De dwa da dehs nye>s Aboriginal Health Centre

Quality Improvement Plan

2015-16

Health Quality Ontario
2015-16 Quality Improvement Plan - Narrative

Overview

The mission of De dwa da dehs nye>s Aboriginal Health Centre is to improve the wellness of Aboriginal individuals and of the Aboriginal Community by providing services which respect people as individuals with a distinctive cultural identity and distinctive values and beliefs.

"De dwa da dehs nye>s" embodies the concept of "we're taking care of each other amongst ourselves."

De dwa da dehs nye>s Aboriginal Health Centre provides Aboriginal people with access to *culturally appropriate* health care programs and services. The Health Centre focuses on holistic preventive and primary health care that includes a Primary Care Team (Physicians and Nurse Practitioners), Traditional Healing, Mental Health and Addictions Services, Patient Navigation, Seniors' Medical Transportation, Advocacy, Homelessness, and Health Promotion, and Education Services. The Health Centre serves all Aboriginal people, regardless of status and offers assistance to outside service organizations to provide care in a culturally appropriate way. The Health Centre has two sites, one in Hamilton and a second in Brantford, with satellite offices in both communities. In addition, the Health Centre provides mental health services in the Niagara Region.

Integration and Continuity of Care

Our Quality Improvement Plan promotes integration of service/support and facilitates continuity of care of all patients within the Primary Health Care Clinic. To facilitate the continuity of care, De dwa da dehs nye>s works with external health service providers on a case by case basis to provide optimal patient care.

On June 20-21, 2014 the Centre hosted A National Aboriginal Solidarity Day. 135 surveys were received from participants ranging in age from 16-65+. This event created the opportunity for the Centre to connect with members of the community. Participants were asked to describe memorable experiences in the community, share their awareness of the Centre's programs and services, and to provide input into programming opportunities for the Centre. This information was collated and will contribute to focusing our efforts to provide culturally appropriate services and programs that meet the needs of our community.

The 2015 - 2016 Quality Improvement Plan includes completion of an internal referral process across the organization using our new Electronic Medical Record (EMR). This referral process is being revised to be fully implemented through our EMR for both internal and external referrals. This process will support staff to better track their patients through our system and will enable us to monitor and utilize statistical information on this indicator.

In addition, the EMR will help to track the improvements made with our no show rate.

The way that this information is being captured in the EMR by staff is being reviewed to ensure that it is collected in a consistent manner.

Lastly, the Health Promotions Department is enrolling and tracking its participants through the EMR. This practice was introduced late in the 2014-15 fiscal year. Health Promotions staff will be better able to track the impact of programming on Aboriginal Communities in Hamilton and Brantford. This data will form the baseline for this and other quality indicators.

A new EMR is being utilized across the sector. In 2014-15, all Program staff was trained in the use of the new EMR to ensure consistent data entry. Policies and procedures have been developed to support staff with the implementation of the new EMR. The product (EMR program) is continuously evolving and staff have played an active role in identifying coding issues and are working with IT Support to identify solutions.

Challenges, Risks and Mitigation Strategies

As the new EMR implementation progresses, one of our greatest challenges continues to be the lack of funding to support data collection and analysis. Staff/Practitioners have overcome several hurdles related to implementing the new EMR and ongoing training continues. However, we recognize that we are not yet consistently and effectively documenting in a way that allows us to fully use the new EMR's capabilities. The data entry and collection processes are becoming more refined and we are more confident in the accuracy of the data that we are collecting. With additional financial resources we are confident that we are on the path to being able to efficiently and effectively use this valuable data to achieve Best Clinical Practices for our clients.

Without the ability to efficiently record data and subsequently to mine the relevant data in a timely manner, the risk is that the data gathered is incomplete, outdated and has limited relevance and value to quality improvement initiatives. The risk is also that internal and external comparisons using the Centre’s outcome data are flawed and compromise the ability of the Board and Management to use this data to advocate for the Centre.

To mitigate this risk, we are supporting Staff/Practitioners by making the recording process, as efficient as possible to facilitate compliance with data entry. We are also prioritizing the data to be collected so that we can be confident in its accuracy without overwhelming the new Operations Manager as she transitions into her new role.

Information Management System

There have been a number of challenges with the transition to the new EMR including process issues as well as issues with the program itself. We are addressing these challenges in collaboration with our Staff/Practitioners. We are becoming more confident in the consistency and accuracy of data entry by all Staff/Practitioners. We have hired an Operations Manager who is responsible for overseeing the quality initiatives of the Centre. However, we still a Data Management Coordinator to lead the process of data extraction and analysis.

