect and interpret data and present findings; and an administrative leader who has enough influence to implement and sustain the change, and remove any barriers to the team’s success.
There are many ways for a team to develop ideas for change from different angles: critical thinking tools, creative and lateral thinking tools, watching the process in action, using focus groups and surveys, hunches, theories, research data, asking the people who are experiencing the process that you are trying to change, asking experts in the subject area. Health Quality Ontario’s website offers a number of tools.

Change initiatives focus on specific processes within the organization. Appendix F has a list of various processes Mainstay has that could be assessed to achieve improvements in specific outcomes.

The best QI initiatives have several different types of change initiatives. Below are examples of different types of change, with examples from hospital QI initiatives.

- Measurement and feedback (e.g. various ways to track hand washing)
- Reminders, program supports (e.g. discharge checklist for hospital physicians)
- Process improvement (e.g. prior to discharge, book follow-up appointment with 5 days of discharge)
- Skills development (e.g. review effectiveness and use of the asthma teaching packages by completing a chart audit on all patients with asthma to assess percentage of readmissions)
- Tenant engagement (e.g. post signs in patient rooms “Remind me to wash my hands”)
- Incentives and motivation (e.g. awards for units with best hand hygiene numbers)

TESTING THE CHANGE IDEAS
The QI literature places a strong emphasis on testing change ideas. Failure in testing is a good thing; a gift that ensures that implementation won’t fail. Test and adapt the change until it is clear it will actually make the hoped-for improvement. Then and only then do you implement the change. Once testing is complete, the successful changes are spread to the rest of the organization. Using this process avoids the error of adopting an innovative idea that has worked elsewhere too quickly, allowing the organization to figure out how best to adapt it to the particular environment. It also helps to prevent resistance; small tests of change are low-risk and can help generate buy-in.

Here is an example of using the PDSA cycle to test a change. To improve patient safety on a ward, a daily safety huddle (short meetings of staff providing care) was tried out. The first PDSA cycle involved planning the questions for discussion in the huddle and who would test it (P), testing with one doctor, one nurse and one group of patients (D), getting feedback and deciding what to change (S), modifying the questions (A). The next PDSA cycle involved testing the safety huddle for two days with two more doctors and two more
nurses. Then, based on feedback, the time of day was changed. Now two huddles per day were tried out and they were tested on the night shift. Based on that experience, the safety huddles went back to once a day. Huddles were now tested on the weekend shift and with other health professionals involved. Thus, the proposed change was tested, modified (changed questions, location, frequency) and tested again with more variations (night shift, weekend shift, other health professionals) to see how it worked and what worked best in all situations.

IMPLEMENTATION
Preparation for implementation includes putting the supports in place such as training, forms and documentation aids; mitigating resistance to change by recognizing the impact the change will have on people and communicating well how the change will improve the process; and assessing impact of the change on other processes (e.g. What isn’t being done when everyone is in a huddle, and what are the implications of having to coordinate schedules for even a very short meeting?).

During the testing phase, the capacity of the organization to hold these changes must also be tested, for example by forcing the changes to fail (e.g. trying the safety huddles out in the most challenging circumstances) in order to understand the limitations of the change idea. To support holding the change, during implementation multiple PDSA cycles should continue to support the team in learning, including gathering and using the feedback from all affected. After implementation, it is important not to drop the project, assuming the change has been integrated. Systems are likely to fall back to the way they were before unless they are monitored and the results included as part of ongoing management processes. At Mainstay the departments meets at predictable times as sub-teams and as whole department. Case studies prepared by each SHW and trend analysis based on data sets collected will help to surface what it working well, better practice, and issues impacting tenant members such as an upsurge in eviction notices.

DEVELOPING A QUALITY IMPROVEMENT PLAN

The template for hospital QIPs provided by the provincial government is based on the Model for Improvement described above. Below is the template, with a partially completed illustrative example for Mainstay (Figure 1). Following that is an excerpt from an actual QIP from the Ottawa Hospital (Figure 2). The latter is a better example of realistic objectives, measures and change ideas because a team of front line staff, technical experts and administrators based on real world experience developed it. Figure 1 is not based on experience but is simply an illustrative example.
Figure 1

Example of QIP for Mainstay (looking only at one objective for one dimension)

<table>
<thead>
<tr>
<th>AIM</th>
<th>MEASURE</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality dimension/characteristic</td>
<td>Objective</td>
<td>Measurement/Indicator</td>
</tr>
<tr>
<td>Successful tenancy</td>
<td>Reduce number of evictions</td>
<td>The number of evictions and eviction notices 2011/2012</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTES:

