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

## 2017-18

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Excellent Care for All

## Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 1 | 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.<br>( Counts; All patients; 2015-16; EMR/Chart Review) | 92212 | 19.00 | 12.00 | 17.00 | We continue to address No-Show clients at De dwa da dehs nye>s Aboriginal Health Centre. For the first three quarters of the 2016-17 fiscal year, we have are averaging 17% No Show rate in our Primary Care Department. We continue to do complete reminder the calls the day prior. |

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

| Change Ideas from Last Years QIP (QIP 2016/17) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Clinicians are following up with No-Show patients by telephone. | Yes | Physicians do contact patients that have missed appointments to identify the reason and to assist in rescheduling. |
| Walk in access for Chronic No Show Patient | Yes | In Primary Care, the DAHC piloted a process to assist a Chronic No Show Client who has acknowledged their difficulty keeping scheduled appointments, to have the client attend in clinic on a walk-in basis. This has been successful for this client and the client has not missed a follow up appointment since the implementation of the new protocol. We will be expanding this process to additional Chronic No Show patients at both clinics. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 2 | 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 patients; 2015-16; EMR/Chart Review) | 92212 | 6999.00 | 8000.00 | 5884.00 | We continue to provide community outreach through our Healthy Living Department. We conduct large community events, program workshops, lunch and learns and camps. |

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|---|---|---|
| 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. | Yes | We continue to grow our programming to meet the needs of the community. We provide meals at every program to ensure that participants have access to food security. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 3 | Percent of eligible patients/clients who are up-to-date in screening for breast cancer. ( %; PC organization population eligible for screening; 2015-16; EMR/Chart Review) | 92212 | 38.00 | 40.00 | 51.00 | We have achieved and exceeded our target at the end of the third quarter of 2017-18. |

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|---|---|---|
| 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. | Yes | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 4 | Percent of patients or clients who visited the emergency department (ED) for conditions "best managed elsewhere" ( %; PC org population visiting ED (for conditions BME); April 2014 – March 2015; DAD, CAPE, CPDB) | 92212 | 12.50 | 12.00 | 12.50 | At this time we are awaiting the refresh of our Practice Profile. The information for this indicator is available in this report. |

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| Change Ideas from Last Years QIP (QIP 2016/17) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| We have access to Clinical Connect and staff will be reviewing discharge data to identify patients who require follow up | Yes | Although we have access to Clinical Connect it is important to note that we are not alerted in the program to when one of clients have been discharged from hospital. |
| Empowering Patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital. | Yes | When patients are calling to schedule an appointment, our reception staff are asking if the appointment is in follow up to a discharge from hospital. As well, clinicians are reminding patients that if they were in hospital that they should notify the health centre for follow up. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 5 | 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); April 2015 - March 2016 ; In-house survey) | 92212 | 97.00 | 100.00 | 95.00 | The patient experience survey was opened up to a larger group for input this year. As a result, the current performance is slightly lower than reported in the past fiscal year. |

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|---|---|---|
| To make paper/electronic surveys available to our patients. | No | No, we will be utilizing this approach in the 2017-18 fiscal year. It was the first year we offered the survey across the organization and we are still finalizing questions for the survey. The survey will then be made available on our website and on other remote technology to allow patients to provide feedback. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 6 | 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); April 2015 - March 2016 ; In-house survey) | 92212 | 96.00 | 100.00 | 94.00 | The patient experience survey was opened up to a larger group for input this year. As a result, the current performance is slightly lower than reported in the past fiscal year. |

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| To make paper/electronic surveys available to our patients. | No | No, we will be utilizing this approach in the 2017-18 fiscal year. It was the first year we offered the survey across the organization and we are still finalizing questions for the survey. The survey will then be made available on our website and on other remote technology to allow patients to provide feedback. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 7 | Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions. ( %; Discharged patients with selected HIG conditions; April 2014 – March 2015; CIHI DAD) | 92212 | 32.10 | 33.00 | 31.00 | The current performance is based on the 2012-14 Practice Profile. The refresh of the Practice Profile report was intended to be released in December 2016. However, due to technical glitches we have not received the refreshed report and we are utilizing the current data that we have. |

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|---|---|---|
| We have access to Clinical Connect and staff will be reviewing discharge data to identify patients who require follow up | Yes | We have access to Clinical Connect, however, the program does not alert you when a patient has been admitted and/or discharged from hospital. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 8 | 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); April 2015 - March 2016 ; In-house survey) | 92212 | 96.00 | 100.00 | 99.00 | We are doing well with this indicator. As a result, we have increased the target in 2017-18 to 100%. |