We are fortunate to have .2 FTE support for IT issues from North Hamilton Community Health Centre. However, as Information Management increasingly continues to become an integral and essential part of the Centre's operations this .2 FTE is not enough to support the IT infrastructure, staff education and training, and to mine data.

Engagement of Clinical Staff and Broader Leadership

The Board of Directors has led the development of a Strategic Plan 2012-2015 which, among other data and information, has formed the foundation for annual Quality Plans. The Board will meet in 2015/16 to review and revise the Strategic Plan. The Board has also identified the need to formalize governance and operating policy statements related to the Centre's continuous quality improvement activities. This work will be completed by the Quality Committee in 2015/16

The Board of Directors has a standing Quality Committee that meets quarterly and reports to the Board. This Committee includes: two Board Members, the Executive Director, the Operations Manager, two Program Managers, a Community Member with skills and knowledge in Continuous Quality Improvement, and two patients (one from each of our sites - Brantford and Hamilton). Staff input is represented by the two Program Managers. The Committee monitors the organization's performance through review of the quality indicators on our Balanced Scorecard. This information is submitted to the Board.

The Management Team also discusses quality improvement with staff within Departments at staff meetings. Across the organization, Program Managers discuss issues that could cross departments where collaboration would be useful.

The representation on the Committee helps to facilitate two way communication around quality issues and initiatives and helps to ensure that there is understanding by staff, Management, the Committee and the Board related to the priority objectives selected for the annual Quality Improvement Plan.

Accountability Management

At De dwa da dehs nye>s Aboriginal Health Centre, Continuous Quality Improvement is viewed as a team exercise that includes the Board, Quality Committee, Management and Staff. The Board is accountable and responsible for the submission of an annual Quality Plan.

The Quality Committee is accountable and responsible for providing oversight for a comprehensive Quality Plan that evaluates and monitors processes for maintaining and achieving quality within all aspects of the Centre to ensure a high standard of culturally relevant client care and consumer satisfaction.

Achievement of annual quality improvement outcomes and targets documented in the annual Quality Plan are tied to Executive Director compensation, The Executive Director is accountable and responsible for providing leadership by supporting staff ensuring that outcomes and targets in the Quality Plan can be met.

The Management Team is accountable and responsible for reviewing monthly updates on the department/organization's performance related to quality improvement indicators to ensure that targets are being met. Together, as a team, we identify what is needed, manageable, and leads to quality culturally relevant processes/service for our clients and for the community.
Other
De dwa da dehs nye>s Aboriginal Health Centre is growing at a rapid pace. Although we are in our infancy related to having data and information to support our quality improvement efforts and we have days when we feel that the task is overwhelming, we believe that the new EMR will, in time, prove to be one of the best investments that the organization and Ministry of Health and Long Term Care could make to support achieving best practice for those we serve.
Internal QI Note
The ongoing training, development and support of staff related to the efficient and effective use of the EMR will be integrated into Centre operations to ensure a consistent and unified approach to data entry.

2015/16 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

De Dwa Da Dehs Nyes Aboriginal Health Centre 200-678 Main Street East, Hamilton, ON L8M 1K2