1. A full QIP would have several quality dimensions, some of which would have more than one objective.
2. In the example above, there could be a number of objectives for successful tenancy such as increase positive tenant-staff relations, decrease in complaints by tenants about tenants, increased economic stability, etc.
3. The total impact of the change ideas should be enough to impact the measure for the overall objective. Other change ideas for successful tenancy may relate to reducing rent arrears, % of tenants with relapse plans, etc.
4. The change ideas should be tried out using the testing process described earlier – making small changes to see if they have the expected impact, and adjusting or altering completely the change initiative before implementing fully.
5. Note: These are uneducated examples that are simply for illustration. They may not represent good change ideas.
## Figure 2

Excerpt from The Ottawa Hospital 2012/2013 QIP ([www.ottawahospital.on.ca](http://www.ottawahospital.on.ca))

<table>
<thead>
<tr>
<th>AIM</th>
<th>MEASURE</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality dimension</td>
<td>Objective</td>
<td>Methods and process measures</td>
</tr>
<tr>
<td>Integrated</td>
<td>Reduce unnecessary hospital readmission</td>
<td>Goals for change ideas 2012/13</td>
</tr>
<tr>
<td>Percentage of inpatients that are urgently admitted within 30 days of a previous discharge (for General Internal Medicine -GIM).</td>
<td>Percentage of inpatients that are urgently admitted within 30 days of a previous discharge (for General Internal Medicine -GIM).</td>
<td>Plan will follow the principles of health literacy and patient education materials. Content will be informed by best practice in the literature and feedback from patients' and family members. This data is obtained from the client surveys completed by discharged patients. These have been previously collected at a unit level. The data will be collected at a service level to determine its potential contribution to readmission rates and provide baseline %. Real-time communication at admission and discharge. At admission is important for planning and proactive measures.</td>
</tr>
<tr>
<td>MEASURE</td>
<td>13.9% for GIM</td>
<td>At least 90% of patients will receive a patient-friendly post hospital care plan</td>
</tr>
<tr>
<td>Current performance</td>
<td>11.4% for GIM</td>
<td>≥90% of patients will receive a reconciled medication list</td>
</tr>
<tr>
<td>Target 2012/13</td>
<td>Represents 20% decrease in rate as per current literature which shows 20% of readmissions are preventable</td>
<td>95% Yes, completely for each question</td>
</tr>
<tr>
<td>Target justification</td>
<td>1) To improve real time handover communications:</td>
<td></td>
</tr>
<tr>
<td>Priority level</td>
<td>a) Give patient and family members a patient-friendly post-hospital care plan, which includes a clear medication list.</td>
<td></td>
</tr>
<tr>
<td>Planned improvement initiatives (Change ideas)</td>
<td>% of patients receiving a patient-friendly post hospital care plan and a clear medication list</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Provide customized, real-time critical information to the next clinical care provider(s) for all GIM patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Yes, completely on Q1 &quot;Did someone on the hospital staff explain the purpose of the medicines you were to take at home in a way you could understand?&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Yes, completely on &quot;Did someone tell you about medication side effects to watch for when you went home?&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Yes, completely on &quot;Did they tell you what danger signals about your illness or operation to watch for after you went home?&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Yes, definitely on &quot;Did the doctors and nurses give your family or someone close to you all the information they needed to help you recover?&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Yes on &quot;Did you know who to call if you needed help or had more questions after you left the hospital?&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[NO MEASURE PROVIDED FOR CUSTOMIZED CRITICAL INFORMATION]</td>
<td></td>
</tr>
</tbody>
</table>
What does “quality” mean for Mainstay Housing?

2) To Ensure Post-Hospital Care Follow-up:
   a) Prior to discharge, schedule timely follow up care
   b) Implement Post Visit Phone Calls as a standard of care for all inpatient units

<table>
<thead>
<tr>
<th>2) To Ensure Post-Hospital Care Follow-up</th>
<th>% of next scheduled physician visits booked prior to discharge</th>
<th>90% of next scheduled physician visits booked prior to discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monthly % call attempt rate</td>
<td>Monthly % call complete rate</td>
</tr>
<tr>
<td></td>
<td>Monthly % call attempt rate</td>
<td>100% call attempt rate</td>
</tr>
<tr>
<td>Balance indicator for all project initiatives</td>
<td>Acute Length of Stay</td>
<td>Acute length of stay is less than expected length of stay</td>
</tr>
<tr>
<td></td>
<td>Expected Length of Stay</td>
<td>The balance indicator is important to ensure improvement initiatives do not increase patient length of stay.</td>
</tr>
</tbody>
</table>

NOTES:

1. The measure/indicator defines the arena within which change will be, i.e. the population is specific, not all patients in the hospital but in one area “General Internal Medicine”.
2. The target is a “stretch” (challenging but achievable), not vague, not tiny and not too big to be realistic.
3. Each change initiative is SMART: specific, measurable, achievable, realistic and within a time frame (one year in this case). They are not large changes but small improvements. This is a key feature of quality improvement, that when the proper analysis is done, with clear objectives and the supports in place, small changes can add up to a significant difference.
4. Notice the balance indicator in the last row. Balance indicators are important to ensure that in fixing one problem you don’t aggravate another. Action to ensure people don’t return to hospital quickly is not helpful if it involves unnecessarily increasing the length of stay. Both problems block beds from people who really need them.
In analyzing the quality improvement plans submitted by Ontario hospitals, HQO identified three key features of a good quality improvement plan:

- A limited number of priorities
- Targets that are a good stretch (challenging but achievable, as opposed to no stated target or a vague or minimal target such as “do better”)
- Change ideas that cover many aspects of the organization (such as client engagement, better access to data for providers, infrastructure change, better accountability mechanisms, addressing staff skills).

A Note about Indicators and Data

It is important, when developing a quality improvement plan not to start with what data is already being collected or the measure/indicators already being assessed. Planning starts with what outcomes you want to achieve, then identifying what indicators will tell you you’re getting there, then what data you need. There may be a tendency to start by asking what can our data tell us about quality, or what indicators does the LHIN or do other health service providers measure. That is putting the cart before the horse. Improving quality may mean you need to collect new data or develop new indicators. Beginning with aims is a more effective way to address quality improvement.

THE ROLE OF THE BOARD

Just as boards are accountable for the financial management of the organization, there is increasing recognition that they should be equally as accountable for the quality of what the organization does. To do so they must provide leadership, understand what quality means, be involved in setting quality goals, receive and understand reports on quality and quality improvement, and be involved enough to have confidence that quality is being assessed and where needed, improved.

The Board’s Role is Strategic

The board role in monitoring quality is strategic. Management’s role is both strategic and operational. For example, understanding how building maintenance ensures that snow is cleared in the winter in a timely fashion is an operational issue. However it could be relevant to the board if there is a strategic quality priority related to safety. Alternatively, it is something that should come to the board if there has been a critical incident where someone was hurt or if there was a near miss that relates to system-wide practices. A third way that it might come to the board is through the organization’s risk management system if the latest risk assessment identifies something related to winter maintenance as a high risk to the organization even though there has been no incident (e.g. if there is a growing
What does “quality” mean for Mainstay Housing?

Public outcry related to snow-clearing at Mainstay that threatens the organization’s reputation. Operational aspects of quality are a board quality concern only if they are related to strategic issues, a critical incident or a priority issue in the risk management assessment.

Quality at the Board Level

Health Quality Ontario’s Quality and Patient Safety Governance Toolkit provides clear and detailed guidance for boards. It suggests that Boards select a maximum of 3 to 5 “big dot” indicators of quality to monitor. Big dot indicators should be related to strategic priorities. They may be more obviously quantitative (e.g. the rate of hospital acquired infections) or qualitative (in-patient experience of quality care). To achieve big dot indicators requires a number of “small dot” indicators for managers and staff to address. For example, a big dot indicator of patient experience of hospital care involves small dot indicators related to pain control, response to call bell and the percent of positive responses to patient survey questions on input into decision-making and courteousness of staff.

There are a variety of ways to do this. One suggestion is to start with 10 to 20 quality indicators and then narrow it down to a few system-wide indicators. These are not necessarily 3 to 5 of the 20 but something that is related to a cluster of smaller indicators. Another suggestion is to develop the QIP and then look it over to decide on what the board will monitor.

Some suggestions for big dot indicators for Mainstay

<table>
<thead>
<tr>
<th>ATTRIBUTE/DOMAIN</th>
<th>BIG DOT INDICATOR</th>
<th>SMALL DOTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective</td>
<td>Tenant capacity to stay housed (Eviction rate/Notice of Evictions)</td>
<td>Measures for each of the practices/processes for eviction prevention – are they being implemented and implemented according to guidelines, timely, appropriately for the individual, etc.</td>
</tr>
<tr>
<td>Effective</td>
<td>Tenant integration in community (summary of Community integration outcomes)</td>
<td>Community integration outcomes (relates to SD1 point 3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tenant-Centered</th>
<th>Tenant satisfaction</th>
<th>Change in tenant access to services as per SD2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenant participation in the organization</td>
<td>Scores related to tenant satisfaction survey; number of complaints from tenants and their families</td>
<td></td>
</tr>
</tbody>
</table>

Other big dot indicators related to Mainstay’s strategic directions could be:

- SD1 – Select a particular program or service that you think could have better outcomes. In the QIP plan all the types of change that will be introduced to improve it: innovations, better adoption of best practices, more efficient procedures, etc. The big dot indicator would be the change in the program’s intended outcome.
- Find a high level indicator for Mainstay’s involvement in research, documenting, and sharing its own emerging practices and adopting best practices – some kind of measure of research and best practice. The individual small dot indicators would relate to particular research projects; documenting emerging practices or adoption of best practices for particular programs or services or specific procedures within a program; presentations at conferences and meetings; publications;
- Something related to staff engagement
- Something related to Board engagement

Board Responsibilities

Health Quality Ontario’s Quality and Patient Safety Governance Toolkit offers a number of questions to guide the board in each stage of its role in prioritizing quality indicators, developing quality improvement plans, reviewing the QIP and in reviewing quality reports. It also has detailed guidelines for Boards (agendas, terms of reference for quality committee, etc.)
The Board’s role in quality is to:
- Oversee the development and execution of the quality improvement planning
- Ensure that management has identified appropriate performance measures, targets and improvement goals that are clearly understood by the board
- Ensure management has plans to address performance variances and oversee implementation of these plans
- Have a strong understanding of the key (big dot) quality indicators

Management’s role in quality with respect to the board is to:
- Ensure sufficient and timely reports to the board to have a good discussion
- Ensure data collection and reporting tools allow for timely information to be presented consistently
- Develop clear aims and detailed plans for improvement

A joint board-management responsibilities is to:
- Prioritize quality improvement in the strategic planning process and include it in the plan

Other recommendations from the literature to assist the board in its role are:
- Recruit board members with knowledge and skills in quality improvement
- Educate all board members enough that they can carry out the board’s quality oversight responsibility
- Create a quality committee of the board with both board and senior staff involvement. The whole board is responsible for quality monitoring but the committee does the bulk of the work and is responsible for ensuring quality is embedded in board processes, such as allocating resources needed for QI initiatives.
- Spend as much time at meetings on quality as on finances.
- Bring stories of tenant experience to the board – including direct contact with tenants.

Guidance documents for board governance of quality were developed based on the experience of large complex organizations (primarily hospitals) in a sector that was experiencing a serious quality concern (the need for much improved patient safety). Smaller organizations, such as Mainstay, where no major issue has been identified and quality improvement is already entrenched in the organization may not need to implement all the recommended practices. Mainstay may not have the resources for the high degree of board involvement recommended and may already have some practices that supersede some recommendations, for example there is direct contact with tenants already since they...
are on the board. Nevertheless the Quality and Patient Safety Governance Toolkit provides many practical tools to assist the Board in its role.

Allocating Resources for Quality

Quality improvement requires human and financial resources. New practices must sometimes be researched, appropriate targets (stretch indicators) assessed, new measures identified, new ways of analyzing existing data implemented, and new data collection systems developed. Creating teams or putting systems in place for testing and quick data on changes (implementing PDSA cycles) may also involve new tasks for staff and new types of teamwork. A focus on quality at the Board level will require board resources as well.

CONCLUSION

There is much that Mainstay has done and is doing to ensure a high quality of service. In looking over attributes, characteristics, standards and indicators of quality from multiple sources, it is clear that Mainstay’s approach and systems are consistent with many of the standards and indicators.

Mainstay already has two foci for quality: successful tenancy that is sustainable in or out of supportive housing; and creating community and belonging. This paper has suggested some options for maintaining these, reframing them and/or adding other dimensions of quality.

However Mainstay decides to define quality, it will need to decide on what aspects of quality it wishes to improve and develop plans and implementation strategies. The provincial government template for quality improvement plans is one option for a structure for Mainstay’s QI initiatives. The Model for Improvement, described in this paper, offers a best practice in planning and implementing individual QI initiatives. To ensure that the QI work is aligned with strategic priorities, the board will need to take an active role and ensure resources are allocated for quality improvement.
## APPENDIX A  
### Mainstay Outcomes & Performance Measures