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|---|---|---|
| To make paper/electronic surveys available to our patients. | No | No, we will be utilizing this approach in the 2017-18 fiscal year. It was the first year we offered the survey across the organization and we are still finalizing questions for the survey. The survey will then be made available on our website and on other remote technology to allow patients to provide feedback. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 9 | 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.<br>( %; Discharged patients with selected HIG conditions; April 2014 – March 2015; CIHI DAD) | 92212 | 8.00 | 7.50 | 8.00 | At this time we are awaiting the refresh of our Practice Profile. The information for this indicator is available in this report. |

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|---|---|---|
| We have access to Clinical Connect and staff will be reviewing discharge data to identify patients who require follow up | Yes | Although we have access to Clinical Connect it is important to note that we are not alerted in the program to when one of clients have been discharged from hospital. |
| Empowering Patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital. | Yes | When patients are calling to schedule an appointment, our reception staff are asking if the appointment is in follow up to a discharge from hospital. As well, clinicians are reminding patients that if they were in hospital that they should notify the health centre for follow up. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
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| 10 | Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.<br>( %; PC organization population (surveyed sample); Apr 2015 – Mar 2016 (or most recent 12-month period available); In-house survey) | 92212 | 35.00 | 40.00 | 41.76 | We have left spots open each day for same day appointments. |

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|---|---|---|
| Keeping one appointment time open each day, at each site, to support patients when needed. | Yes | Yes this approach has been successful in providing greater access to patient appointments. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 11 | Percentage of patients with diabetes, aged 40 or over, with two or more glycated hemoglobin (HbA1C) tests within the past 12 months ( %; patients with diabetes, aged 40 or over; Annually; ODD, OHIP-CHDB,RPDB) | 92212 | 54.00 | 57.00 | 58.00 | We have exceeded our target for 2016-17 by the end of the third quarter. |

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|---|---|---|
| To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them. | Yes | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 12 | Percentage of people/patients who report having a seasonal flu shot in the past year ( %; PC organization population eligible for screening; Annually; EMR/Chart Review) | 92212 | 31.00 | 36.00 | 35.00 | We are at 35% at the end of the third quarter of 2016-17. It is anticipated that we will reach the full rate by the end of the fiscal year. |

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|---|---|---|
| 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. | Yes | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the vaccine and were contacted to schedule the appointment. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 13 | Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years, other investigations (i.e., flexible sigmoidoscopy) within the past 10 years or a colonoscopy within the past 10 years.<br>( %; PC organization population eligible for screening; Annually; See Tech Specs) | 92212 | 26.00 | 30.00 | 38.00 | We have exceeded our 2016-17 target at the end of the third quarter. |

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|---|---|---|
| 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. | Yes | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 14 | Percentage of women aged 21 to 69 who had a Papanicolaou (Pap) smear within the past three years ( %; PC organization population eligible for screening; Annually; See Tech Specs) | 92212 | 23.00 | 30.00 | 60.00 | We have exceeded our target for 2016-17 at the end of the third quarter. |

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|---|---|---|
| To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them. | Yes | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment. |

| ID | Measure/Indicator from 2016/17 | Org Id | Current Performance as stated on QIP2016/17 | Target as stated on QIP 2016/17 | Current Performance 2017 | Comments |
|---|---|---|---|---|---|---|
| 15 | The new EMR will allow for internal referrals within the organization to be completed and reported on within the patient electronic medical record<br>( Counts; All patients; 2016-17; EMR/Chart Review) | 92212 | 415.00 | 436.00 | 664.00 | We have surpassed our 2016-17 target at the end of the third quarter. |

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| Change Ideas from Last Years QIP (QIP 2016/17) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| To make referrals/access to the organizational basket of services more transparent and user friendly. | Yes | Yes the referrals across all programs at De dwa da dehs nye>s have exceeded the target. As an AHAC we are wrapping the services that we offer around the patient which exemplifies how we are taking care of each other amongst ourselves. |

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

**3/28/2017**

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.

## 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 wholistic 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. There continues to be a Wait List for Mental Health services. This indicator is monitored quarterly on the Centre's Balanced Scorecard.

Throughout 2016-17, the Primary Care Clinics have been understaffed due to paternity leaves and as a result Wait Lists were implemented for service. Internal staff resources were adjusted to allow for appropriate coverage in both clinics. In October 2016, we secured a locum to provide coverage for the paternity leave. Although both clinics are accepting new patients there is still a backlog of potential clients on the waiting list. As of December 31, 2016 there are 78 people on the waiting list in Brantford and 25 on the waiting list in Hamilton for Primary Care Services. In addition, we also had 21 people each on the waiting list in both Hamilton and Brantford for Mental Health Services.