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performa	Target	Target justification	Planned improvement initiatives (	Methods	Process measures	Goal for change ide	Comments
0	**Access to primary care when needed**	Percent of patients/clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	% / PC organization population (surveyed sample)	In-house survey /EMR Reporting 2015-16	92212*	88	95	In 2014-15 patient satisfaction surveys were conducted of our Primary Care Clients in both clinics. The average of of those identified that they are satisifced that they had a reasonable wait time for an appointment for this indicator is 88%. We believe that a 95% satisfaction rate is achievable in 2015-16.	1)Keeping one appointment time open each day, at each site, to support patients when needed.	Filling the open appointment on a first come, first serve basis.	Measuring how many days the open appointment is through consistent coding across both sites in the EMR.	Increasing access to care for same day appointments	
	Reduce ED use by increasing access to primary care	Percent of patients/clients who visited the ED for conditions best managed elsewhere (BME).	% / PC org population visiting ED (for conditions BME)	Ministry of Health Portal / TBD	92212*	CB	5	In 2014-15 we spent the year training staff on the EMR and by the end of 2014-15 all staff will have had the training to access the EMR in a unified manor. Policies have been put in place to streamline data effectively. The product has continuously evolved and staff have identified coding issues in our EMR to capture this data. We are working internally to identify a way for this information to be tracked in our EMR. In addition, we have no electronic data sharing capability with hospitals as of yet. This is planned as part of the integration of our new technology within the 2015-16 fiscal year.	1)Join Clinical Connect so that we have access in a timely fashion to a list of our patients visiting ED.	Join Clinical Connect	Until we receive access to ClinicalConnect, we will continue to count the number of patients that have accessed ED for conditions BME.	Identify patients and their corresponding issues.	
	Decrease the number of "No Show" patients in the Primary Health Care Clinic	Currently, patient "no shows" are an issue. We have implemented some measures over the past year (2014 - 2015) that have improved our no-show rate, however, we still have an average of 21% no shows per day.	Counts / N/a	EMR/Chart Review / 2015-16	92212*	21	12	In 2014-15 we focused on increasing access to care and reducing the number of "No Show" patients to appointments. Strategies have been put in place to reduce the number of no-shows and staff are continuing to review best practices to assist in lowering this indicator. In 2015-16 our goal is to reduce the number of "No Show	1)Improve the patient no-show rate	Calling the patients to confirm their appointment the day before	Quarterly reporting on no-show rate	To reduce the no-show rate to 12%	
Integrated	**Timely access to primary care appointments post-discharge through coordination with hospital(s).**	Percent of patients/clients who saw their primary care provider within 7 days after discharge from hospital for selected conditions (based on CMGs).	% / PC org population discharged from hospital	Ministry of Health Portal / TBD	92212*	CB	10	In 2014-15 we spent the year training staff on the EMR and by the end of 2014-15 all staff will have had the training to access the EMR in a unified manor. Policies have been put in place to streamline data effectively. The product has continuously evolved and staff have identified coding issues in our EMR to capture this data. We are working internally to identify a way for this information to be tracked in our EMR. In addition, we have no electronic data sharing capability with hospitals as of yet. This is planned as part of the integration of our new technology within the 2015-16 fiscal year. As well, by joining Clinical Connect we will have access to this informaiton.	1)Join Clinical Connect to identify patients who are discharged from hospital	Join Clinical Connect	Measure Quarterly the number of patients having access post-discharge through coordination with hospitals.	To provide access to primary care appointments post-discharge through coordination with	
	Reduce unnecessary hospital readmissions	Percent of a primary care organization's patients/clients who are readmitted to hospital after they have been discharged with a specific condition (based on CMGs).	% / PC org population discharged from hospital	Ministry of Health Portal / TBD	92212*	CB	10	In 2014-15 we spent the year training staff on the EMR and by the end of 2014-15 all staff will have had the training to access the EMR in a unified manor. Policies have been put in place to streamline data effectively. The product has continuously evolved and staff have identified coding issues in our EMR to capture this data. We are working internally to identify a way for this information to be tracked in our EMR. In addition, we have no electronic data sharing capability with hospitals as of yet. This is planned as part of the integration of our new technology within the 2015-16 fiscal year. As well, by joining Clinical Connect we will have access to this informaiton.	1)Join Clinical connect to identify patients/clients who are readmitted to hospital	Join Clinical connect	Quarterly reporting of the number of patients who are readmitted to hospital	To provide seamless primary care service/support to our patients	
	An internal program referral process will be in place across the organization	The new EMR will allow for internal referrals within the organization to be completed and reported on within the patient electronic medical record	Counts / N/a	EMR/Chart Review / 2015-16	92212*	115 (Q3)	200	In 2014-15 we spent the year training staff on the EMR and by the end of 2014-15 all staff will have had the training to access the EMR in a unified manor. Policies have been put in place to streamline data effectively. Based on the iinformation gathered in 2014-15, a target of 200 has been identified.	To make referrals/access to the organizational basket of services more tranparent and user friendly.	Internal referrals will be made between organizational departments through the EMR.	Quarterly reporting on the number of referrals made through the new EMR.	To ensure quick and efficient hand-off of patients amongst departments.	

