De dwa da dehs nye>s Aboriginal Health Centre

Quality Improvement Plan

2019-20

678 Main Street East, Hamilton, Ontario L8M 1K2 Phone: 905.544.4320 Fax: 905.544.4247
36 King Street, Brantford, Ontario N3T 3C5 Phone: 519.752.4340 Fax: 519.752.6096

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 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 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
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; All patients; 2017-18; EMR/Chart Review)	92212	4453.00	8000.00	6549.00	Research findings from the Our Health Counts Study conducted on the Hamilton First Nation population, indicate that only 78% of the First Nations people studied earn more than $20,000 per year and as a result have less access to the social determinants of health. At every Healthy Living Program we run we provide access to healthy foods.

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Change Ideas from Last Years QIP (QIP 2018/19)	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 the Healthy Living Department engaged members of the community through programs and services such as camps, healthy living programs, and diabetes education sessions. All of the Health Promotions programming have cultural component to enrich the participants spirit as well as their physical health.	Yes	At the end of Q3 we are on track to meet the annual target for Outreach by the Healthy Living Department.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
2	Percent of eligible patients/clients who are up-to-date in screening for breast cancer. (%; PC organization population eligible for screening; 2017-18; EMR/Chart Review)	92212	46.26	53.00	49.34	At the end of the third quarter of 2018-19 fiscal year we have not met our annual target. However, we are on track to meet the target or be close to the target at the end of the fiscal year. Staff utilize the electronic medical record (EMR) to identify and offer the screening to eligible patients. We continue to monitor our progress through the Aboriginal Health Access Centre (AHAC) Practice Profile. The most recent report was released for April 2015 to March 31, 2017.

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Continue to use EMR to identify eligible patients. To continue to include discussions about breast screening in patient appointments.	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.
We obtained cancer screening promotional materials from the regional cancer centre that were specific to the Indigenous Community.	Yes	Indigenous specific cancer screen promotional materials help our patients feel more comfortable toward the screening and to relate to the images of other Indigenous people.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	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); 2017-18; In-house survey)	92212	99.50	100.00	100.00	Relationships are the foundation to how we provide clinical services. 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 our patient satisfaction survey results. Our clinicians include patients in decision-making throughout their health journey to improve health outcomes beginning with 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. With the 2018-19 feedback from the Patient Experience Satisfaction Survey we continue Health and Safety and Training. Update reports 67% compliance with the Indigenous Cultural Sensitivity 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 2017 - March 2018; In-house survey)	92212	100.00	100.00	91.86	Relationships are the foundation of how we provide service. It is through dialogue and discussion and getting to know our patients stories that relationships and trust are built and sustained. Understanding the patient "story" and knowing what is important to the patients/participants can be used in the language the clinician uses when connecting health diagnosis and/or treatments to the patients/participants in a way that is meaningful. An assumption is made that an increase of 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 at each visit in the waiting rooms.		At the end of the third quarter of the 2018-19 fiscal year we are below our target based on the responses received through Patient Experience Satisfaction survey. We will continue to encourage and embrace all patient and participant feedback to improve the patient experience and improve health outcomes. As part of our standard of providing quality care, we consider ourselves equal partners with our patients throughout their health journey from the waters of the mother's womb to the end of the life cycle. We continue to provide culturally safe and relevant training opportunities, resources and tools for our staff

to, better understand the importance of being a culturally safe health partner in our patient's health journey. This will continue to be a focused question on the Patient/Participant Experience Satisfaction Survey.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
5	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); 2017-18; In-house survey)	92212	100.00	100.00	99.00	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 make paper/electronic surveys available to our patients at each visit in the waiting rooms.	Yes	We are slightly below our target in the 2018-19 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 for the patient. This will continue to be a focused question on the Patient/Participation Experience Satisfaction Survey.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
6	Percentage of Ontario screen-eligible individuals, 50-74 years old, who were overdue for colorectal screening in each calendar year (%; PC organization population eligible for screening; Annually; See Tech Specs)	92212	CB	CB	NA	We do not report on this indicator. We report on FOBT Testing instead.

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N/A		

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7	Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period. (%; PC organization population eligible for screening; Annually; CCO-SAR, EMR)	92212	60.83	63.87	61.60	At the end of the third quarter of the 2018-19 fiscal year we are below the annual target; however, we continue to use the EMR to identify and offer testing to qualifying patients.

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Continue to utilize the data mining component of the new EMR to identify eligible patients and to offer to provide the service to them.		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.
We obtained cancer screening promotional materials from the regional cancer centre that were specific to the Indigenous Community.	Yes	Indigenous specific cancer screen promotional materials help our patients feel more comfortable toward the screening and to relate the to the images of other Indigenous people.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
8	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 2018 - March 2019; In-house survey)	92212	37.00	44.00	28.48	In October we opened up same day access clinics at both sites on Wednesdays and we continue with our walk in clinics at each site on Wednesday evenings. We will need to review this survey question next year to ensure it is gathering the correct data from survey respondents.

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Keeping one appointment time open each day, at each site, to support patients when needed.		With the addition of walk in clinics one evening and day per week at each clinic has allowed greater access to primary care without needing to make appointments. As a result, more people did not answer this question on the surveys.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
9	Percentage of patients identified as meeting Health Link criteria who are offered access to Health Links approach (%; Patients meeting Health Link criteria; most recent 3 month period; In house data collection)	92212	CB	CB	NA	We do not collect or report on this data.