In June 2016, the Board of Directors approved the 2016-2019 Strategic Plan. The Strategic Plan includes four pillars: Breaking Ground, Quality, Cultural Reclamation, and Enhanced Leadership. The Board of Directors have identified the importance of Quality Improvement and have identified key priorities for Quality Improvement for the organization. As a result, in January 2017, the staffing structure was restructured to better meet the four pillars of the strategic plan.

During the 2017-18 fiscal year, we will begin the readiness assessment for the accreditation process with the Canadian Centre for Accreditation. As a result, we will be conducting a review of our policies and procedures. Completing the readiness assessment has been identified as a Strategic Initiative for DAHC over the next two years.

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 Rights 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. At every Board Meeting and Staff Meeting the Calls to Actions for the Truth and Reconciliation Commission are reviewed.

Programs throughout the DAHC are experiencing a significant No Show Rate. To address this issues, staff at both sites conduct reminder calls for all patient appointments the day prior. Although these calls do reduce the number of No Show appointment, it is a significant investment of staff time. The Leadership Team are exploring the use of students and/or volunteers to conduct the reminder calls.

In Primary Care, the DAHC piloted a process to assist a Chronic No Show Client who acknowledged difficulty keeping scheduled appointments, to have the client attend on a walk-in basis. After several No Show appointments, the Clinic Services Manager met with the patient to identify a process to serve the patient in a manner that would best suit the patient. The patient who has Fetal Alcohol Spectrum Disorder (FASD) acknowledge that he does not manage well with pre-scheduled appointment times and often becomes stressed resulting in missed appointment(s) with his providers. The Clinic Services Manager and the patient agreed not to schedule appointments for this client; however, to offer the patient walk-in appointments on specific dates and times to alleviate the anxiety and stress the patient was experiencing with pre-scheduled appointments. It was acknowledged that obtaining appointments in this matter may require the patient to have a longer wait for the appointment. This has been successful for this client and the client has not missed a follow up appointment since the implementation of the new protocol. As a result of the success of this pilot we will be expanding this process to additional Chronic No Show patients at both clinics.

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

## Population Health

De dwa da dehs nye>s Aboriginal Health Centre (DAHC) services the Urban Indigenous Populations in Hamilton and Brantford. With investments by the Hamilton Niagara Haldimand Brant Local Health Integration Network we have been able to extend our reach into the Niagara region by providing Adult Mental Health and Patient Navigation Services.

In 2015-16 fiscal year, a Practice Profile Report was prepared by the Institute for Clinical Evaluation Services (ICES) for the AHAC Sector. The report compared the Aboriginal Health Access Centres (AHACs) on a number of indicators. The data to support this report was collected from data from our Electronic Medical Record (EMR) and the broader health care sector via health card number for the period of April 1 2012 to March 31, 2014. Some of our earlier patient information was not able to be migrated from our previous EMR to Nightingale on Demand (NOD), thus only a portion of data was used for comparison (1086 patients), it still represented the fourth highest data sample compared. We are in the process of refreshing the practice profile report; however, the updated report has not been released by ICES.

A summary of the key indicators is below:

- 63.6% of the patients seen by DAHC are in the two lowest income Quintiles (the AHAC average is 58.8%)
- 65.9% of our patients were not seen by or enrolled with another Primary Care Provider (the AHAC average is 39.5%)
- DAHC SAMI score was 1.5 (AHAC average is 1.34)
- DAHC has exceeded the AHAC average for the three cancer screenings compared
  - Mammography - 50.8% (DAHC) compared to 44.9% (AHAC sector)
  = Cervical Screening - 73.0% (DAHC ) compared to 64.4% (AHAC sector)
  - Colorectal Screening - 56.2% (DAHC) to 43.4% (AHAC Sector)

The Practice Profile Report pulls data from across the health sector (based on health card number) for the rostered patients in the DAHC. This number will differ from what is internally generated from our Electronic Medical Record as we only have our internal data.

Relationships are an important part of the Indigenous culture and of the DAHC. It is important for our staff to develop and cultivate relationships with our clients in order to create an environment that is culturally safe. This is evident in our Practice Profile which identifies that 65.9% of our patients are not enrolled with or seen by any other Primary Care Provider. As we continue to proceed in our capital planning process, there will be a greater demand for services from DAHC.

In 2011, De dwa da dehs nye>s, in partnership with Ontario Native Women's Association (ONWA), and Tungasuvvingat Inuit (TI) and a health research team led by Dr. Janet Smylie based at the Centre for Research on Inner City Health (CRICH), Saint Michael's Hospital released Our Health Counts.

Our Health Counts is a unique, collaborative research project developed by OUR First Nations community for the benefit of OUR people. It is the culmination of two and half years of work, bringing to light missing population-based health information on First Nations adults and children living in an urban setting. Seven hundred and ninety people living in the city of Hamilton participated in detailed discussions to help us better understand how their health, housing, poverty, history of colonization and culture intersect.

