De dwa da dehs nye>s Aboriginal Health Centre

We're Taking Care of Each Other Amongst Ourselves.

De dwa da dehs nye>s Aboriginal Health Centre

Quality Improvement Plan

2016-17

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Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

De dwa da dehs nye>s Aboriginal Health Centre

3/30/2016

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Ontario

Overview

The mission of De dwa da dehs nye>s Aboriginal Health Centre is to improve the wellness of Indigenous individuals and of the Indigenous 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 Indigenous 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 Indigenous 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.

QI Achievements From the Past Year

During the summer of 2015, the Mental Health Team suspended admission to the programs in order to put in place policies and procedures specific to the work of the Mental Health Team. A new referral process was implemented with the focus being placed on self-referrals to the program. As well, a new intake screening process was implemented to ensure that new clients are receiving the right care in the right place at the right time. New patients were accepted as of October 1, 2015. By November, there was no one on the Mental Health Waiting List. This indicator is monitored quarterly on the Centre's Balanced Scorecard.

Throughout 2015-16, the Primary Care Clinics have been understaffed and as a result Wait Lists were implemented for service. Internal staff resources were adjusted to allow for appropriate coverage in both clinics. In December, the Hamilton Clinic began taking on new patients. It is anticipated that by the end of the 2015-16 fiscal year, the Brantford Clinic will begin taking on new patients. The outstanding physician .2 FTE vacancy was filled in January 2016. A Wait List policy with an accompanying Decision Tree has been developed for Primary Care Services to provide direction to Managers and staff for a consistent method of optimizing access to services for clients.

The Quality policy for the Centre has also been under review in 2015/16 and is a work in progress for the Quality Committee in 2016/17. The aim is to have the policy reflect an Indigenous focus on health.

The model of care is also being reviewed. The intent is that the model reflects the coexistence of traditional healing practices and western medicine at the Centre. The model also incorporates the principles from applicable articles from the United Nations Declaration for the Treatment of Indigenous Peoples and recommendations from the Truth and Reconciliation Commission as they relate to health. The goal is that the model is universally used within the Centre by all programs and services and becomes a foundation for service delivery and all quality initiatives.

The Quality Committee also reviewed and refined the indicators on the Balanced Scorecard to improve how the information was presented and interpreted.

Integration & 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. These service providers include Corrections Services, Children's Aid Society to name a few.

During the spring of 2015, the Aboriginal Health Centre conducted a series of Community Engagement Sessions. At the sessions we asked participants to identify the enablers and barriers to individual health, family health and community health. In addition, we asked participants to identify their vision for the future. As well, children were given the opportunity to provide feedback either by survey or by drawing pictures related to each topic. This information will be used in Capital Planning and to inform quality initiatives in each Department.

Between June 19-21,2015 the Centre participated in A National Aboriginal Solidarity Day events in Hamilton and Brantford. At these sessions, community members were encouraged to answer a survey. The questions were the same as used during the spring community engagement sessions. 184 surveys were received from participants ranging throughout the age spectrum. This event created the opportunity for the Centre to connect with members of the community. Information will contribute to focusing our efforts to provide culturally appropriate services and programs that meet the needs of our community.

The Aboriginal Health Centre has focused on the utilization of the Centre's Electronic Medical Record (EMR) to track the internal and external referrals. With staff education the number of referrals continues to rise at both sites and is an indicator monitored on a quarterly basis on the Balanced Scorecard

Through the EMR the Aboriginal Health Centre is able to track the No Show rate. Although the rate remains higher than our identified target (12%), we persist in implementing different strategies to reduce the No Show rate.

Lastly, the Health Promotions Department has been utilizing the EMR to track its participants. This practice was introduced late in the 2014-15 fiscal year. As a result, the Health Promotions staff is better able to track the impact of programming on Indigenous Communities in Hamilton and Brantford. This data will also form the baseline other quality indicators.

Engagement of Leadership, Clinicians and Staff

The Board of Directors are beginning a Strategic Planning Process in the fall of 2015 and future sessions are scheduled for early spring 2016. At the upcoming sessions the Board will finalize the Strategic Plan for 2016-19. Following the finalized report, the Quality Committee will use the Strategic Plan to work on identifying some culturally appropriate indicators for the Health Centre to be tracking.

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, Program Managers, a Community Member with skills and knowledge in Continuous Quality Improvement. Staff input is represented by the

Management Team in attendance. The Committee monitors the Centre's performance through review of the quality indicators on our Balanced Scorecard

as well as the MSSA indicators. Compliance with regulatory requirements such as Occupational Health and Safety training are also monitored by the Committee and all of this information is summarized for submission to the Board.

The Management Team discusses quality improvement opportunities with staff at staff meetings and individual team 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.

Patient/Resident/Client Engagement

In December 2015, a Patient Satisfaction Survey was undertaken in the Primary Care Clinics. The survey provided respondents with the opportunity to identify areas where we are doing well and opportunities for improvement. The results of the survey were very positive. The responses also specifically provided feedback on some of our Improvement Targets and Initiatives. For example for the question about whether health care providers include the client in decisions about treatment/care, 14% of respondents rated this as good, 28% very good and 54% excellent. The Quality Committee reviewed the results of this survey Feedback obtained from all sources helps to determine how well we are doing on existing indicators and helps to inform 2016-17 quality improvement activities. Responses also inform Capital Planning and future space and resources needs of our clients. The results were summarized and presented to the Board.