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10	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); 2015-2017; ICIS Report)	92212	12.10	11.50	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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Explore opportunities for evening and weekend access to primary care services.		We were very close to meeting our target at the end of March 31, 2018. However, the source for reporting this indicator is from the 2015-17 Practice Profile report. We have no other way to collect this information, we are reporting on stale data. We have incorporated a walk in clinic model one evening per week and same day access appointments 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 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
11	Percentage of patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs) (%; Discharged patients ; Last consecutive 12 month period; See Tech Specs)	92212	47.00	47.30	45.20	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. However, we did not have a refresh of this report prior to completing this report and as this report is the only source to respond to this indicator. Therefore we do not have a true indication of our performance on this indicator.

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Empowering patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital.		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 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
12	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 2016 - March 2017; DAD, CAPE, CPDB)	92212	7.30	6.94	7.30	7.3% of our patients have been identified, in the 2015-17 Practice Profile report, as being readmitted within 30 days of discharge. As we did not have a refresh of the report at the end of the 2017-18 fiscal year we are using stale data to complete this report. 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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Empowering patients to notify De dwa da dehs nye>s Aboriginal Health Centre of discharge from hospital.		We are currently focusing on identifying patient discharges from hospital and supporting appropriate follow up.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
13	Percentage of patients with diabetes, age 18 or over, who have had a diabetic foot ulcer risk assessment using a standard, validated tool within the past 12 months (%; patients with diabetes, aged 18 or older; Last consecutive 12 month period; EMR/Chart Review)	92212	CB	CB	NA	We do not report on this indicator

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ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
14	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	75.86	79.65	71.65	Through an inter-professional 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 regarding programs and procedures.

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Continue 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 identified 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 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
15	Percentage of patients with medication reconciliation in the past year (%; All patients; Most recent 12 month period; EMR/Chart Review)	92212	CB	CB	CB	We are collecting baseline data and understanding how our EMR data can be used to report on this indicator.

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16	Percentage of people/patients overe 65 who report having a seasonal flu shot in the past year (%; PC organization population eligible for screening; 2017-18; EMR/Chart Review)	92212	40.94	42.98	51.88	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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Continue to utilize the data mining component of the new EMR to identify eligible patients to offer to provide the service to them.	Yes	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.	Yes	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 numbers will increase over the year.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
17	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; 2017-18; EMR/Chart Review)	92212	48.64	51.07	NA	We continue to use the EMR to identify and offer testing to eligible patients.

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Continue 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 identified 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 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
18	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; 2017-18; EMR/Chart Review)	92212	431.00	698.00	270.00	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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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 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
19	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; 2017-18; EMR/Chart Review)	92212	23.00	12.00	22.00	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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Make sure that all of the available booking slots are efficiently and effectively used.		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 22% No Show rate in our Primary Care Department. We continue to complete reminder calls the day prior.
Better understand the reasons behind "chronic" no shows. Implement strategies to meet needs.		We continue to look at the reasons behind patient no shows. Primary Care clinics are open 1 evening per week for walk-in appointments.
Introduction of walk-in appointments and access to same day appointments.	Yes	In addition, in Brantford we have included same day access appointments one afternoon per week and in Hamilton for three afternoons per week.

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

2/6/2019

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 (DAHC)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, Housing Services, 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.

De dwa da dehs nye>s 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.

The 2015-17 Practice Profile Report, prepared by the Institute for Clinical Evaluation Services (ICES) for the AHAC Sector has been used to support the development of the Quality Improvement Plan for the 2018-19 fiscal year. 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 2015 to March 31, 2017.

A summary of the key indicators is below:
- 73.8% of the patients seen by DAHC are in the two lowest income Quintiles (the AHAC average is 66.1%)
- 53.1% of our patients were not seen by or enrolled with another Primary Care Provider (the AHAC average is 38.3%)
- DAHC SAMI score was 1.64 (AHAC average is 1.53)
- DAHC has exceeded the AHAC average for the three cancer screenings compared:
- Mammography - 47.3% (DAHC) compared to 44% (AHAC sector)
- Cervical Screening - 67.1% (DAHC) compared to 61.3% (AHAC sector)
- Colorectal Screening - 55.6% (DAHC) to 51.8% (AHAC Sector)

The Practice Profile Report pulls data from across the health sector (based on health card number) for the rostered patients at De dwa da dehs nye>s. 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 Indigenous cultures and of De dwa da dehs nye>s. It is important for our staff to develop and cultivate relationships with our clients in order to create an environment that is culturally safe. 67% of our staff have completed Indigenous Cultural Sensitivity Training and the others are on the waiting list to attend the training. This is evident in our Practice Profile which identifies that 53.1% of our patients are not enrolled with or seen by any other Primary Care Provider. As we continue to proceed with our capital planning process, there will be a greater demand for services from De dwa da dehs nye>s. The DAHC must ensure that our data accurately reflects current use and community needs and that projections accurately reflect future need so that we do not outgrow the new sites before we take possession.

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. Although the data is over eight years old the findings are still relevant today.