Some of the key findings from Our Health Counts are outlined below:

Health Access:
- "Our health deserves appropriate and dedicated care"
- There is an urgent need for improved health care access
- 40% of FN people rated access to health care as fair to poor
- Barriers to care that people report:
  - 48% report long waiting lists
  - 35% report difficulty accessing transportation
  - 32% can't afford direct costs associated with health care
  - Doctors are not available
  - 24% lack trust in health care providers
- Stigma & discrimination play a contributing role
  - "We need more Aboriginal people in health care, education, places where people are looking up to other people. More native role models."

De dwa da dehs nye>s has programs in place to help the urban Indigenous population in Hamilton and Brantford have greater access to Health Service. The programs are:

- Wheels for Seniors - this is a transportation program for seniors and those with chronic mobility issues. to attend programs and services that will improve their physical, mental, emotional, and spiritual health. Due to the prevalence of

chronic disease in the Indigenous population, early on-set aging is experienced at a higher rate.
- Access to Care - We have one evening clinic per week at each site. We have also piloted Saturday Walk-in Clinics for rostered primary care patients at the Hamilton site. These initiatives are providing patients who have difficulty attending during regular clinic hours the opportunity to access weekend appointment.

Chronic Disease & Disability:
- First Nations people are carrying a greater health burden and at a younger age
- Poor health limits their functional activity
- 16% of FN people have diabetes (3 x general pop.)
- 26% have high blood pressure (20% general pop.)
- 31% have arthritis (20% general pop.)
- 9% FN people have Hepatitis C (> 1% within the general population)
- 36% of people report their health is fair to poor
- Half to 3/4 of adults have limitations due to illness
- First Nations men feel their health is better than FN women
- 18% of First Nations women feel health is excellent/good
- Compared to 61% for women within general population.

De dwa da dehs nye>s has a Diabetes Education Program that provides diabetic education, nutritional counselling and foot care services (chiropody, reflexology and foot care nurse)to diabetic patients or those who are at risk of diabetes.

Emergency Room (ER)Use:
- First Nations more likely to use Emergency Room (ER) to access health care
- People are using ER for both acute & non-acute illness
- 50% report using ER in past year - compared to 22% for general population
- 11% people report having more than 6 visits - compared to < 2% general population
- ER use rates holds true for both children and adults
- Children are less likely to be admitted to hospital than non-native children
- Even with comparable or more severe symptoms of illness
- This raises questions of whether there is a systemic bias toward not admitting non-native children?

The Aboriginal Patient Navigator positions at De dwa da dehs nye>s assists indigenous patients who are in community and/or hospital to navigate the available services available (internal to De dwa da dehs nyes, other Indigenous community support programs and/or mainstream programs and services). The APN program was initially targeted for Indigenous individuals living in the community that are having difficulty in navigating the health system. Through the evolution of the program there has been a greater utilization of the APN services for indigenous persons in Hospital. This increase demand is due to advocacy the APNs provide on behalf of their clients is able to break down barriers in health navigation.

## Equity

The Health Centre serves all Indigenous people, regardless of status and offers assistance to outside service organizations to provide care in a culturally appropriate and safe manner, throughout the life cycle.

We know from Our Health Counts (although only conducted in Hamilton we will use the data to support the Brantford community as well) that the Indigenous population have an inequitable access to the social determinants of health. Social determinants of health include: food security, income, healthcare, housing, employment & job security, transportation, early childhood education, education and training.

Only 57% of adults 18 and older have completed high school. 69% of FN people in Hamilton are on provincial or municipal assistance. Only 22% of First Nations people in Hamilton earn over $20,000.

Homeward Bound: From Homelessness to Community
In April 2015, De dwa da dehs nye>s received funding from the City of Hamilton through the Housing First initiative, to provide services to the chronically and episodically homelessness indigenous persons in the City of Hamilton.

When an Indigenous person is without a home, the ability to attain and maintain a job is compromised, as is their access to education, food security, social safety network, health services, and community resources. There is a negative impact on their families, including their children. Issues of gender, disability and race are all compounded by inequities in the existing systems. According to Statistics Canada, just over 3% of Hamilton's population self identifies as Aboriginal, yet they make up 28% of the homeless in our city. We seek to meet people where they are, work with them to develop goals, and walk beside them on their journey.

The full team was assembled in May 2015, and by June 10th we had housed our first individual. By March 31, 2106, we had housed 33 individuals, with lower than the city average needing re-housing or returning to homelessness. This represents almost half of the City of Hamilton housing rate.

