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

2018-19

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Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 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.

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1	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 (Count; Health Promotions; 2016-17; EMR/Chart Review)	92212	5884.00	8000.00	4453.00	During the 2017-18 fiscal year the Healthy Living Department restructured some of the community events that were offered. Some of the larger community events were held on a smaller scale to focus on the DAHC patients and participants. The focus on the programming was to better align with the promotion of healthy living and health promotions. 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.

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In 2016-17 the Healthy Living		Process evaluation resulted in program

Department hasengaged members of the community through programs and services such as camps, healthy living programs, and diabetes education sessions. By Q3 of 2016-17, we have on our track to meet the annual target. However, with the delay in the funding for the Healthier You Programs (received January 2017) programs were reduced. This number is indicator is monitored quarterly by our Quality Committee. All of the Health Promotions programming has cultural component to enrich the participants spirit as well as their physical health.

changes and improvement. Some of the larger community events that were offered that did not align with the mandate of the Healthy Living programs were purposely scaled back and/or cancelled. We acknowledge that this is a stretch target; however, we are committed to focusing on programs that are relevant to our patients and participants and support their ability to access services in a culturally safe setting, when they need them. In 2018 the aim is to have significant outreach in the communities that we serve.

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To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the screening to them.	Yes	We continue to use the EMR to identify patients that are eligible for cancer screenings. This method appears to be effective in identifying patients. We continue to engage patients in discussions about the importance of screening. We need to identify barriers to participation in screening and focus support strategies.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
3	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); 2016-17; In-house survey)	92212	95.00	100.00	100.00	Relationships are key to the service we provide to our patients/participants. It is through dialogue and discussion that relationships and trust are built and sustained. Understanding the "story" of our patients aids the clinician in connecting health diagnosis and/or treatments to the patients/participants in a way that is meaningful to the patient/participant and their family.

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Patients are satisfied with the amount of time that the clinician spends with them during their appointment.	Yes	We achieved our target in the 2017-18 fiscal year according to feedback from the Patient Experience Satisfaction Survey. We will continue to strive to include patients in their health journey to improve the quality of life from the waters of the mother's womb to the end of the life cycle. We acknowledge that it is important for all service providers to understand that “telling stories” around health takes more time and is an integral part of developing effective treatment plans. The 2017-18 Health and Safety and Training Update reports 91% compliance with the Indigenous Cultural Sensitive training. The goal is for all staff to be certified.

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4	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 2016 - March 2017; In-house survey)	92212	94.00	100.00	100.00	Relationships are key to the service we provide to our patients/participants. It is through dialogue and discussion that relationships and trust are built and sustained. Understanding what is important to the patients/participants aids the clinician in connecting health diagnosis and/or treatments to the patients/participants in a way that is meaningful. An assumption is made that increase participation on decision making can increase compliance and lead to better outcomes.

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To make paper/electronic surveys available to our patients.	Yes	We achieved our target in the 2017-18 fiscal year according to our Patient Experience Satisfaction survey. We will continue to strive to include patients in their health journey to improve the quality of life from the waters of the mother's womb to the end of the life cycle. Through ongoing training that increase awareness of Culturally appropriate approach to interviews, staff will better understand how each patients wants/needs to participate in decision making around care. This will continue to be a focused question on the Patient/Participant Experience Satisfaction Survey.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
5	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 2015 - March 2016; CIHI DAD)	92212	31.00	33.00	47.00	We continue to engage our patients/participants in their health journey. It is through their involvement we are able to maximize the care provided. Data from the 2015-17 Practice Profile Report is helping us identify performance trends for this measure.

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Empowering Patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital.	Yes	We continue to ask patients calling for appointments whether this is in follow up to a hospital discharge.
Ask patients whether appointment is a follow up to hospitalization and to remind patients that they should notify the Health Centre if they have been in hospital.		There appears to be a key system information transfer challenge. Information is not consistently transferred from hospitals to primary care “flagging” patient discharge. This creates a local challenge in relying on patients for this information.

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6	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); 2016-17; In-house survey)	92212	99.00	100.00	100.00	Relationships are key to the service we provide to our patients/participants. It is through dialogue and discussion that relationships and trust are built and sustained. Understanding whether patients/participants feel comfortable asking questions aids the clinician in connecting health diagnosis and/or treatments to the patients/participants in a way that is meaningful.