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:

<u>Health Access:</u>
- "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 incorporated these indicators in all aspects of the Centre's business to ensure that our patients/participants receive culturally safe and appropriate care at the right place at the right time by the right person. 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 include:

- Wheels for Seniors - This service offers medical transportation to seniors and those with chronic mobility issues enabling them to attend medical appointments, as well as social programs and services in the community that will improve their physical, mental, emotional, and spiritual health. Due to the prevalence of chronic disease in the Indigenous population and higher rate of early-onset aging, adults experiencing early on-set aging may also be served by this program.

- Access to Care - We have one evening clinic per week at each site where appointments are accessed on walk-in basis. This initiative is providing patients who have difficulty attending during regular clinic hours the opportunity to access weeknight appointment. We are exploring opportunities for expanding after hour clinics; however, with the limited staff resources this will require additional funding to support additional after hours care.

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
- FN men feel their health is better than FN women
- 18% of FN 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 counseling and foot care services (chiropody, reflexology and foot care nurse)to diabetic patients or those who are at risk of diabetes.

<u>Emergency Room (ER) Use:</u>
- FN 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 a question of systemic bias toward not admitting native children?

The Aboriginal Patient Navigator (APN) positions at De dwa da dehs nye>s assists Indigenous patients who are in community or hospital to navigate services available across the health care system (including De dwa da dehs nye>s programs and services, other Indigenous community

support programs and 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 hospitals. This increased demand is due to the high quality advocacy service provided by the APNs on behalf of their clients. APNs are consistently able to break down barriers in health navigation and improve Indigenous Peoples experiences of the health care system.

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 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.

Housing Services: From Homelessness to Community (formerly known as Homeward Bound)- 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 homeless Indigenous persons in the City of Hamilton. This program applies a wholistic, intensive approach to case management and addresses complex issues impacting the social determinants of health.

When a 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 at, 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. Between April 2018 to February 2019, we have housed 82 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 2018-19, the Housing Services team has housed 69 Indigenous individuals this fiscal year. The example below provides a snapshot of the services offered through our Housing Services Program.

The Housing Services Program began working with a middle aged man, who when he connected to the program was residing within the shelters and sleeping on the streets.

When he first connected to the program he spoke about wanting a better life for him and his child who was currently in CAS care. He openly admitted that he struggled with addictions, but was wanting to make a conscious effort to change his path in life to a more positive path, one in which his child would be proud of him.

He attended life skills programming on a daily basis despite still being homeless, and utilized the Homeward Bound's sobriety support groups to start addressing his addictions and building self-confidence.

About a month after being connected with the program, he moved into his own place and the program worked with him to create an environment he could call home and feel proud about the positive changes he has been making, one day at a time.

Through all of the support he has been receiving to walk a healthier life path, he has been sober for over two months and has resumed visitation with his child and currently working on bringing his child home.

Describe your organization's greatest QI achievement from the past year

In June, the Housing Services Program (formerly known as Homeward Bound Program) received a provincial transformative change award from the Alliance for Healthier Communities. This award recognizes the work of not only the Housing Services Program Team but all program staff at De dwa da dehs nye>s. It is through the bundle of services offered by De dwa da dehs nye>s that we have been successful in making an impact on the health and well-being of the homeless Urban Indigenous Population in Hamilton. The video filmed as part of the presentation of the award can be viewed by clicking on the following link: https://vimeo.com/275681508

In October 2018, De dwa da dehs nye>s hosted its 4th Annual October Moon Gala. Although the gala's primary purpose is to support the capital projects undertaken by De dwa da dehs nye>s, we provide entertainment at the event. The key note speaker for the last year's gala was Ryan McMahon. Ryan is best known for his commentary on the documentary "Colonization Road". During his address, Ryan presented current day issues with a humorous approach to promoted education and awareness of current Indigenous issues.

20th Anniversary Celebration

In 2018, De dwa da dehs nye>s celebrated our 20th Anniversary at both sites. It was important for us to come together to plan an event that marked the evolution of De dwa da dehs nye>s. Twenty years has brought us to this point that we are at now. We had a traditional opening, drumming, singing, speeches, food and cake. There was an opportunity for community to express what they wanted to see more of in terms of our program approach to Traditional Healing

Even though our AHAC has seen much transition and has climbed steep learning curves, we can appreciate that we are still very much on our way. We face new challenges as we embark on our dreams for a new home for our services, amongst many goals. It was an important opportunity to engage with our community, celebrate with our staff and participate with our stakeholders. It was a milestone to be celebrated. In Brantford, we had approximately 75 people attend and there was a much higher proportion of the community represented. In Hamilton, we had approximately 125 people attend and there was a large presence of dignitaries and key stakeholders.

Save the Children

We would like to acknowledge and thank Conrad Prince and his team from Save the Children for selecting De dwa da dehs nye>s to receive a generous donation of almost 800 pairs of Tommy Hilfiger infant, toddler and youth shoes for back to school! In addition to this generous donation, Save the Children provided more than 1500 pairs of Tommy Hilfiger socks for toddlers and youth! This donation will help support our families with the cost of back to school items needed for children returning to school. The shoes and socks have been provided to families of De dwa da dehs nye>s in Hamilton and Brantford, the families of Niwasa Kendaaswin Teg, and the Hamilton Regional Indian Centre and other local Indigenous organizations.

Thank you Conrad Prince and Save the Children!