At the end of the third quarter of the 2016-17 fiscal year, the Homeward Bound team has housed 38 indigenous individuals.

Our collaborative work methods extend beyond our team, and we work with our sister organizations to provide wrap around support for the individuals we serve. We have partnerships with many other programs including the Mental Health and Street Outreach Team through Public Health, City of Hamilton. Both teams work together to walk the streets, trails and parks of Hamilton and engage those in need. Homeward Bound: From Homelessness to Community is now represented at many planning tables and committees in Hamilton. Our team is also involved in providing programming and support, such as talking circles, drumming, traditional dancing, socials, and educational sessions on health and wellness encompassing all four directions of the medicine wheel.

## Integration and Continuity of Care

Our Aboriginal Patient Navigators (APNs) work very closely with the hospitals in the Hamilton (Hamilton Health Sciences and St. Joseph's Healthcare Hamilton), Brantford (Brant Community Health System), and Niagara (Niagara Health System) for client referrals to provide navigation and support services for patients in hospital and upon discharge. In addition, the APNs also work closely with the community based Indigenous and main stream agencies to link services for patients within the program.

Our Mental Health Youth Patient Navigator works with the local school and Indigenous and mainstream agencies to health link Indigenous youth to services to improve their social determinants of health.

Our Diabetes Education Program works with the Ophthalmology Clinic, run in partnership with St. Joseph's Healthcare Hamilton and Hamilton Health Sciences, to provide retinal screening for our diabetic patients that are enrolled in the Diabetes Education Program. 16% of First Nations people have diabetes is is hoped that this partnership will contribute to vision health for our patients.

Our Primary Care Clinic is forging a relationship with the Hamilton Pain Clinic to provide our clinicians with assistance in providing care to our complex patients with pain management needs.

## Access to the Right Level of Care - Addressing ALC Issues

As stated previously, our name translates to "taking care of each other amongst ourselves". This concept is foundational in how the organization operates. Everything we do is for the benefit of our patients. We know that being in hospital longer than required is not in the best interest of our patients. That is why our APNs are providing a greater number of services in hospitals connecting patients with programs and supports to assist in their discharge and to support them living independently in the appropriate environment.

The following are success stories of the APN impact on the Brantford, Hamilton and Niagara communities:

Brantford Success Story:
I received a call from a gentleman who was homeless and had some medical issues. I made some calls and got him into the Salvation Army Men's Hostel. There he had a bed and food. He needed help with getting his ID. I provided him with the forms and assisted him in the completion of the documentation as also had vision issues.

Over the coarse of our meetings he would open up more and more and became more trusting of me. He had a history of being taking advantage of in the past which left him in debt and lost his family, home, car, etc. As a result, it has taken a toll on clients well being. He said he almost lost his will to be happy again. I assisted him with transportation arrangements, medical bracelets, and switching pharmacies for more accessibility. He is now living in transitional housing for indigenous men. His health is back on track as I connected him with the DAHC where is he is receiving great health care advice from our Dietitian, foot care, reflexology, traditional healing and he is also participating in programming now. He still needs reminders of some appointments he has and to keep on track with a calendar we created. Since everything seems to becoming full circle with his well being, he is now focusing on more permanent housing. He is very grateful for all the continued help he receives.

Hamilton Success Story
I received a text from a daughter of a patient at Hamilton General Hospital ICU. The patient had a serious stroke and was in critical condition. The family had gathered at hospital ICU waiting area and met with APN. I explained services offered by DAHC and said at this time we would be able to provide supportive visits and traditional healing due to patient's condition. The family had learned of the APN program from Contact Cards I had placed in ICU waiting room.

I did not meet patient this day as he was unconscious. I connected with traditional healing program at the DAHC and requested a joint visit. I feel this is important for our own support and well being in these critical situations. The hospital's Spiritual Care was contacted as to request a time for our visit as there would be five or more people attending this small ceremony in ICU room. A time was arranged, family was gathered (partner, daughter and two sons), Traditional Healing Service Coordinator and myself. A water ceremony was performed for the patient. Family was very receptive, participated and was grateful for the visit and our time.

We visited again 2 weeks later. This time, the patient was sitting up in a chair, not speaking but seemed moderately responsive to people and sounds. His daughter-

in-law, sister, daughter and partner were present this time. The Traditional Healing Service Coordinator sang a song and the patient was moving his feet as though in time with the song. The family was joyous as was everyone in the room. The patient seemed to fully enjoy the songs provided on this day.

Niagara Success Story:
The APN program continues to grow in the Niagara Region. Community engagement and program promotion have been successful measured from the variety and amount of referrals coming into the program. Most recently, I was able to successfully follow through with a community member dealing with complex health issues with positive outcomes.