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To gauge patient's opportunity to ask questions about recommended treatment.	Yes	We achieved our target in the 2017-18 fiscal year. We will continue to strive to include patients in their health journey to improve the quality of life from the waters of the mother's womb to the end of the life cycle. Through ongoing Cultural Sensitivity Competency Training staff will better understand how to ask questions and elicit question in a way that is culturally safe fro the patient. This will continue to be a focused question on the Patient/Participation Experience Satisfaction Survey

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
7	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed. (%; PC organization population (surveyed sample); April 2016 - March 2017; In-house survey)	92212	41.76	44.00	37.00	With the addition of walk in clinics one evening at each clinic has allowed greater access to primary care without needing to make appointments.

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Keeping one appointment time open each day, at each site, to support patients when needed.	Yes	Keeping one appointment open each day, we have put measure in place to evaluate the use of this slot and the impact on wait list and “no show rate”. We have incorporated walk-in clinics in Hamilton and Brantford at each of the Primary Care Clinics one evening per week. This change idea has an impact on operating budgets and broader planning within the organization. Additional staffing resources are needed.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
8	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); 2016-17; ICIS)	92212	12.50	12.00	12.10	By offering evening walk in clinics we are making increasing access to primary care outside of regular business hours.

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We are exploring opportunities for evening and weekend access to primary care services.	Yes	We were very close to meeting our target at the end of March 31, 2018. We have incorporated a walk in clinic model one evening per week at each site. This change idea has an impact on operating budgets and broader planning within the organization. Additional staffing resources are needed.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
9	Percentage of patients who were discharged in a given period for a condition within selected HBAM Inpatient Grouper (HIGs) and had a non-elective hospital readmission within 30 days of discharge, by primary care practice model. (%; Discharged patients with selected HIG conditions; April 2015 - March 2016; DAD, CAPE, CPDB)	92212	8.00	7.50	7.30	We continue to engage and empower our patients/participants in their health journey. It is through their involvement we are able to maximize the care provided.

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Empowering Patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital.	Yes	We are currently focusing on identifying patient discharges from hospital and supporting appropriate follow up.
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.	Yes	7.3% of our patients have been identified, in the 2015-17 Practice Profile report, as being readmitted within 30 days of discharge. Further investigation is needed to identify who these patients are, why they were readmitted within 30 days of discharge, and could anything have been done by our Primary Care team to prevent readmission.

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10	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	58.00	61.00	75.86	Through an interprofessional model of care for our diabetic patients, we are able to monitor blood glucose levels. This program continues to be a work in progress for clarity for programs and procedures.

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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.		Identification and consultation with our diabetic patients appears to be making a difference. Our current performance is above our target. We need to look more specifically at how many were identify by EMR, how many were contacted and how many were tested. This will evaluate the result of this initiative and to identify why some of the testing has not been completed.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
11	Percentage of people/patients overe 65 who report having a seasonal flu shot in the past year (%; PC organization population eligible for screening; 2016-17; CCO-SAR, EMR)	92212	35.00	36.75	40.94	We hosted flu shot clinics at each of our sites. In addition, we ask patients/participants beginning each fall whether they have received their flu shot

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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.		We have met and exceeded this target.
Discussions with patients at regular appointments to offer the flu shot or to identify if the flu shot has been received elsewhere.		Providing the clinics and offering immunization at regular appointment opened up access choice for our patients. We continue to use this strategy to determine whether number will increase over the year.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
12	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. (%; PC organization population eligible for screening; Annually; See Tech Specs)	92212	38.00	40.00	48.64	We continue to use the EMR to identify and offer testing to eligible patients.

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To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the screening to them.		We have met and exceeded this target this fiscal year. We need to look more specifically at how many were identify by EMR, how many were contacted and how many were tested. This will evaluate the result of this initiative and to identify why some of the testing has not been completed.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
13	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	60.00	63.00	60.83	We continue to use the EMR to identify and offer testing to qualifying patients.

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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	We did not meet our target in this past year. However, we continue to use our EMR to identify patients who qualify for treatments. We need to continue to monitor this indicator to see if our Participation rates change (up or down). We need to better understand why we did not meet this target. Some areas to consider are whether the patient understands the importance of this preventative measure, and is the information presented in a culturally safe manner.