Registered Nursing Association of Ontario Workshop on Addressing Substance Abuse

On August 10, 2018 De dwa da dehs nye>s partnered with the RNAO (Registered Nurses Association of Ontario) to host a one day workshop on Addressing Substance Use. The Addressing Substance Use Level 1 (Foundational) workshop provided nurses and other allied health professionals with the tools and skills to provide safe, ethical and competent care to persons in all clinical settings who use substances. Participants learned concepts related to stigma, licit and illicit drugs, social determinants of health, harm reduction and explore best practices related to screening, brief interventions and referral to treatment. This content from the training will be integrated with key content from the RNAO *Toolkit: Implementation of Best Practice Guidelines, Second Edition.*

Same Day Urgent Access Walk-in Availability

In the second quarter we introduced same day/urgent access walk-in availability at both of our sites. Same day access is available to patients who require urgent access/care for non-life threatening illnesses. The same day access appointments allow us to manage the episodic health needs of our patients within our clinic environment and avoid ER visits for non life threatening illness.

Internal Monitoring of Quality Initiatives

The Board of Directors approved a Strategic Plan in June 2016. 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 to identify culturally appropriate indicators.

The Board of Directors has a standing Quality Committee that meets five times per year 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. In addition, we review program success stories to help identify strategies that are working and may be able to be implemented more broadly throughout the organization.

The Management Team discusses quality improvement opportunities with staff at staff meetings and individual team meetings. Across the organization, Managers and Team Leads discuss issues that could cross departments where collaboration would be useful. Managers and Team Leads are also demonstrating an increased understanding of process measurements and the value of incorporating them into day to day operations. Quality is not seen as an "add on" but as an integral part of each work process.

Patient/client/resident partnering and relations

Patient/Participant Feedback

In December 2018, 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 reviewed the preliminary results of the survey. The Leadership team will be reviewing comments identified for areas for improvement to identify trends and strategies for Quality Improvement.

Key areas that the participants identified as doing well were providing a culturally safe environment, providing meals at programming and the addition of walk-in access for Primary Care Clients. The key theme identified for opportunities for improvement by participants were the need for; accessible buildings, more cultural spaces, additional parking and additional financial and health human resource investments to reduce wait times for services.

The results were summarized and will be presented to the staff and Board in spring 2019.

Feedback obtained from the patient satisfaction survey as well as feedback received by De dwa da dehs nye>s informs how we are doing on existing indicators and helps to inform 2018-19 quality improvement activities. Responses also inform Capital Planning and future space and resource needs of our clients.

Patient/Participant Testimonials

Testimonial #1

Amazing programs at AHC!! Just want to let your centre know that all of you are doing a wonderful job in serving community.

I look at your calendars from the Healthy Living program and the flyers on your bulletin board and I am so happy to see all of the "living well" that include cultural programming. As a patient, I am so pleased with the level of care that I receive from reception and the Nurse Practitioners' and the increase in cultural programming. It would be nice to see a variety of Traditional Healers, but that could be a budget thing. Organizations need to allocate funds where they are best served and I trust in your leadership's decisions.

I so welcome the safe space that De dwa da dehs nye provides and that the health care team allow me to have a voice in my health and well-being. This is so important to my healing and wellness journey.

Testimonial #2

I can not thank you enough for providing us with such a wealth of knowledge today. I am overwhelmed and greatly appreciative of the amount of preparation you did prior to our visit, the amount of time you spent sharing your wealth of knowledge with us and answering all of our questions. We learned so much from you .....and from your colleagues. Please share our deepest thanks to them as well from all of us.

I know that the students and myself are just scratching the surface of understanding all the issues that face Indigenous People .....not only in Healthcare but in every aspect of your lives.

We will be ....in the near future .....formally thanking you for sharing all the knowledge with us today. I will contact you with further details as they are arranged.

Thank-you again for everything you did for us. As I mentioned to you today....you opened up your "second home" the Aboriginal Health Centre to students for the first time, but you also opened up your heart to share so much.....and for that we are honoured.

Collaboration and Integration

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) to identify referrals for system navigation and support services for Indigenous patients in hospital and upon discharge. APNs work closely with the community based Indigenous and main stream agencies to link services for program patients.

As stated previously, our name translates to "taking care of each other amongst ourselves". This concept is the foundation on which our organization develops and operates all our programs. 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 the patients. This is why our APN Program staff are providing a greater number of services in hospitals connecting patients with programs and supports to assist in their early discharge and to support them living independently in the appropriate environment.

The following success stories illustrate the partnership and regular collaboration that takes place with local community hospitals, regional hospitals and community support agencies; these also showcase the significant impact in the lives of community members as a result of the APN program in Brantford, Hamilton, and Niagara:

Brantford Success Story #1:
The Brantford APN, received a call from a community member in hospital. I followed up with clients name on my hospital visits. Community member was very happy to see me as they had some concerns. Their concerns were not with themselves or the hospital but about their partner and upcoming appointments. They felt helpless as they had no phone or way of communication. The APN offered him help and support.

This client (pseudonym: Joe) is the main caregiver of their partner who is a paraplegic. Joe gets their partner up, dressed and feeds them before going to work each day. Joe recently had a heart attack and needs bypass surgery, however they are most concerned about care for their partner. Joe also had some upcoming appointments and work phone calls to make. I was able to gather the phone numbers needed, and assist with making work cancellations and other arrangements.