A woman in her later 40's experiencing chronic health issues and addiction was referred to the APN program earlier in the year (May 2016). Upon meeting the client it was clear that this individual was facing many barriers: low income, family discord, discrimination, accessibility, and safe housing. This individual often found themselves in and out of hospital and on the streets due to addiction and lack of social and cultural support. With no where left to go and very little support from surrounding resources, a medical social worker from the Greater Niagara General Hospital and I were able to work closely with this individual to create a plan of care that was specific to her needs.

After many discussions and interactions the APN identified that this particular community member was in need of returning to her home community for the cultural and social support she required (Durham Region). The client agreed. Once this was established, I was able to arrange a safe transfer to a therapeutic facility close to her home reserve that met all the client's needs in terms of her mental and physical health. To ease the transition I also contacted the clients Band Office to arrange an Outreach Worker to meet with her once she arrived and was settled in the area. In addition to coordinating the services and providers involved, including an Aboriginal Mental Health Worker in the area, I also worked with the medical social worker to arrange a medical transfer (transportation), required medical equipment (Wheel Chair) and CCAC services.

Had this plan not followed through it was very possible that this individual would have ended up back on the streets with traumatic results. Since then this individual has contacted me to express her thanks and gratitude for all the support and time given to support her.

Our people are amongst the most marginalized and impoverished in Ontario. Many need transportation services to access care. In addition, our Wheels for Seniors program is aimed at providing transportation services for socially isolated seniors and individuals with mobility issues.

The program provides greater opportunities to attend medical and specialist appointments. As well, there is greater access to surgical procedures that may have not received due to lack of transportation to and/or from the service location. The Program provides transportation opportunities for isolated seniors to attend a harmony of western and traditional practices.

The APN program also provides services to Alternate Level of Care patients in hospital and community. The APNs assist ALC clients to navigate the health system to access the appropriate levels of care. In some instance, through advocacy and navigation by the APNS have been able to have patients who were in hospital return to home with the appropriate supports in place.

## Engagement of Clinicians, Leadership & Staff

The Board of Directors approved a Strategic Plan in June 2017. The Strategic Plan includes four pillars: Breaking Ground, Quality, Cultural Reclamation and Enhanced Leadership. The Quality Pillar identifies that the health centre will begin the process for accreditation and identify culturally appropriate indicators.

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, Chief Operating Officer, Program Managers, Team Leads and a Community Member with skills and knowledge in Continuous Quality Improvement.

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, Leadership Team, the Committee and the Board related to the priority objectives selected for the annual Quality Improvement Plan.

## Resident, Patient, Client Engagement

In December 2016, a Patient Satisfaction Survey was undertaken across all programs of the health centre. 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. The Quality Committee reviews the results of the survey.

Feedback obtained from all sources helps to determine how well we are doing on existing indicators and helps to inform 2017-18 quality improvement activities. Responses also inform Capital Planning and future space and resources needs of our clients.

The results were summarized and will be presented to the staff and Board.

## Staff Safety & Workplace Violence

Every year the staff of De dwa da dehs nye>s are required to participate in Workplace and Harassment Training. In the 2016-17 fiscal year we have created and approved policies to ensure the safety of clients, staff and volunteers. In addition, the complaint policy was revised and streamlined.The Leadership Team presents through the Quality Committee to the Board on staff satisfaction and incident reports.

All complaints or workplace violence and/or harassment are investigated and the results are communicated to all parties involved.

Annually, all staff are required to take WHMIS training.

Staff are ensuring that the current policies are compliant with the new requirements under Bill 132 and then the policy will undergo a legal review to ensure it meets all requirements under the legislation.

## Contact Information

The contact information for De dwa da dehs nye>s Aboriginal Health Centre is as follows:

De dwa da dehs nye>s Aboriginal Health Centre
678 Main Street East
Hamilton ON  L8M 1K2
905-544-4320

The following are the Quality Improvement Contacts for the organization:

Staff Lead:
Jo-Ann Mattina, Chief Operating Officer
ext. 231 or jmattina@dahac.ca

Executive Director:
Constance McKnight, Executive Director
ext. 261 or cmcknight@dahac.ca

Board Chair:
Pat Mandy, Board Chair
ext. 261 or pmandy@dahac.ca

Quality Committee Chair:
Lina Rinaldi, Quality Committee Chair
ext. 261 or lworkman@dahac.ca

## 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 in the 2017-18 fiscal year and as a result will simplify the data mining process so that information from the EMR will be readily available.

2016-17 has been a year of forward momentum for the quality initiatives 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.