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator</th>
<th>Measures</th>
<th>Explanation</th>
<th>Corridor Target</th>
<th>Reports Generated</th>
<th>Frequenc</th>
<th>Users</th>
<th>Data sets &amp; Tools to Collect Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful Tenancy</td>
<td>Housing Stability</td>
<td>Eviction Notices - Aggregate (A)</td>
<td>We use these measures to tell story of tenant member growth in capacity and knowledge and ability to maintain housing.</td>
<td>C- multi year data sets (2000 +) Trends</td>
<td>Eviction Prevention – General (G) and selected Program specific (P) Mental health counseling Housing stability (move outs &amp; reasons, length of tenure) (G and P) CASH refusals and denials CDS (MSAA) Note: we do not report by demographic profile per building or in reports. We do however run year to year trend lines for move-in.</td>
<td>Monthly</td>
<td>TMS ED as required</td>
<td>By person, by unit, By building, By portfolio, by SSA.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eviction Notices - Unique (U)</td>
<td>We use measures to inform interventions with tenant members and to help them see/own growth. As they grow in confidence, they have more incentive to keep housing, and believe they can solve problems and thus be in charge of housing as a bridge to address unmet needs.</td>
<td>Variance allows for follow up or focus group with tenant members Variance surfaces practice and training issues or emerging best practice</td>
<td></td>
<td></td>
<td></td>
<td>Board, ED SSA TC LHIN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evictions-A</td>
<td>We use measures to theorize on which profile needs what kind and intensity of support to achieve outcome and theorize on discharge or step down process/service.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>By agency.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Move-outs-A</td>
<td>We use measures to drive staff performance, individual support, and program quality and service planning.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>At move in: demog profile and Common Application</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Length of Tenure</td>
<td>We use measures to discuss quality support with SSA partners and assess continuing relationship.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OCAN future</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counseling interventions-A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Manual data collection, and monthly input into Excel;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Case Studies* (used by TMS staff)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>REMS reports;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demographic profile</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>New: OCAN met and unmet needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## What does “quality” mean for Mainstay Housing?

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator</th>
<th>Measures</th>
<th>Explanation</th>
<th>Corridor Target</th>
<th>Reports Generated</th>
<th>Frequency</th>
<th>Users</th>
<th>Data sets &amp; Tools to Collect Data</th>
</tr>
</thead>
</table>
| **Community and belonging**                  | Participation | CD Programs-Groups and types  
Participants- A  
By building  
By Portfolio  
Meeting Themes*  
Meeting Evaluation*  
Volunteers  
WRAP participation  
Opportunity Fund ($$$, awards, applicants) | We use these measures to tell story of how tenant member moves from social isolation to relationship and demonstrate their engagement with others to improve their quality of life, confidence in problem solving and growth. (unique journey of recovery).  
We use these measures to assess 'quality of life' within each building community.  
We use these measures to identify and address unmet needs and determine investment of resources.  
We use these measures to provide feedback to tenant members on their accomplishments as leaders, volunteers and community members.  
We use these measures to improve performance, inform program planning and service design and individual support. | Monitor Only at this point  
CD tracked by G which includes S2H and VA  
And by ARSH  
Year to year data | Community Development –A and P (ARSH,S2H,VA)  
Note: We do not show CD by building, by portfolio.  
Primary Care –P (S2H), (ARSH) ED/Detox (ARSH and collected by partner agency)  
CDS (MSAA)  
We do not provide reports to board on: -meeting themes -Meeting evaluations -WRAP**  
-Opportunity Fund**  
-Deaths** | Monthly  
Quarterly  
Annual | TMS  
Board ED  
TCLHIN  
Board ED  
TC LHIN  
public via annual report  
Future: to SSA | Collect by aggregate participants per activity per occurrence per building and per Program  
(No demog or unique individuals) | Manual collection and monthly input |
APPENDIX B

Mainstay’s Approach

The Essence of our Approach

Chronically Homeless People Bring Extraordinary Complexity

The interplay of challenges, internalized stigma, experiences of discrimination, affects the new tenant’s ability and confidence to succeed as a tenant.

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APPENDIX C

Accreditation Standards

In Canada there are several accreditation bodies for health and human services: the Canadian Accreditation Council (CAC), the Council on Accreditation (COA) (an American organization that has adapted its standards for Canada), Accreditation Canada (AC) and the Canadian Centre for Accreditation (CCA). There are also accreditation organizations for specific sectors (e.g. pharmacy) but none specific to supportive housing or mental health. For the purposes of this paper, the standards of all but the Canadian Centre for Accreditation were reviewed. (The CCA is a relatively new organization that has been developed for community-based services. To date it has not developed standards for adult mental health or supportive housing services and although it may have some relevant standards there was no response to a request for information.)

The CAC, COA and AC have generic standards that apply to all services. These cover aspects of organizational health not addressed in the CSH framework including leadership and governance; health and safety; and many aspects of human resource management/staff experience. Should Mainstay include these areas as part of its definition of quality, the accreditation standards can help Mainstay with the operational side of assessing its quality in these areas.

The CAC and COA have specific standards for supportive living, but they are more for board and care settings. AC has standards for community-based mental health and addiction services but not specifically for supportive housing. Accreditation Canada’s standards for community-based mental health services and supports are broad enough to be relevant to Mainstay and are similar to the CSH although the latter cover much more ground, since they are designed for supportive housing. Like COA and COC, the AC standards and indicators are much less in-depth than CSH, but relative to COA and COC, the AC has more standards, more indicators for each standard and more guidance for each indicator.