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14	The new EMR will allow for internal referrals within the organization to be completed and reported on within the patient electronic medical record (Count; All patients; 2016-17; EMR/Chart Review)	92212	664.00	698.00	431.00	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. However, we do know that we also need to empower our clients in their healthcare journey, especially with Mental Health Services. It is this empowerment that will contribute to the success of the treatments offered.

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To make referrals/access to the organizational basket of services more transparent and user friendly.	Yes	In some programs (i.e. Mental Health) it is preferred that there is a self referral process to ensure that the client is empowered throughout their healthcare journey. A change in referral process to include self referrals will change the cross program counts. Although these counts are an important metric it is also important for us to identify whether the patient/participant needs are being met

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15	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; 2016-17; EMR/Chart Review)	92212	17.33	12.00	23.00	Reminder calls do not appear to be enough to lower the “no show” rate. One patient situation, a chronic “no show” patients was resolved with flexible appointments. This situation resulted in extended hours once per week per site for a walk-in clinic for rostered patients. This strategy is challenging with existing staffing resources.

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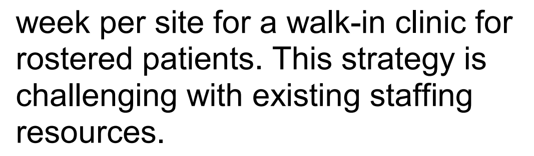
In 2016-17 we continued with our focused efforts to increasing access to care and reducing the number of “No Show” patients to appointments. Strategies have been put in place to reduce the number of no-shows and staff are continuing to review best practices to assist in lowering this indicator. This past year we have seen a 2% reduction in this indicator. In 2017-8 our goal is to reduce the number of "No Show Appointments to 12% from 17.33%.		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 23% No Show rate in our Primary Care Department. We continue to do complete reminder the calls the day prior.
Reducing the No Show Rate by meeting the needs of the patients.	No	
Reminder calls the day before the appointment.	No	Reminder calls do not appear to be enough to lower the “no show” rate.
One slot open per day per site for Walk ins, urgent (including no show patients)	Yes	One patient situation, a chronic “no show” patients was resolved with flexible appointments. This situation resulted in extended hours once per



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changes and improvement. Some of the larger community events that were offered that did not align with the mandate of the Healthy Living programs were purposely scaled back and/or cancelled. We acknowledge that this is a stretch target; however, we are committed to focusing on programs that are relevant to our patients and participants and support their ability to access services in a culturally safe setting, when they need them. In 2018 the aim is to have significant outreach in the communities that we serve.

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To utilize the data mining component of the new EMR to identify eligible patients to offer to provide the screening to them.	Yes	We continue to use the EMR to identify patients that are eligible for cancer screenings. This method appears to be effective in identifying patients. We continue to engage patients in discussions about the importance of screening. We need to identify barriers to participation in screening and focus support strategies.

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3	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); 2016-17; In-house survey)	92212	95.00	100.00	100.00	Relationships are key to the service we provide to our patients/participants. It is through dialogue and discussion that relationships and trust are built and sustained. Understanding the "story" of our patients aids the clinician in connecting health diagnosis and/or treatments to the patients/participants in a way that is meaningful to the patient/participant and their family.

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Change Ideas from Last Years QIP (QIP 2017/18)	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?
Patients are satisfied with the amount of time that the clinician spends with them during their appointment.	Yes	We achieved our target in the 2017-18 fiscal year according to feedback from the Patient Experience Satisfaction Survey. We will continue to strive to include patients in their health journey to improve the quality of life from the waters of the mother's womb to the end of the life cycle. We acknowledge that it is important for all service providers to understand that “telling stories” around health takes more time and is an integral part of developing effective treatment plans. The 2017-18 Health and Safety and Training Update reports 91% compliance with the Indigenous Cultural Sensitive training. The goal is for all staff to be certified.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
4	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 2016 - March 2017; In-house survey)	92212	94.00	100.00	100.00	Relationships are key to the service we provide to our patients/participants. It is through dialogue and discussion that relationships and trust are built and sustained. Understanding what is important to the patients/participants aids the clinician in connecting health diagnosis and/or treatments to the patients/participants in a way that is meaningful. An assumption is made that increase participation on decision making can increase compliance and lead to better outcomes.