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performa	Target	Target justification	Planned improvement initiatives (	Methods	Process measures	Goal for change ide	Comments
Patient-centred	**Receiving and utilizing feedback regarding patient/client experience with the primary health care organization.**	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) give them an opportunity to ask questions about recommended treatment?	% / PC organization population (surveyed sample)	In-house survey / 2014/2015	92212*	88	95	In 2014-15 patient satisfaction surveys were conducted of our Primary Care Clients in both clinics. The average of of those identified that they are satisifed that they had a reasonable wait time for an appointment for this indicator is 88%. We believe that a 95% satisfaction rate is achievable in 2015-16.	1) To make electronic surveys available to our patients.	To equip tablets and computers on-site with satisfaction surveys.	Quarterly reporting on patient satisfaction.	To ensure patient satisfaction.	
		Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment?	% / PC organization population (surveyed sample)	In-house survey / 2014/2015	92212*	83	90	In 2014-15 patient satisfaction surveys were conducted of our Primary Care Clients in both clinics. The average of of those identified that they are satisifed that they had a reasonable wait time for an appointment for this indicator is 83%. We believe that a 90% satisfaction rate is achievable in 2015-16.	1)To make electronic surveys available to our patients.	To equip tablets and computers on-site with patient satisfaction surveys	Quarterly reporting on patient satisfaction.	To ensure patient satisfaction	
		Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) spend enough time with them?	% / PC organization population (surveyed sample)	In-house survey / 2014/2015	92212*	92	98	In 2014-15 patient satisfaction surveys were conducted of our Primary Care Clients in both clinics in April 2014 and January 2015. The average of of those identified that they are satisifed that they had a reasonable wait time for an appointment for this indicator is 92%. We believe that a 98% satisfaction rate is achievable in 2015-16.	1)To make electronic surveys available to patients.	To equip tablets and computers on-site with satisfaction surveys.	Quarterly reporting on patient satisfaction.	To ensure patient satisfaction.	
Population health	**Reduce influenza rates in older adults by increasing access to the influenza vaccine.**	Percent of patient/client population over age 65 that received influenza immunizations.	% / PC organization population aged 65 and older	EMR/Chart Review / TBD	92212*	47	57	In 2014-15 we spent the year training staff on the EMR and by the end of 2014-15 all staff will have had the training to access the EMR in a unified manor. Policies have been put in place to streamline data effectively. Based on 2014-15 performance, a target of 57% is thought to be achievable.	1)To utilize the data mining component of the new EMR to identify older adults who would benefit from the influenza vaccine.	Identify and encourage older adults to come in to receive the influenza vaccine.	Quarterly reporting on older adults who have received the influenza vaccine.	To reduce influenza rates in older adults.	
	Reduce the incidence of cancer through regular screening.	Percent of eligible patients/clients who are up-to-date in screening for breast cancer.	% / PC organization population eligible for screening	EMR/Chart Review / TBD	92212*	24	35	In 2014-15 we spent the year training staff on the EMR and by the end of 2014-15 all staff will have had the training to access the EMR in a unified manor. Policies have been put in place to streamline data effectively. Based on 2014-15 performance, a target of 35% is thought to be achievable.	1)To utilize the data mining component of the new EMR to identify those who are in need of breast cancer screening.	Identify and encourage those at risk of breast cancer to come in and begin the screening process.	Quarterly reporting on the number of people (predominantly women) who have accessed breast cancer screening.	To reduce the incidence of cancer in eligible patients, through regular screening.	
		Percent of eligible patients/clients who are up-to-date in screening for colorectal cancer.	% / PC organization population eligible for screening	EMR/Chart Review / TBD	92212*	20	30	In 2014-15 we spent the year training staff on the EMR and by the end of 2014-15 all staff will have had the training to access the EMR in a unified manor. Policies have been put in place to streamline data effectively. Based on 2014-15 performance, a target of 30% is thought to be achievable.	1)To utilize the data mining component of the new EMR to identify those who are in need of screening for colorectal cancer.	Identify and encourage those who are eligible for colorectal cancer screening to come in and begin the screening process.	Quarterly reporting on the number of people who have accessed colorectal screening.	To reduce the incidence of cancer in eligible patients through regular screening	
		Percent of eligible patients/clients who are up-to-date in screening for cervical cancer.	% / PC organization population eligible for screening	EMR/Chart Review / TBD	92212*	17	27	In 2014-15 we spent the year training staff on the EMR and by the end of 2014-15 all staff will have had the training to access the EMR in a unified manor. Policies have been put in place to streamline data effectively. Based on 2014-15 performance, a target of 27% is thought to be achievable.	1)To utilize the data mining component of the new EMR to identify those who are in need of screening for cervical cancer.	Identify and encourage women to come in for regular pap tests.	Quarterly reporting on the number of people who have had pap tests.	To reduce the incidence of cervical cancer through regular screening.	
	To increase access to Wellness and Healthy Lifestyle programs.	To broadly engage 1000 individuals in Wellness and Healthy Lifestyle programs.	Counts / N/a	EMR / 2014-2015	92212*	1000	1500	In 2014-15 we spent the year training staff on the EMR and by the end of 2014-15 all staff will have had the training to access the EMR in a unified manor. Policies have been put in place to streamline data effectively. In the past, we used to simply do Head Counts.With the implementation of the EMR, the participants in the Wellness and Healthy Lifestyles programs will be able to be tracked electronically in order to inform their primary healthcare practitioner of their activities within our Health Promotion activities. ie. smoking cessation, walking club, etc. Based on 2014-15 Performance and indicator of 2000	1)To have over 2000 persons attending our wellness and healthy lifestyle programs.	To have 2000 participants recorded in the new EMR as attending health promotion programs.	Quarterly reporting on the number of program participants registered within the new EMR	To increase access to Wellness and Healthy Lifestyle programs.	