One of the appealing features of the AC design is that each standard has indicators that cover the wide range of Health Quality Ontario’s attributes of high quality health care services and each indicator is labeled according to which quality characteristic it addresses. For example, one standard is that “the organization develops its services and supports to meet the needs of the individuals, families and community it serves.” The indicators for this standard are:

- Person-centered, strengths based and individual approach (effectiveness)
- Recovery-oriented and focused on well-being (effectiveness)
- Support and engage families (client-centered)
What does “quality” mean for Mainstay Housing?

- Collects information about the service users (population focus)
- Uses this information to define its scope and set priorities (population focus)
- Alignment of services with mission and strategic plan (effective)
- Information about service needs and priorities is made public (population focus)
- Processes and policies to meet diverse needs are established (client-centered)
- Regular review of service demands and utilization; services are adjusted accordingly (effective)

Most of the accreditation organizations’ standards and indicators are quite broad and involve qualitative reporting.

It is important to note that an organization that is not meeting standards is not necessarily a poor quality organization. The idea is that when the standards are met, the organization has achieved a certain degree of high quality service. There is no shame in an honest assessment that an organization is not meeting several standards. The purpose is to recognize what needs to be done, decide where to focus whatever resources the organization has available for quality improvement, develop and implement a plan for improvement, reassess and create a new plan.

Resources

Accreditation Canada. Qmentum Program Standards: Community-based Mental Health Services and Supports Standards, 2012

Accreditation Canada. Qmentum Program Standards: Governance 2012

Accreditation Canada. Qmentum Program Standards: Leadership, 2012


APPENDIX D

The Corporation for Supportive Housing’s Quality Framework

In 2009, the Corporation for Supportive Housing (CSH) in the United States produced a quality framework based on consultation with tenants, providers, funders and others, as well as its experience with successful supportive housing projects. The CSH framework identifies seven domains of quality, a standard for each domain and a set of indicators for each standard. The domains and standards were mentioned briefly in the body of this paper.

The CSH framework provides the most detailed look at all the aspects of providing quality supportive housing. It might be of interest to Mainstay when exploring measurable activities to advance a particular dimension of quality. It has been used by organizations that are similar to Mainstay in that they own the housing but provide only some (or none) of the supports. These organizations have selected particular dimensions, developed a few quality improvement goals and used the appropriate indicators from the CSH framework. For example the Jamboree Housing Corporation in California develops non-profit housing and partners with other organizations for services. Their focus was on dimensions 1,5 and 7 (administration, property management, and data). Their goal was to improve their housing financing and asset management records, strengthen communication with service delivery partners and create agreements to track tenant outcomes that protect confidentiality but allow essential information to be shared. CSH provided funding for this goal to be addressed over one year, and has documented the lessons learned as Jamboree made the changes necessary. This and other stories of quality improvement by other supportive housing providers using the CSH framework are available in a CSH report called, Assuring Quality: Implementing the Seven Dimensions of Quality for Supportive Housing.

There are a number of challenges with using the CSH framework. First, it is not particularly recovery-centred, although there are recovery-related aspects of quality included. Secondly, the term indicator is used loosely by CSH. It includes concrete measurable activities that will help to achieve the standard and broader statements that would need to broken down into activities. For example, key indicators for “administration, management and coordination” (dimension 1) are:

- Effective partnerships between owner, supportive service providers, tenants and any other relevant agencies.
- All partner organizations follow the relevant legal requirements
- All organization regularly update their manuals and plans
What does “quality” mean for Mainstay Housing?

- A collaborative relationship results in effective coordinated strategies to foster tenant housing stability and independence, prevent evictions and address issues related to substance use, relapse and mental health crises.

How would you know that effective partnerships have been developed? What activities or processes are involved?

Third, in some cases the indicators are too prescriptive. For example, one indicator is that “regularly scheduled forums are held at least monthly (and preferably more frequently) for supportive services and property management staff to discuss their roles, the coordination of their efforts, and current issues, and to address gaps in services and operations.” A more appropriate indicator would be “Systems are in place to support regular communication about coordination of services, issues, gaps and roles between Mainstay and service-delivery partners.” It should be up to the organization to decide what form of communication and how frequent it is.

The complete list of indicators can be found in *The Seven Dimensions of Quality for Supportive Housing: Definitions & Indicators*. CSH has refined its indicators more clearly and measurably in its work to take the generic framework and create a supportive housing quality framework for the state of Illinois, *The Seven Dimensions of Quality for Supportive Housing in Illinois*.

The Corporation for Supportive Housing reports are available at [www.csh.org](http://www.csh.org).
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APPENDIX E

The Scottish Recovery Indicators

(From [http://www.sri2.net/31-the-srfi-2-recovery-indicators-and-reflective-questions](http://www.sri2.net/31-the-srfi-2-recovery-indicators-and-reflective-questions))

“The framework of the recovery indicators and reflective questions is shown here to let you see how straightforward and logical the structure of SRI 2 (Scottish Recovery Indicators, version 2) is. At the heart of the web based SRI 2 process are the ten indicators of recovery-focused practice shown here in the first column of the framework starting with ‘Basic needs are identified and addressed’. Each indicator is considered and discussed against evidence from six different sources of evidence and opinion.”