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Change Ideas from Last Years QIP (QIP 2017/18)	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 paper/electronic surveys available to our patients.	Yes	We achieved our target in the 2017-18 fiscal year according to our Patient Experience Satisfaction survey. We will continue to strive to include patients in their health journey to improve the quality of life from the waters of the mother's womb to the end of the life cycle. Through ongoing training that increase awareness of Culturally appropriate approach to interviews, staff will better understand how each patients wants/needs to participate in decision making around care. This will continue to be a focused question on the Patient/Participant Experience Satisfaction Survey.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
5	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 2015 - March 2016; CIHI DAD)	92212	31.00	33.00	47.00	We continue to engage our patients/participants in their health journey. It is through their involvement we are able to maximize the care provided. Data from the 2015-17 Practice Profile Report is helping us identify performance trends for this measure.

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Change Ideas from Last Years QIP (QIP 2017/18)	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?
Empowering Patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital.	Yes	We continue to ask patients calling for appointments whether this is in follow up to a hospital discharge.
Ask patients whether appointment is a follow up to hospitalization and to remind patients that they should notify the Health Centre if they have been in hospital.		There appears to be a key system information transfer challenge. Information is not consistently transferred from hospitals to primary care “flagging” patient discharge. This creates a local challenge in relying on patients for this information.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
6	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); 2016-17; In-house survey)	92212	99.00	100.00	100.00	Relationships are key to the service we provide to our patients/participants. It is through dialogue and discussion that relationships and trust are built and sustained. Understanding whether patients/participants feel comfortable asking questions aids the clinician in connecting health diagnosis and/or treatments to the patients/participants in a way that is meaningful.

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Change Ideas from Last Years QIP (QIP 2017/18)	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 gauge patient's opportunity to ask questions about recommended treatment.	Yes	We achieved our target in the 2017-18 fiscal year. We will continue to strive to include patients in their health journey to improve the quality of life from the waters of the mother's womb to the end of the life cycle. Through ongoing Cultural Sensitivity Competency Training staff will better understand how to ask questions and elicit question in a way that is culturally safe fro the patient. This will continue to be a focused question on the Patient/Participation Experience Satisfaction Survey

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
7	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed. (%; PC organization population (surveyed sample); April 2016 - March 2017; In-house survey)	92212	41.76	44.00	37.00	With the addition of walk in clinics one evening at each clinic has allowed greater access to primary care without needing to make appointments.

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Change Ideas from Last Years QIP (QIP 2017/18)	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?
Keeping one appointment time open each day, at each site, to support patients when needed.	Yes	Keeping one appointment open each day, we have put measure in place to evaluate the use of this slot and the impact on wait list and “no show rate”. We have incorporated walk-in clinics in Hamilton and Brantford at each of the Primary Care Clinics one evening per week. This change idea has an impact on operating budgets and broader planning within the organization. Additional staffing resources are needed.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
8	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); 2016-17; ICIS)	92212	12.50	12.00	12.10	By offering evening walk in clinics we are making increasing access to primary care outside of regular business hours.

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Change Ideas from Last Years QIP (QIP 2017/18)	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 are exploring opportunities for evening and weekend access to primary care services.	Yes	We were very close to meeting our target at the end of March 31, 2018. We have incorporated a walk in clinic model one evening per week at each site. This change idea has an impact on operating budgets and broader planning within the organization. Additional staffing resources are needed.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
9	Percentage of patients who were discharged in a given period for a condition within selected HBAM Inpatient Grouper (HIGs) and had a non-elective hospital readmission within 30 days of discharge, by primary care practice model. (%; Discharged patients with selected HIG conditions; April 2015 - March 2016; DAD, CAPE, CPDB)	92212	8.00	7.50	7.30	We continue to engage and empower our patients/participants in their health journey. It is through their involvement we are able to maximize the care provided.

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Change Ideas from Last Years QIP (QIP 2017/18)	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?
Empowering Patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital.	Yes	We are currently focusing on identifying patient discharges from hospital and supporting appropriate follow up.
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.	Yes	7.3% of our patients have been identified, in the 2015-17 Practice Profile report, as being readmitted within 30 days of discharge. Further investigation is needed to identify who these patients are, why they were readmitted within 30 days of discharge, and could anything have been done by our Primary Care team to prevent readmission.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
10	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	58.00	61.00	75.86	Through an interprofessional model of care for our diabetic patients, we are able to monitor blood glucose levels. This program continues to be a work in progress for clarity for programs and procedures.