I reassured Joe that I would help find care for their partner and get them help in the home, so Joe can focus on themselves and getting better. I made some calls to Joe's partner, LHIN care coordinators, and Participation House Brantford to help with assisted living. Joe's partner was very grateful for the help as they were also worried about how they would live independently without Joe's help; however they didn't want Joe to know about these worries.

Once everything was all set up and the help was arranged, Joe was at ease knowing that their partner was taken care of and they could now focus on their own well being. Joe was scheduled to go to a regional cardiac care hospital at the end of the week for by pass; Joe was very nervous but knew it had to be done. They were very grateful for the help and the supportive visits to calm their mind for the upcoming procedure.

Joe was to have the procedure in another city and return home to Brantford. However due to complications they ended up staying a week in hospital to recover from procedure. I kept in contact with Joe and Joe's partner during this time to ensure they both were managing and to share updates with each other. Transportation and communication was a barrier for both of them as they didn't have cell phones and Joe was his partner's only source of transportation.

Joe was transitioned back home with services to assist on their healing journey. Joe is very thankful for everything as they knew they were taking on too much and needed to focus on rest and self-care. I reminded them that sometimes things happen in our life to open our eyes to

self-care. It could be a blessing in disguise as Joe's partner now has regular help coming into the home.

Brantford Success Story #2:
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 assisted him with a package of forms to fill out with my assistance as he needed glasses as well wish was arranged.

Over the course of our meetings he would open up more and more, the client became more trusting of me. The client had history of being taking advantage of in the past which left him in debt and lost his family, home, car, etc. With this has taken a toll on client's well being . The client said," he almost lost everything and his goal will to be happy again. I assisted him with transportation arrangements, medical bracelets, and switching pharmacies for more accessibility. The client is now living in transitional housing for aboriginal men. The client's health is back on track as I connected him with the Aboriginal health center where is he is receiving great health care advice from our Dietitian, foot care , reflexology . 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, his now focusing on more permanent housing. He is very grateful for all the continued help he receives.

As the Aboriginal Patient Navigator in Brantford Region, I look forward in seeing great things happen in his life as he becomes stronger in mind, body and spirit.

Hamilton Success Story:
APN has been following an elderly client through the hospital system, from ambulance calls, hospital admissions, acute falls, and waiting for a long term care (LTC) bed from the hospitals rehabilitation floor.

Client had a fall in their 1 bedroom bachelor apartment, which is extremely cluttered. Ambulance was called and client went to St. Joseph's Hospital. It was determined through diagnostic testing that client would need a spinal surgery. This surgery would be done at Hamilton General Hospital with a skilled orthopedic surgeon. Surgery went as well as could be expected and client recovered for a couple days in Hamilton General Hospital. Client reported not liking their care or treatment at this hospital and couldn't wait to return to St. Joseph's Hospital where they had developed a good trusting relationship with the rehabilitation floor social worker.

Client never reported having any family or friends to check in on them. They had no visitors other than the APN and hospital staff.

It was determined that due to the stairs at their apartment and now being wheelchair bound, the client could not return to their current home. The amount of clutter and small area would not accommodate a wheelchair.

Client had many mixed emotions surrounding these developments. APN and Social Worker assured client we would assist them and gather some of clients treasured belongings from their apartment. APN got some boxes, social worker gathered bags and gloves. We brought flashlights as there was no heat or hydro. Client drew a map, made a list and face timed APN and Social Worker in apartment. We were able to recover most of the items that client wanted to have with them.

Client is now awaiting LTC bed from hospital.

This story shows how we care for our people and go above and beyond to assist whenever possible. It has been a pleasure to be a part of this client's journey and I hope they will allow me to continue to visit.

Niagara Success Story:
APN was able to assist a client with a life changing experience. While this client has only been with the De dwa da dehs nye>s since 2016, the APN has worked with this individual since 2014 in different capacities and roles in the Niagara community.

This individual was known as a 'hard to reach' person with high risk behaviours. This individual would participate in self destructing behaviours that often left them emotionally disconnected and physically unwell. Addiction, trauma, family dysfunction, and chronic homelessness were often the cause.

While this client had participated in many community outreach programs and attended several treatment centres, they were never able to complete the programs. From the client's point of view, they did not feel the supports available were addressing their core issues and felt like "another person in the long line".

As the APN was able to build a positive rapport with this individual over the years, the APN was able to provide on-going case management as well as consistent emotional and cultural support. However, overtime it was becoming clear that the client was deteriorating and starting to lose hope.

While this downward spiral was becoming increasingly concerning for both the client and community supports, the APN saw a new opportunity to assist the client. Through intensive case management and collaboration with several service providers the APN was able get the client into a six (6) month Indigenous Land Based Mental Health and Addiction program.

Leading up to the admission of the program several things needed to be arranged and organized. The client needed a dental and medical work up, transportation to the facility, financial assistance as well as food and money for travel, completed paperwork and numerous comprehensive video conferences and intake meetings.

Overall, the process to complete the intake package took place over six (6) weeks. Several individuals and agencies were involved.

To date: the client just successfully graduated from the treatment program. The APN was able to send an encouragement letter to be read at the graduation ceremony. In speaking with the program coordinators and clinical staff, the client did extremely well and engaged in every aspect of the program. The APN was informed that the client is moving into the second stage of the program where they will attend secondary school. The client will be taking studies in the social science field as they now want to help others who have experienced the same issues they did.