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Assessments</th>
<th>Core plans</th>
<th>Service Info</th>
<th>Service Provider</th>
<th>Service User</th>
<th>Informal Carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic needs are identified and addressed.</td>
<td>Basic needs are routinely considered.</td>
<td>Basic needs are routinely addressed.</td>
<td>No data required.</td>
<td>We identify and address basic needs.</td>
<td>My basic needs are well met by this service.</td>
<td>Basic needs are well met by this service.</td>
</tr>
<tr>
<td>Goals are identified and addressed.</td>
<td>Goals are identified and addressed.</td>
<td>Personalised self-set goals are routinely addressed.</td>
<td>No data required.</td>
<td>When we plan care we consider people's self-set goals.</td>
<td>My goals are considered when planning my care.</td>
<td>No data required.</td>
</tr>
<tr>
<td>Personalised services are provided.</td>
<td>Personal choice is routinely considered.</td>
<td>Considerable variation between care plans.</td>
<td>Personal choice is identified as fundamental.</td>
<td>We ensure people receive a personal and tailored service.</td>
<td>I get a service that is tailored to my individual needs and circumstances.</td>
<td>This service takes account of people’s strengths, skills and abilities.</td>
</tr>
<tr>
<td>Service is strengths based.</td>
<td>Strengths are routinely identified and explored.</td>
<td>Strengths are routinely integrated.</td>
<td>Strengths based approach is promoted.</td>
<td>We consider people’s strengths, skills and abilities.</td>
<td>My strengths, skills and abilities are considered by this service.</td>
<td>This service helps people connect with their community.</td>
</tr>
<tr>
<td>Service promotes social inclusion.</td>
<td>Social connectedness is routinely considered.</td>
<td>Mainstream services and community integration are routinely addressed.</td>
<td>Information is provided that promotes social inclusion.</td>
<td>We provide a good range of options to promote social inclusion.</td>
<td>This service helps me to feel connected to my community.</td>
<td>This service helps people connect with their community.</td>
</tr>
<tr>
<td>Service promotes and acts on service user involvement.</td>
<td>No data required.</td>
<td>No data required.</td>
<td>Information is provided that promotes service user involvement.</td>
<td>Significant changes have taken place as a result of service user involvement.</td>
<td>People who use this service have a say in how things are done.</td>
<td>People who use this service have a say in how things are done.</td>
</tr>
<tr>
<td>Informal carers are involved.</td>
<td>Informal carers role is routinely considered.</td>
<td>Informal carers are routinely involved.</td>
<td>Information is provided that promotes informal carer involvement.</td>
<td>We fully involve informal carers wherever we can.</td>
<td>If I want it, my informal carer is fully involved.</td>
<td>I am fully involved.</td>
</tr>
<tr>
<td>Service encourages advance planning and self management.</td>
<td>Advance plans and self management plans are routinely considered.</td>
<td>Advance plans and self management plans are routinely integrated.</td>
<td>Information is provided that promotes advance planning and self management.</td>
<td>We encourage advance planning and self management.</td>
<td>I'm encouraged to plan for the future including periods of poor mental health.</td>
<td>This service helps people plan for the future including periods of poor mental health.</td>
</tr>
<tr>
<td>Staff are supported and valued.</td>
<td>No data required.</td>
<td>No data required.</td>
<td>Training, supervision and wellbeing policies or initiatives exist.</td>
<td>Staff are supported and valued and opportunities exist to reflect on practice.</td>
<td>The staff here seem satisfied in their work.</td>
<td>The staff here seem satisfied in their work.</td>
</tr>
<tr>
<td>Practice is recovery focused.</td>
<td>Promotes hope and optimism.</td>
<td>Responsibilities are routinely shared.</td>
<td>Information is provided that identifies recovery focused practice as fundamental.</td>
<td>We are recovery focused practitioners.</td>
<td>The staff are supportive, positive and approachable.</td>
<td>The staff here are supportive, positive and approachable.</td>
</tr>
</tbody>
</table>
APPENDIX F

Mainstay’s Processes

Mainstay’s Support Service Agreement and the Mainstay Outcomes & Performance Measurement chart describe activities or processes that may be explored in developing a QIP for particular dimensions of quality. For example if Mainstay identifies a desire to improve something related to its partnerships, there are a number of processes in the SSA that contribute to the quality of its partnerships. Small changes in some of these processes may add up to create the outcome desired.

The following is by no means a complete list of processes. It is organized around five potential characteristics of quality.