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Change Ideas from Last Years QIP (QIP 2017/18)	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 utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them.		Identification and consultation with our diabetic patients appears to be making a difference. Our current performance is above our target. We need to look more specifically at how many were identify by EMR, how many were contacted and how many were tested. This will evaluate the result of this initiative and to identify why some of the testing has not been completed.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
11	Percentage of people/patients overe 65 who report having a seasonal flu shot in the past year (%; PC organization population eligible for screening; 2016-17; CCO-SAR, EMR)	92212	35.00	36.75	40.94	We hosted flu shot clinics at each of our sites. In addition, we ask patients/participants beginning each fall whether they have received their flu shot

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Change Ideas from Last Years QIP (QIP 2017/18)	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 utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them.		We have met and exceeded this target.
Discussions with patients at regular appointments to offer the flu shot or to identify if the flu shot has been received elsewhere.		Providing the clinics and offering immunization at regular appointment opened up access choice for our patients. We continue to use this strategy to determine whether number will increase over the year.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
12	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. (%; PC organization population eligible for screening; Annually; See Tech Specs)	92212	38.00	40.00	48.64	We continue to use the EMR to identify and offer testing to eligible patients.

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Change Ideas from Last Years QIP (QIP 2017/18)	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 utilize the data mining component of the new EMR to identify eligible patients to offer to provide the screening to them.		We have met and exceeded this target this fiscal year. We need to look more specifically at how many were identify by EMR, how many were contacted and how many were tested. This will evaluate the result of this initiative and to identify why some of the testing has not been completed.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
13	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	60.00	63.00	60.83	We continue to use the EMR to identify and offer testing to qualifying patients.

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Change Ideas from Last Years QIP (QIP 2017/18)	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 utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them.	Yes	We did not meet our target in this past year. However, we continue to use our EMR to identify patients who qualify for treatments. We need to continue to monitor this indicator to see if our Participation rates change (up or down). We need to better understand why we did not meet this target. Some areas to consider are whether the patient understands the importance of this preventative measure, and is the information presented in a culturally safe manner.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
14	The new EMR will allow for internal referrals within the organization to be completed and reported on within the patient electronic medical record (Count; All patients; 2016-17; EMR/Chart Review)	92212	664.00	698.00	431.00	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. However, we do know that we also need to empower our clients in their healthcare journey, especially with Mental Health Services. It is this empowerment that will contribute to the success of the treatments offered.

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Change Ideas from Last Years QIP (QIP 2017/18)	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	In some programs (i.e. Mental Health) it is preferred that there is a self referral process to ensure that the client is empowered throughout their healthcare journey. A change in referral process to include self referrals will change the cross program counts. Although these counts are an important metric it is also important for us to identify whether the patient/participant needs are being met

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
15	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; 2016-17; EMR/Chart Review)	92212	17.33	12.00	23.00	Reminder calls do not appear to be enough to lower the “no show” rate. One patient situation, a chronic “no show” patients was resolved with flexible appointments. This situation resulted in extended hours once per week per site for a walk-in clinic for rostered patients. This strategy is challenging with existing staffing resources.

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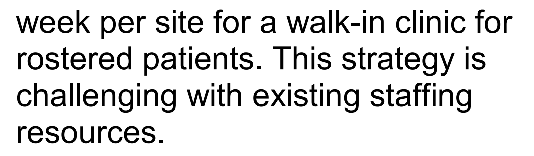
Change Ideas from Last Years QIP (QIP 2017/18)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
In 2016-17 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 2017-8 our goal is to reduce the number of "No Show Appointments to 12% from 17.33%.		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 23% No Show rate in our Primary Care Department. We continue to do complete reminder the calls the day prior.
Reducing the No Show Rate by meeting the needs of the patients.	No	
Reminder calls the day before the appointment.	No	Reminder calls do not appear to be enough to lower the “no show” rate.
One slot open per day per site for Walk ins, urgent (including no show patients)	Yes	One patient situation, a chronic “no show” patients was resolved with flexible appointments. This situation resulted in extended hours once per



week per site for a walk-in clinic for rostered patients. This strategy is challenging with existing staffing resources.