Our Mental Health Youth Patient Navigator works with the local schools and Indigenous and mainstream agencies to facilitate mental health group programs and link Indigenous youth to services that will help improve their social determinants of health. The MHYPN also supports youth/emerging adults to transition more smoothly between youth and adult mental health services. The following patient example demonstrates how the MHYPN works not only with internal providers but also provides linkages and connection to external community and cultural supports.

A youth client (pseudonym: Chris) in Brantford and has been a client of the health centre since 2014. Chris has been working with the Child and Youth Counselor, and recently transitioned to working with the Youth Mental Health Navigator (YMHN). Our staff had built a relationship/rapport with them through the Youth Circle Program. This youth has a history of struggling with anxiety and depression. The first time they met with the YMHN, Chris was very shy and nervous and would not look staff in the face. Chris has a very negative home environment and does not have a supportive family.

Chris accesses many services within the health centre. They continue to come to see the YMHN, while also seeing Psychiatry, Primary Care, Reflexology, and has also attended some of the healthy promotions programs. Chris has a circle of care surrounding her within the health centre. DAHC mental health staff work alongside Primary Care and Psychiatry to assist in supporting this client. The Health Centre is a safe place for Chris, and "it is a place to come and have supportive people support and help me" (her own words). No matter how Chris is feeling they will always show up to appointments.

Today Chris has made a lot of progress. Chris is still living with depression and anxiety but continues to push forward to break free from these struggles. When you meet this youth you would never guess that they struggle with depression and anxiety. Chris works hard towards goals and pushes through the struggle. Chris now stands taller and will look you in the eyes. They just recently finished a college course, and now has a part time job. Chris has more goals that they want to work towards, and still has more healing to do for themselves. This youth has so much motivation to continue on a healing journey and continues to push their own boundaries. Chris continues to come to health centre for support and reaches out when they needs to. They have come a long way and this has been a very positive success.

In September 2018, DAHC engaged in a partnership with the Brantford Rapid Access to Addictions Medicine (RAAM) clinic whereby a DAHC mental health outreach counselor would work on site at the clinic two days per week. This partnership involves DAHC, Brant Community Healthcare System, two mainstream mental health organizations, and addictions

physicians, who have come together to deliver wrap-around service for individuals in need of rapid, comprehensive assessment, diagnosis and treatment for all substance-use disorders. The RAAM clinic only operates two days a week, and approximately 29% of clients are Indigenous. The clinic has supported 103 individuals in the first three (3) months of operation.

The following success story exemplifies the value of collaboration, connection, navigation, advocacy and support provided by our mental health counselor and the Hamilton APN:

A client (pseudonym: Dana) through the Brantford RAAM clinic was recently hospitalized and relocated to a hospital in Hamilton for kidney care. Dana is an elderly individual, who lives with their daughter and 2 grandchildren. Last November Dana was evicted from their home and has been staying at a temporary motels since then. It has been very difficult for the family and it has been even harder on Dana's personal health, which they have neglected since becoming homeless. I connected Dana with Stephanie, the Aboriginal Patient Navigator, who began visiting at the hospital to offer support. Initially Dana was very insistent that they return to live with their family – but we knew that this would be putting their health at dire risk. While staying with their family, personal and medical care was being neglected and food was scarce. When Dana was admitted to the hospital, they were very thin, malnourished and had sores on their body from the cold and lack of care. Although Dana's family loves them very much, at this time they were not in a position to care for Dana. Recently Dana agreed to relocate to a care facility in Brantford, where they could be close to their family and also receive the much needed care and medical attention required. As a team providing wrap around service for Dana, we were all pleased to see them come around and acknowledge that they are worth caring for too. The family is happy with this solution and is now focusing on ways they can secure better housing for themselves.

According to 'Our Health Counts' (OHC) 16% of First Nations people have diabetes. This partnership will contribute to better vision health for our diabetic patients. Our Diabetes Education Program has continued to cultivate partnerships 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. In addition, hearing screening clinics are also offered to patients in the Diabetes Education Program.

Our Primary Care Clinic is continuing to cultivate a relationship with the Hamilton Pain Clinic to provide our clinicians with assistance in providing care to our complex patients with pain management needs. In late 2018, clinicians from the Pain Clinic attended onsite at De dwa da dehs nye>s to meet with complex patient and De dwa da dehs nye>s clinicians to provide guidance and support for managing pain.

In the 2018-19 year we also initiated our partnership with a local geriatrician to provide our Primary Care clinicians support for caring for our geriatric clients. In addition to this, our Hamilton and Brantford sites have LHIN Care Coordinators housed in our offices to provide direct case management and homecare support for our clients.

Over the last few years, the Healthy Living Department has delivered initiatives over the holidays in both sites designed to alleviate the burden that people can feel during this time of

year. In Brantford, we deliver in partnership with Brantford Native Housing, an annual basis the Children's Annual Holiday party. The event is targeted toward Brantford Native Housing tenants and De dwa da dehs nye>s patients and program participants. A festive meal is provided and every child that registers is given a gift from Santa. This is event is growing in popularity over the years. We served over 300 individuals at the 2018 event.

In Hamilton, the Healthy Living Team, in partnership with the other departments provides holiday hampers for patients/participants who are in need. The hampers provide the necessities for a holiday meal and staples such as toiletries and household products to assist them through January. Each hamper comes with a gift card for the purchase of a turkey.