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 we are making strides in obtaining quality data. It is anticipated that we will be adding Business Intelligence Reporting Tool (BIRT) on to our EMR and as a result will simplify the data mining process so that information from the EMR will be readily available.

Summary

2015/16 has been a year of forward momentum for the quality intiatives of the Centre. We are looking forward to developing our model of care and to exploring how we can take a leadership role in developing EMR outcome measures that address the unique issues of our Indigenous clients. Resource challenges remain however the ongoing support and commitment of all staff is what enables us to set and exceed our targets and to adjust those targets to sustain our gains.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Pat Mandy
Board Chair

Lina Rinaldi
Quality Committee Chair

Constance McKnight
Executive Director

2016/17 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 performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	Improve rate of cancer screening.	Percentage of patients aged 50-74 who had a fecal occult blood test within past two years, sigmoidoscopy or barium enema within five years, or a colonoscopy within the past 10 years	% / PC organization population eligible for screening	See Tech Specs / Annually	92212*	26	30.00	The data being collected is from our EMR and not based on laboratory data. We continue to monitor this indicator quarterly through our Management Committee.	1)The data being collected is from our EMR and not based on laboratory data. We continue to monitor this indicator quarterly through our Management Committee.	To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them.	Identify through the Business Implementation Reporting Tool (BIRT) and Nightingale on Demand eligible patients for colorectal cancer screening and encourage those patients 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
		Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years	% / PC organization population eligible for screening	See Tech Specs / Annually	92212*	23	30.00	The data being collected is from our EMR and not based on laboratory data. We continue to monitor this indicator quarterly through our Management Committee.	1)To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them.	Identify through the Business Implementation Reporting Tool (BIRT) and Nightingale on Demand eligible patients for pap tests and encourage those patients to come in and begin the screening process.	Quarterly reporting on the number of people who have had pap tests.	To reduce the incidence of cervical 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 / 2015-16	92212*	38	40.00	The data being collected is from our EMR and not based on laboratory data. We continue to monitor this indicator quarterly through our Management Committee.	1)To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them. Clinic staff would contact eligible patients to offer to provide the service to them.	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.	
	Improve rate of HbA1C testing for diabetics	Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months	% / All patients with diabetes	Ontario Diabetes Database, OHIP / Annually	92212*	54	57.00	This is a new indicator to our QIP. The data being collected is from our EMR and not based on laboratory data. We continue to monitor this indicator quarterly through our Management Committee.	1)To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them.	Identify through the Business Implementation Reporting Tool (BIRT) and Nightingale on Demand the number of patients that have received two or more HbA1C tests within the year to ensure that they are being monitored for pre-diabetes or diabestes.	Quarterly reporting on the number of people who have had two or more HbA1C tests in the past year.	To identify and support patients who are at risk or have diabetes to control blood sugar levels.	
	Improve seasonal Immunization rates	Percentage of people/patients who report having a seasonal flu shot in the past year	% / PC organization population eligible for screening	EMR/Chart Review / Annually	92212*	31	36.00	The data being collected is from our EMR and not based on laboratory data. In 2015-16 Flu Shot Clinics were offered in both clinic locations of the DAHC. We have noted a decrease in the number of flu shots receive by those 65+ this year. With pharmacies now offering free flu shot clinics, it is difficult to capture the true number of patients that are receiving the flu shot. Patients must self disclose to staff if they received their flu shot.	1)To utilize the data mining component of the new EMR to identify older adults who would benefit from the influenza vaccine. Clinic staff would contact eligible patients to offer to provide the service to them.	Continue to host Flu Shot Clinics in our offices	Inquired with patients to identify if they have received their flu shot at another location.	To reduce influenza rates in older adults.	
	Reduce hospital readmission rate for primary care patient population	Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission, by primary care practice model.	% / PC org population discharged from hospital	DAD, CAPE, CPDB / April 2014 – March 2015	92212*	8	7.50	This indicator is based on the the preliminary Practice Profile that was completed by the AOHC and ICES in October 2015. The Practice Profile analysed our data from April 1, 2012 to March 31, 2014. During this period we transitioned our Electronic Medical Record from Practice Solutions to Nightingale on demand. As a result we only had a sampling of data to be included in the calculation. A refresh of the profile is currently under way and will provide us with a better understanding of the current base for this indicator.	1)We have access to Clinical Connect and staff will be reviewing discharge data to identify patients who require follow up	We continue to encourage patients to follow up directly with the DAHC following discharge for follow up Care.	We are working with the hospitals to identify partnerships to provide better transitions for our clients.	To provide seamless primary care service/support to our patients	
Efficient	Decrease Emergency Department visits for conditions best managed elsewhere (BME)	Percentage of patients or clients who visited the emergency department (ED) for conditions “best managed elsewhere” (BME)	% / PC org population visiting ED (for conditions BME)	DAD, CAPE, CPDB / April 2014 – March 2015	92212*	12.5	12.00	This indicator is based on the the preliminary Practice Profile that was completed by the AOHC and ICES in October 2015. The Practice Profile analysed our data from April 1, 2012 to March 31, 2014. During this period we transitioned our Electronic Medical Record from Practice Solutions to Nightingale on demand. As a result we only had a sampling of data to be included in the calculation. A refresh of the profile is currently under way and will provide us with a better understanding of the current base for this indicator.	1)We have access to Clinical Connect and staff will be reviewing discharge data to identify patients who require follow up	We continue to encourage patients to follow up directly with the DAHC following discharge for follow up Care.	We are working with the hospitals to identify partnerships to provide better transitions for our clients.	Identify patients and their corresponding issues.	
	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 / All patients	EMR/Chart Review / 2016-17	92212*	415	436.00	Training was provided to clinical staff on how to complete internal referrals through the EMR. Staff were encouraged to refer patients/participants within the organization for other programs and services	1)To make referrals/access to the organizational basket of services more transparent 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.	
Equitable	Other	Add other measure by clicking on "Add New Measure"	Other / Other	Other / other	92212*	0	0.00	N/A	1)N/A	N/A	N/A	N/A	N/A