2017-18 will continue to build on the momentum of the last fiscal year.  In addition to beginning the process for Accreditation and two capital projects, we will be hosting a national conference in October 2017.  The Building on Our Roots: Indigenous Health Research and Practice Conference will be held in Hamilton on October 17 & 18, 2017.  There will be some pre-conference activities on October 16, 2017.  The vision of the conference is to provider researchers, practitioners (any person providing services related to the social determinants of health and educators to present on best practices and to push the quality improvement spectrum for the care of the Indigenous and mainstream communities.

In addition, we are presently in Stage 1 of the Community Capital Planning Process for new community hubs in the Cities of Brantford and Hamilton. As we collect data to support our capital projects we utilize the data that we have been collecting to support our planning for the projects to increase the health and well being of the Indigenous Community.

## 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

Board Chair Pat Mandy

Quality Committee Chair or delegate Lina Rinaldi

Executive Director / Administrative Lead Constance McKnight

# 2017/18 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 | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Quality dimension | Issue | Measure/Indicator | Unit / Population | Source / Period | Organization Id | Current performance | Target | Target justification |
| Effective | Effective transitions | Percent of patients/clients who see their primary care provider within 7 days after discharge | % / Discharged patients with selected HIG conditions | CIHI DAD / April 2015 - March 2016 | 92212* | 31 | 33.00 | We are still collecting baseline data for this indicator. At the end of the |
| | | Percentage of acute hospital inpatients discharged with selected HIGs that are readmitted to any | % / Discharged patients with selected HIG conditions | CIHI DAD / April 2015 - March 2016 | 92212* | 8 | 7.50 | We have not adjusted this indicator in the 2017-18 QIP as we are awaiting |
| | **Population health - cervical cancer 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* | 60 | 63.00 | We had a significant increase in this indicator in 2016-17; therefore, we |
| | **Population health - colorectal cancer screening** | Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years, other | % / PC organization population eligible for screening | See Tech Specs / Annually | 92212* | 38 | 40.00 | We exceeded the target for this indicator in 2016-17; therefore, we are projecting a |
| | **Population health - diabetes** | Percentage of patients with diabetes, aged 40 or over, with two or more glycated | % / patients with diabetes, aged 40 or over | ODD, OHIP-CHDB,RPDB / Annually | 92212* | 58 | 61.00 | This is only the second year collecting this information. By the third quarter |
| | **Improve seasonal Immunization rates** | Percentage of people/patients overe 65 who report having a seasonal flu shot in the past year | % / PC organization population eligible for screening | CCO-SAR, EMR / 2016-17 | 92212* | 35 | 36.75 | We were close to meeting this indicator at the end of Q3 in 2016-17; |

| | | | | | | | | |
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| | | | | | | | | therefore, we are projecting a 5% increase in this indicator for 2017-18. |
| | **Population health - breast cancer screening** | Percent of eligible patients/clients who are up-to-date in screening for breast cancer. | % / PC organization population eligible for screening | CCO-SAR, EMR / 2016-17 | 92212* | 51 | 53.00 | We exceeded the target for this indicator in 2016-17; therefore, we are projecting a |
| **Efficient** | **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 | Counts / All patients | EMR/Chart Review / 2016-17 | 92212* | 664 | 698.00 | We have exceeded our 2016-17 target as of the end of the third quarter |
| | **Decrease Emergency Department visits for conditions best managed elsewhere (BME)** | Percentage of patients or clients who visited the emergency department (ED) for | % / PC org population visiting ED (for conditions BME) | ICIS / 2016-17 | 92212* | 12.5 | 12.00 | We are still waiting for the release of the Practice Profile for the |
| **Equitable** | **Outreach to the community** | Health equity allows people the opportunity to reach their full health potential and receive | Counts / Health Promotions | EMR/Chart Review / 2016-17 | 92212* | 5884 | 8000.00 | We had an aggressive target in 2016-17 for the Healthy Living |
| **Patient-centred** | **Person experience** | Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else | % / PC organization population (surveyed sample) | In-house survey / April 2016 - March 2017 | 92212* | 94 | 100.00 | To gauge the patients involvement in their health care journey. |
| | **Improve Patient Experience: Opportunity to ask questions** | Percent of respondents who responded positively to the question: "When you see your | % / PC organization population (surveyed sample) | In-house survey / 2016-17 | 92212* | 99 | 100.00 | To gauge patient's perception of their involvement in |
| | **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 | % / PC organization population (surveyed sample) | In-house survey / 2016-17 | 92212* | 95 | 100.00 | To gauge patient's perception of the amount of time spent with |