Our Housing Services Program (formerly known as Homeward Bound team) works collaboratively 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. As mentioned above our Housing Services Program: From Homelessness to Community was provincially recognized in June for the impact it is having on the Urban Indigenous Homeless Individuals in Hamilton. Our program has exceeded performance targets since its inception (house 90 individuals over three years) and to date we have house 276 individuals.

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. We also develop relationships with local landlords and provide assurance against property damage and rent arrears.

Capital Planning

De dwa da dehs nye>s is in Stage 2 of a Capital Planning process for new sites in Hamilton and Brantford. A potential site, a surplus school under the Hamilton Wentworth Catholic District School Board (HWCDSB), has been identified for the Hamilton project. In February 2017, the HWCDSB declared the property surplus and the City of Hamilton passed a motion to support the City's purchase of the property to hold for De dwa da dehs nye>s to build a new community hub. De dwa da dehs nye>s has been meeting with the other Indigenous agencies in Hamilton and current programs offered on the site to develop the Biindigen Community Hub. Biindigen is an Anishinaabe word meaning Welcome!-Come In!

In Brantford, staff are working with the local Indigenous agencies to identify partnerships in the new hub. Although land has not been confirmed we are working with the City of Brantford to identify possible sites for the new hub.

With both hubs, staff are looking at the possibility of sharing common back office functions such as reception, security, building maintenance and possibly IT Infrastructure, Human Resources and Financial Services.

Workplace violence prevention

Every year the staff of De dwa da dehs nye>s are required to participate in Workplace and Harassment Training. With the introduction and passing of Bill 132 Sexual Violence and Harassment, De dwa da dehs nye>s has undertaken a review of the current Workplace Harassment and Violence policy and the policy was updated. The new policy was inclusive of the requirements outlined in Bill 132. Training on the new policy was provided at the April 2018 All Staff Meeting and at the February 2018 Board meeting.

All complaints of workplace violence and/or harassment are take seriously and investigated. Findings of investigations are communicated to all parties involved.

Annually, all staff are required to take WHMIS training.

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:
Bryanne Smart, Quality Committee Chair
ext. 261 or jmattina@dahac.ca

Other

In December of every year we conduct our Annual Patient Experience Survey. The testimonials below were received as from patients as part of the survey process:

- De dwa da dehs nye>s has helped people a lot. They saved me. I am very proud of myself. Health Centre helped me live and stay alive. I thank them all every day!

- There are services in the community life food banks and crisis intervention that are serviced by Catholic Institutions. Having grown up without access to my Anishinaabe culture because my culture was replaced by Christianity through residential schools and other vehicles of cultural genocide, I resent that I need to access Catholic institutions like the good shepherd (food security) or COAST (Crisis intervention). Those funds should be redirected to you so Indigenous people can access services from a culturally appropriate provider.

- Connected on a personal level to become aware of exactly what my needs at that moment were for that situation.

- Treated me with respect and kindness and were present with me. I didn't feel rushed.

- The Aboriginal Health Centre listens to me use my voice.

- When I needed to be seen right away. I was able to get in that same day I called.

- I feel that I was and always am treated like a person, not just a patient, but someone who is care about and thought of. I APPRECIATE THIS AND ALL THE RECEPTIONISTS and nurses/doctors

- All my questions were answered all my concerns were dealt with.

- Relaxed non-threatening atmosphere.

- Made me feel welcome, important and cared for.

- Thank you for being their for me, to help strengthen me and close our problems from the past.

- I appreciate everything you all do. You have helped me get my life back. Thank you.

- Been to 4-5 other centers This has been the best experience.

Sign-off

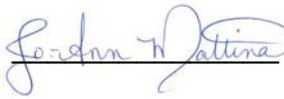
It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

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

Pat Mandy, Board Chair  (signature)

Bryanne Smart, Quality Committee Chair or delegate  (signature)

Constance McKnight, Executive Director/Administrative Lead  (signature)

Jo-Ann Mattina, Other leadership as appropriate  (signature)

2019/20 Quality Improvement Plan for Ontario Primary Care
"Improvement Targets and Initiatives"