- **Builds tenant capacity to stay housed**
  - Tenants receive the individual supports they need to maintain successful tenancy (this could be broken down into specific supports, particularly the role of the SHW and that of other agency worker(s))
  - At intake, tenants are assessed accurately for their capacity to live independently with supports
  - Individual tenant support needs to stay housed are identified early
  - Everything reasonable is done to prevent eviction (could be more specific wording based on eviction prevention policy)
  - Seeks rent subsidies where appropriate
  - Provides tenancy education
  - Crisis intervention
  - Tenants are assisted to understand and meet the obligations of tenancy
  - Services are provided to support client transition if they leave or are evicted from Mainstay

- **Collaborative, coordinated, flexible and responsive support structures**
  - A service agreement between partners includes roles and responsibilities of each, services provided by each and specifies how partners will work together
  - Leadership of partner organizations is engaged and collaborative
  - Front-line staff responsible for clients collaborate proactively to solve problems and identify service barriers, gaps or needs.
  - All partners provide data according to the agreed upon Scorecard
  - All partners engage in regular evaluation of the partnership and of outcomes
  - A crisis plan is developed and crisis support is available
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- Timely response to each other’s communication
- Regular communication as agreed in the service agreement

- Supports self-determination
  - Tenants are involved in any discussion or decisions about them
  - Tenants have a lease and the organization is governed by the Landlord and Tenant Act
  - Tenants have an agreement (individual support plan) with the support agency that they are involved in creating.
  - Individual support plan includes goals for better life as defined by tenant, and strategies to get there

- Provides good quality housing and maintains it.
  - On-call staff 24/7 for building emergencies

- Involves tenants in the community (internal and external) and the organization and supports tenants to build/maintain a social network
  - Provides community development initiatives
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What does “quality” mean for Mainstay Housing?


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GLOSSARY

Various quality frameworks and documents about quality and quality improvement use the following terms in different ways. Below is an explanation of how they are used.

Attribute

Health Quality Ontario has identified nine attributes of a high quality health care system: accessible, effective, efficient, equitable, integrated, patient-centered, population health focused, safe and appropriately resourced. The government of Ontario expects hospitals to create quality improvement plans based on five of these attributes, as they apply at the level of the organization.

A 2005 paper on the values and standards for supportive housing identified nine values for a high quality supportive housing system. These are similar to the Health Quality Ontario attributes so that term has been used in this paper. These attributes are: appropriateness and choice, access to resources, self-determination and voice, accountability, affordability, housing rights and legal security of tenure, quality, social support and integration.

Characteristic

The term characteristic is not used in the quality literature. It is a unique term used in this paper for all of the ways that quality can be defined: by attribute, dimension, or other ways of categorizing all the features of quality in supportive housing.

Domain/Dimension

Dimensions or domains of quality are the category within which quality improvement goals are created. The domains can be by attribute, as they are in the government’s template for QIPs (safety, accessibility, etc.). They can also be by area of the organization, as they are in the Corporation for Supportive Housing framework (administration, property, etc.) The CSH framework actually has a mix of domains, some by work area and some by attribute.

Indicator

For performance measurement and quality improvement planning, an indicator is a specific, observable and measurable characteristic that can be used to show changes or progress a programme is making toward achieving a specific outcome. This meaning of indicator can be interchangeable with the term “measure.” For example, the number of evictions, or the percent of tenants responding positively to a survey question. Some quality documents, however use the term indicator to describe a set of activities, sometime specific and measurable and sometimes not. For example, The Corporation for Supportive Housing as a key indicator for the domain of access that says “There is no discrimination on the basis of race, color, gender, sexual orientation, disability, religion, or national origin in the provision of housing or services to applicants or tenants.” This is more of a standard than the true meaning of indicator.
What does “quality” mean for Mainstay Housing?

Measure
A measure is a numerical way of seeing whether a change has achieved its intended outcome. It is sometimes used interchangeably with the term “indicator”. An example is the rate of evictions or the number of participants in a program.

Standard
Standards are agreed-upon best way of doing things across a sector so that good quality looks similar in similar organizations. For example, accreditation organizations have standards against which organizations going through accreditation are assessed. The Corporation for Supportive Housing uses the term “definitions” to describe its explanations of the seven dimensions of quality. These definitions are actually written in the language of standards.

An example from Accreditation Canada of a standard for all community-based mental health services is: “The organization develops its services and supports to meet the needs of the individuals, families and community it serves.” This is a fairly general standard. A more specific one from the Corporation for Supportive Housing is: “Tenant rights are protected within consistently-enforced policies and procedures, tenants are provided with meaningful input and leadership opportunities, and staff-tenant relationships are characterized by respect and trust.” This could also be broken down into three separate standards.