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| **Timely** | **Timely access to care/services** | Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or | % / PC organization population (surveyed sample) | In-house survey / April 2016 - March 2017 | 92212* | 41.76 | 44.00 | To ensure timely access to primary care services. |
| | **Improve timely access to primary care when needed** | To reduce the number of no show appointments in order to provide greater access to primary care services for those who are requesting appointments. | % / All patients | EMR/Chart Review / 2016-17 | 92212* | 17.33 | 12.00 | De dwa da dehs nye>s Aboriginal Health Centre's Quality Committee has internally set a target of 12% for no shows. |

| Change | | | | |
|---|---|---|---|---|
| **Planned improvement initiatives (Change Ideas)** | **Methods** | **Process measures** | **Target for process measure** | **Comments** |
| 1)Empowering Patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital. | When patients are calling to schedule an appointment, our reception staff are asking if the appointment is in follow up to a discharge from hospital. As well, clinicians are reminding patients that if they were in hospital that they should notify the health centre for follow up. | An increase in the number of patients seeing their primary care provider within 7 days after discharge from hospital for selected conditions. | To provide access to primary care appointments post-discharge through coordination with | |
| 1)Empowering Patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital. | When patients are calling to schedule an appointment, our reception staff are asking if the appointment is in follow up to a discharge from hospital. As well, clinicians are reminding patients that if they were in hospital that they should notify the health centre for follow up. | An reduction in the percentage of patients who are readmitted to hospitals for select HIGs. | To provide seamless primary care service/support to our patients. | |
| 1)To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them. | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment. | Reports from our EMR will be utilized to identify patients eligible for the screening. | To reduce the incidence of cervical cancer through regular screening. | |
| 1)To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the screening to them. | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment. | Reports from our EMR will be utilized to identify patients eligible for the screening. | To reduce the incidence of cancer in eligible patients through regular screening | |
| 1)To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them. | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment. | Reports from our EMR will be utilized to identify patients eligible for the screening. | To identify and support patients who are at risk or have diabetes to control blood sugar | |
| 1)To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them. | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the vaccine and were contacted to schedule the appointment. | Reports from our EMR will be utilized to identify patients eligible for the vaccine. | To reduce the incidence of influenza in people/patients over the age of 65. | |

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| 2)Discussions with patients at regular appointments to offer the flu shot or to identify if the flu shot has been received elsewhere. | Clinicians (Physicians and Nurse Practitioners) will offer patients the flu shot at appointments during the flu season. If the patient has received a flu shot elsewhere it will be noted in the patient file. | Conversations with patients regarding the benefits of flu shots and offering the vaccine at scheduled appointments. | Reduce the number of patients/participants over 65 contracting the flu. | |
| 1)To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the screening to them. | Through the utilization of our Electronic Medical Record (EMR) we were able to identify patients who were eligible for the screening and were contacted to schedule the appointment. | Reports from our EMR will be utilized to identify patients eligible for the screening. | To reduce the incidence of cancer in eligible patients through regular screening | |
| 1)To make referrals/access to the organizational basket of services more transparent and user friendly. | Staff have utilized the Electronic Medical Record to record in the internal referrals between programs offered at De dwa da dehs nye>s. | Quarterly reporting on the number of referrals made through the new EMR. | To ensure quick and efficient hand-off of patients amongst departments. | |
| 1)We are exploring opportunities for evening and weekend access to primary care services. | We are piloting monthly weekend primary care clinics in Hamilton. | Reducing the percentage of patients from access the Emergency Departments for conditions best managed elsewhere. | Identify patients and their corresponding issues. | |
| 1)In 2016-17 the Healthy Living Department hasengaged members of the community through programs and services such | 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. | |
| 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 | |
| 1)To gauge patient's opportunity to ask questions about recommended treatment. | To make paper/electronic surveys available to our patients. | To equip tablets and computers on-site with satisfaction surveys. | To ensure patient satisfaction. | |
| 1)Patients are satisfied with the amount of time that the clinician spends with them during their appointment. | To make paper/electronic surveys available to our patients. | To equip tablets and computers on-site with satisfaction surveys. | To ensure patient satisfaction. | |

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|---|---|---|---|---|
| 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 | |
| 1)In 2016-17 we continued with our focused efforts to increasing access to care and reducing the number of "No Show" patients to | Reminder calls will be made the day prior to the appointment. | Clinic Administrative staff place reminder calls to all primary care patients the day prior to their appointment. | To reduce the no-show rate to 12%. | |
| 2)Reducing the No Show Rate by meeting the needs of the patients. | In Primary Care, the DAHC piloted a process to assist a Chronic No Show Client who has acknowledged their difficulty keeping scheduled appointments, to have the client attend in clinic on a walk-in basis. This has been successful for this client and the client has not missed a | To determine if revising the way appointments are made for some patients may result in a reduction of the No Show rate. | To reduce the no-show rate to 12%. | |