De Dwa Da Dehs Nyes Aboriginal Health Centre 200-678 Main Street East

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Percentage of patients who have had a 7-day post hospital discharge follow up for selected conditions. (CHCs, AHACs,NPLCs)	P	% / Discharged patients	See Tech Specs / Last consecutive 12-month period.	92212*	45.2	47.00	The 2015-2017 Practice Profile Report (covering the period of April 1 2015 to March 31, 2018) is the source of data for this indicator. As we are using old data to report and build a target and based on the data have not achieved this target that the target remain the same for the 2019-20 fiscal year.		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 be added to the clinic voice mail for patients to inform reception staff if they have recently been discharged from hospital. Signage with reminders will also be placed around the clinic.	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 coordination with hospitals.	
		Percentage of those hospital discharges (any condition) where timely (within 48 hours) notification was received, for which follow-up was done (by any mode, any clinician) within 7 days of discharge.	P	% / Discharged patients	EMR/Chart Review / Last consecutive 12-month period.	92212*	CB	CB	We do not report on this indicator.		1)At this time we do not report on this indicator, we report on a similar indicator.	At this time we do not report on this indicator, we report on a similar indicator.	At this time we do not report on this indicator, we report on a similar indicator.	At this time we do not report on this indicator, we report on a similar indicator.	At this time we do not report on this indicator, we report on a similar indicator.
	Timely	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or next day, when needed.	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	92212*	28.48	44.00	We are keeping the target in the 2019-20 fiscal year. With the additional of Same Day Access and Walk-in Clinics we find that the patients/participants are not necessary answering this question appropriately. We will review the question being asked to ensure it captures the data for this target		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 and next day appointments.	
											2)Introduction of weekly evening walk-in clinics for rostered patients	Providing clients with walk in access to Primary Care services one evening per week to meet urgent episodic care.	Measure the utilization of the walk-in clinic appointments at each site to ensure it is being utilized to its fullest.	Patient satisfaction with access to same day and next day appointments.	
											3)Introduction of Same Day Access for Primary Care Patients	Currently the Brantford clinic offers one afternoon per week with Same Day Access appointments. In Hamilton there are three afternoons being offered for Same Day Access	Measure the utilization of the same day access appointments at each site to ensure it is being utilized to its fullest and promoting an efficient use of Clinician time.	Patient satisfaction with access to same day and next day appointments.	
Theme II: Service Excellence	**Patient-centred**	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?	P	% / PC organization population (surveyed sample)	In-house survey / April 2018 - March 2019	92212*	91.86	100.00	We dropped a bit in this indicator in the 2018-19 year so we are keeping the target the same.		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.	

		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?"	C	% / PC organization population (surveyed sample)	In-house survey / 2018-19	92212*	100	100.00	To gauge patient's perception of the amount of time spent with clinicians.		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.	
		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?"	C	% / PC organization population (surveyed sample)	In-house survey / 2018-19	92212*	99	100.00	We achieved 99% for this indicator in 2017/18 and 2018/19 we dropped slightly. We 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 Survey	Patient understands their treatment options and treatment.	
Theme III: Safe and Effective Care	**Effective**	Proportion of primary care patients with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	92212*	CB	CB	At this time no target has been identified as we are collecting baseline data on this indicator and will report on once data is available		1)A review of the EMR data for this indicator will take place.	Reports will be generate by our EMR to ensure that we are pulling the data correctly and to identify base line performance.	Once a base line performance level is identified we will begin developing process measures for the indicator.	To identify palliative care needs early though a comprehensive and wholistic assessment.	
		Percentage of Ontario screen-eligible women, 21-69 years old, who completed at least one Pap test in 42-month period.	C	% / PC organization population eligible for screening	EMR/Chart Review / 2018-19	92212*	61.6	63.87	Although we did not meet this target we have kept this target the same for this year. Our current performance is taken from the results at the end of Q3 for the 2018-19 fiscal year.		1)Continue to utilize the data mining component of the new EMR to identify eligible patients and to offer to provide the service to them.	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.	
		Percentage of patients with diabetes up-to-date with glycated hemoglobin (HbA1C) tests	C	% / patients with diabetes, aged 40 or over	ODD, OHIP-CHDB,RPDB / 2018-19	92212*	71.65	79.65	This is only the third year collecting this information. By the third quarter of 2017-18 we exceeded our initial target; therefore, we are increasing this indicator for 5% in 2019-20.		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 levels. Decrease diabetes related complications.	
		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 / 2018-19	92212*	51.88	55.00	We exceeded the target for this indicator at the end of Q3 in 2018-19 therefore, we are projecting a 5% increase in this indicator for 2019-20.		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.	
											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.	
		Percentage of screening eligible patients up-to-date with cervical cancer screening QIP	C	% / PC organization population eligible for screening	EMR/Chart Review / 2018-19	92212*	49.34	53.00	We have not met the target as of the end of the third quarter of the 2018-19 fiscal year. As a result, we		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.	
		Percentage of screening eligible patients up-to-date with colorectal cancer screening (Retired)	C	% / PC organization population eligible for screening	EMR/Chart Review / 2018-19	92212*	51.85	54.00	We did not meet this target for this indicator in 2018-19; therefore, we are keeping this indicator the same for 2019-20.		1)Continue 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 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.	

	Safe	Percentage of non-palliative patients newly dispensed an opioid within a 6-month reporting period prescribed by any provider in the health care system	P	% / Patients	CAPE, CIHI, OHIP, RPDB, NMS / Six months reporting period ending at the most recent data point	92212*	CB	CB	At this time we are collecting our base line data and will report on this indicator when data is available.		1)A review of the EMR data for this indicator will take place.	Reports will be generated by our EMR to ensure that we are pulling the data correctly and to identify base line performance.	Once baseline performance level is identifed we will begin developing process measures for this indicator.	to identify non-palliative patients newly dispensed an opioid within a 6 month report period.	
Equity	**Equitable**	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.	C	Count / All patients	In house data collection / 2017-18	92212*	6549	8500.00	Our target in 2018-19 is 8000 and we are on track to meet the target by the end of Q4. As a result, we have increased the target to 8,500 for the 2019-20 fiscal year.		1)In 2017-18 the Healthy Living Department engaged members of the community through programs and services such as camps, healthy living programs, and diabetes education sessions. All of the Health Promotions programming have cultural component to enrich the participants spirit as well as their physical health.	To have over 8,500 persons attending our wellness and healthy lifestyle programs.	Quarterly reporting on the number of program participants registered within the new EMR.	To increase access and attendance to Wellness and Healthy Lifestyle programs.	