2018/19 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	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	Percentage of patients identified as meeting Health Link criteria who are offered access to	A	% / Patients meeting Health Link criteria	In house data collection / most recent 3 month period	92212*	CB	CB	At this time we do not collect this data but can add as a reporting	1)N/A	N/A	N/A	N/A	At this time we do not collect this data but can add as a reporting indicator on NOD
	Effective transitions	Percentage of patients who have had a 7-day post hospital discharge follow up. (CHCs,	P	% / Discharged patients	See Tech Specs / Last consecutive 12 month period	92212*	47	47.30	DAHC has received the 2017 Practice Profile Report (covering the	1)Empowering patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital.	When patients call to schedule an appointment, reception staff ask if the appointment is in follow up to a discharge from hospital. Clinicians remind patients that if they were in hospital that they should notify the health centre for follow up. In addition, a reminder will	An increase in the number of patients seeing their primary care provider within 7 days after discharge from hospital for selected conditions.	Patients have access to primary care appointments post-discharge through	
		Percentage of patients who were discharged in a given period for a condition within selected	A	% / Discharged patients with selected HIG conditions	DAD, CAPE, CPDB / April 2016 - March 2017	92212*	7.3	6.94	DAHC has received the 2017 Practice Profile Report (covering the	1)Empowering patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital.	When patients call to schedule an appointment, reception staff ask if the appointment is in follow up to a discharge from hospital. Clinicians remind patients that if they were in hospital that they should notify the health centre for follow up. In addition, a reminder will	An reduction in the percentage of patients who are readmitted to hospitals for select HIGs.	There is seamless primary care service/support to our patients.	
	Wound Care	Percentage of patients with diabetes, age 18 or over, who have had a diabetic foot ulcer	A	% / patients with diabetes, aged 18 or older	EMR/Chart Review / Last consecutive 12 month period	92212*	CB	CB	We are looking at ENCODES used to see if we can pull this data.	1)N/A	N/A	N/A	N/A	We are looking at ENCODES used to see if we can pull this data
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	C	Count / All patients	EMR/Chart Review / 2017-18	92212*	431	698.00	At the end of Q3 of 2017-18 we are below meeting the performance	1)Make referrals/access to the organizational basket of services more transparent and user friendly.	Staff have utilized the EMR 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.	There is quick and efficient hand-off of patients amongst departments.	
	Decrease Emergency Department visits for conditions best managed elsewhere (BME)	Percentage of patients or clients who visited the emergency department (ED) for	C	% / PC org population visiting ED (for conditions BME)	ICIS Report / 2015-2017	92212*	12.1	11.50	At the end of Q3 of the 2017-18 fiscal year we are close to meeting this	1)Explore 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 accessing Emergency Departments for conditions best managed elsewhere.	Identify patients and their corresponding issues and direct them to the	
Equitable	Population health - cervical cancer screening	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least	A	% / PC organization population eligible for screening	CCO-SAR, EMR / Annually	92212*	60.83	63.87	Although we did not meet this target we have kept this target the same for this	1)Continue to utilize the data mining component of the new EMR to identify eligible patients and to offer to provide the service to	Through the utilization of our 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.	The incidence of cervical cancer is reduced in our patients through regular screening.	
	Population health - colorectal cancer screening	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for	A	% / PC organization population eligible for screening	See Tech Specs / Annually	92212*	CB	CB	We use a different indicator to report on	1)N/A	N/A	N/A	N/A	We report this indicator differently
		Percentage of screen eligible patients aged 50 to 74 years who had a FOBT within the past two years,	C	% / PC organization population eligible for screening	EMR/Chart Review / 2017-18	92212*	48.64	51.07	We exceeded the target for this indicator in 2017-18; therefore, we	1)Continue to utilize the data mining component of the new EMR to identify eligible patients to offer to provide the screening to	Through the utilization of our EMR we were able to continue 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.	
	Population health - diabetes	Percentage of patients with diabetes, aged 40 or over, with two or more glycated	A	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / Annually	92212*	75.86	79.65	This is only the third year collecting this information. By the third quarter	1)Continue 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 EMR we were able to continue 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	
	Improve seasonal Immunization rates	Percentage of people/patients overe 65 who report having a seasonal flu shot in the past year	C	% / PC organization population eligible for screening	EMR/Chart Review / 2017-18	92212*	40.94	42.98	We exceeded the target for this indicator at the end of Q3 in 2017-18	1)Continue 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.	