		Health equity allows people the opportunity to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are	Counts / Mental Health / Addiction patients	EMR/Chart Review / 2015-16	92212*	6999	8000.00	In 2015-16 the Health Promotions have engaged members of the community through programs and services such as camps, healthy living programs, and diabetes education sessions. By Q3 of 2015-16, we have exceeded our target by 5999 participants . This number is indicator is monitored quarterly by our Quality Committee. All of the	1)In 2015-16 the Health Promotions have engaged members of the community through programs and services such as camps, healthy living programs, and diabetes education sessions. By Q3 of 2015-16, we have exceeded our target by 5999 participants.	To have over 8000 persons attending our wellness and healthy lifestyle programs.	Quarterly reporting on the number of program participants registered within the new EMR	To increase access to Wellness and Healthy Lifestyle programs.	
Patient Experience	**Improve Patient Experience: Opportunity to ask questions**	Percent of respondents who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office give you an opportunity to ask questions about recommended treatment?"	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	92212*	96	100.00	The Patient Experience Feedback Survey was revised this year to better capture this indiciator. This new format, alllows respondents to directly answer this question.	1)To make paper/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.	
	Improve Patient Experience: Patient involvement in decisions about care	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 / April 2015 - March 2016	92212*	96	100.00	The Patient Experience Feedback Survey was revised this year to better capture this indicator. This new format, allows respondents to directly answer this question.	1)To make paper/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	
	Improve Patient Experience: Primary care providers spending enough time with patients	Percent of patients who responded positively to the question: "When you see your doctor or nurse practitioner, how often do they or someone else in the office spend enough time with you?"	% / PC organization population (surveyed sample)	In-house survey / April 2015 - March 2016	92212*	97	100.00	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 100% satisfaction rate is achievable in 2015-16. The new format of the survey has resulted in a 14% increase in satisfaction from the previous year.	1)To make paper/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.	
Timely	**Improve 7 day post hospital discharge follow-up rate for selected conditions**	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / PC org population discharged from hospital	DAD, CIHI / April 2014 – March 2015	92212*	32.1	33.00	This indicator is based on the the preliminary Practice Profile that was completed by the AOHC and ICES in October 2015. The Practice Profile analysed our data from April 1, 2012 to March 31, 2014. During this period we transitioned our Electronic Medical Record from Practice Solutions to Nightingale on demand. As a result we only had a sampling of data to be included in the calculation. A refresh of the profile is currently under way and will provide us with a better understanding of the current base for this indicator.	1)We have access to Clinical Connect and staff will be reviewing discharge data to identify patients who require follow up	We continue to encourage patients to follow up directly with the DAHC following discharge for follow up Care.	We are working with the hospitals to identify partnerships to provide better transitions for our clients.	To provide access to primary care appointments post-discharge through coordination with hospitals.	
	Improve timely access to primary care when needed	Percent of patients/clients who responded positively to the question: "The last time you were sick or were concerned you had a health problem, how many days did it take from when you first tried to see your doctor or nurse practitioner to when you actually SAW him/her or someone else in their office?"	% / PC organization population (surveyed sample)	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period available)	92212*	35	40.00	The Patient Experience Feedback Survey was revised this year to better capture this indicator. In previous years we have not specifically requested feedback on the availability of appointments within the same or next day.	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	
		Currently, patient "no shows" are an issue. We have implemented some measures over the past year (2015-16) that have improved our no-show rate; however, we still have an average of 19% per quarter.	Counts / All patients	EMR/Chart Review / 2015-16	92212*	19	12.00	In 2015-16 we continued with our focused efforts to 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. This past year we have seen a 2% reduction in this indicator. In 2016-17 our goal is to reduce the number of "No Show Appointments to 12% from 19%.	1)Clinicians are following up with No-Show patients by telephone.	Calling the patients to confirm their appointment the day before	Quarterly reporting on no-show rate	To reduce the no-show rate to 12%	