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)

									therefore, we are projecting a 5% increase in this indicator for 2018-19.	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) offer patients the flu shot at appointments during the flu season. If the patient has received a flu shot elsewhere it is noted in the EMR.	Conversations with patients regarding the benefits of flu shots and offering the vaccine at scheduled appointments.	To reduce the incidence of influenza in people/patients over the age of 65.	
	Outreach to the community	Health equity allows people the opportunity to reach their full health potential and receive	C	Count / All patients	EMR/Chart Review / 2017-18	92212*	4453	8000.00	We had an aggressive target in 2017-18 for the Healthy Living	1)In 2016-17 the Healthy Living Department engaged members of the community through programs and services such as camps,	To have over 8000 persons attending our wellness and healthy lifestyle programs.	QQuarterly reporting on the number of program participants registered within the new EMR.	To increase access and attendance to Wellness and Healthy Lifestyle programs.	
	Population health - breast cancer screening	Percent of eligible patients/clients who are up-to-date in screening for breast cancer.	C	% / PC organization population eligible for screening	EMR/Chart Review / 2017-18	92212*	46.26	53.00	We did not meet this target as of the Q3 in the 2017-18 fiscal year; therefore,	1)Continue to use EMR to identify eligible patients. To continue to include discussions about breast screening in patient	Clinicians continue to engage eligible patients in discussions about benefits of screening and encourage them to be screened. Try to identify barriers to participation on screening.	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.	To reduce the incidence of breast cancer in eligible patients through regular screening.	
Patient-centred	**Person experience**	Percent of patients who stated that when they see the doctor or nurse practitioner, they or	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	92212*	100	100.00	We achieved this target in 2017-18 and we will continue to strive for 100%	1)To make paper/electronic surveys available to our patients at each visit in the waiting rooms.	Paper/Electronic surveys available to our patients when they are in the waiting rooms.	Annual reporting on Patient Experience Satisfaction Survey.	Patient satisfaction with their involvement in decision making.	
	Improve Patient Experience: Opportunity to ask questions	Percent of respondents who responded positively to the question: "When you see your	C	% / PC organization population (surveyed sample)	In-house survey / 2017-18	92212*	100	100.00	We achieved 99% for this indicator in 2017/18 and we will continue to	1)To make paper/electronic surveys available to our patients at each visit in the waiting rooms.	Paper/Electronic surveys available to our patients when they are in the waiting rooms.	Annual Reporting on Patient Experience Survey	Patient understands their treatment options and treatment.	
	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	C	% / PC organization population (surveyed sample)	In-house survey / 2017-18	92212*	99.5	100.00	To gauge patient's perception of the amount of time spent with	1)Patients are satisfied with the amount of time that the clinician spends with them during their appointment.	To make paper surveys available to our patients.	To equip departments with satisfaction surveys.	To ensure patient satisfaction.	
Safe	**Medication safety**	Percentage of patients with medication reconciliation in the past year	A	% / All patients	EMR/Chart Review / Most recent 12 month period	92212*	CB	CB	We are looking at the ENCODES to see if we can pull this data	1)N/A	N/A	N/A	N/A	We are looking at the ENCODES to see if we can pull this data.
Timely	**Timely access to care/services**	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or	P	% / PC organization population (surveyed sample)	In-house survey / April 2017 - March 2018	92212*	37	44.00	To ensure timely access to primary care services.	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.	Patient satisfaction with access to same day appointments.	
	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.	C	% / All patients	EMR/Chart Review / 2017-18	92212*	23	12.00	We achieved 17.33% last year with a 12% target so we have kept the target the same.	1)Make sure that all of the available booking slots are efficiently and effectively used.	Reminder calls will continue to be made the day prior to the appointment. All open appointments are filled.	Quarterly reporting and monitoring of the "no show" rate by the Quality Committee.	DAHC understands the root causes of "no shows" for our patients.	
										2)Better understand the reasons behind "chronic" no shows. Implement strategies to meet needs.	Pilot extended hours within budget and resources.	Quarterly reporting of strategies implemented to address the "no show" rate by the Management Team.	Patients report increase satisfaction with their access to care.	