De dwa da dehs nye>s Aboriginal Health Centre

Quality Improvement Plan

2020-21

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Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2019/2020 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 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	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; In house data collection)	92212	6549.00	8500.00	3755.00	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 2019/20)	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 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.		During the first two quarters of the 2019-20 fiscal year one Health Promoter position was vacant. The position was filled late in the second quarter and as a result the outreach numbers have increased considerably in the third quarter.

ID	Measure/Indicator from 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
2	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); 2018-19; In-house survey)	92212	100.00	100.00	98.50	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.		The results of the 2019-20 Patient Experience Survey reports that 98.5% of the respondents feel their clinician spends enough time with them during their appointment. 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 Training. All staff and Board Members have or are in the process of receiving the Indigenous Cultural Sensitivity training. The goal is for all staff to be certified.

ID	Measure/Indicator from 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
3	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 2018 - March 2019; In-house survey)	92212	91.86	100.00	89.95	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's "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 2019-20 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 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
4	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); 2018-19; In-house survey)	92212	99.00	100.00	99.40	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.		We are slightly above our target in the 2019-20 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 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
5	Percentage of non-palliative patients newly dispensed an opioid prescribed by any provider in the health care system within a 6-month reporting period. (%; Patients; Six months reporting period ending at the most recent data point; CAPE, CIHI, OHIP, RPDB, NMS)	92212	CB	CB		

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A review of the EMR data for this indicator will take place.		We are waiting for a report from our Data Management Support to identify progress on this indicator.

ID	Measure/Indicator from 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
6	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; 2018-19; EMR/Chart Review)	92212	61.60	63.87	55.71	

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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.		The 2019-20 QIP had similar indicators to measure this cancer screening. As a result, we are reporting under the performance under the other target. We will not be reporting on this target in the 2020-21 QIP.

ID	Measure/Indicator from 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	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 2019 - March 2020; In-house survey)	92212	28.48	44.00	30.16	We have continued with 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.		
Introduction of weekly evening walk-in clinics for rostered patients		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.
Introduction of Same Day Access for Primary Care Patients		

ID	Measure/Indicator from 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
8	Percentage of patients who have had a 7-day post hospital discharge follow up, by a community care provider for selected conditions- CHCs. (%; Discharged patients ; Last consecutive 12-month period.; See Tech Specs)	92212	45.20	47.00	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 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
9	Percentage of patients with diabetes up-to-date with glycated hemoglobin (HbA1C) tests (%; patients with diabetes, aged 40 or over; 2018-19; ODD, OHIP-CHDB,RPDB)	92212	71.65	79.65	72.48	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 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
10	Percentage of people/patients overe 65 who report having a seasonal flu shot in the past year (%; PC organization population eligible for screening; 2018-19; EMR/Chart Review)	92212	51.88	55.00	51.30	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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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 numbers will increase over the year.

ID	Measure/Indicator from 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
11	Percentage of screening eligible patients up-to-date with cervical cancer screening QIP (%; PC organization population eligible for screening; 2018-19; EMR/Chart Review)	92212	49.34	53.00	55.71	At the end of the third quarter of the 2019-20 fiscal year we are above 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 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 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
12	Percentage of screening eligible patients up-to-date with colorectal cancer screening (Retired) (%; PC organization population eligible for screening; 2018-19; EMR/Chart Review)	92212	51.85	54.00	NA	

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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.		This indicator is retired. No reporting is required.

ID	Measure/Indicator from 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
13	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. (%; Discharged patients ; Last consecutive 12-month period.; EMR/Chart Review)	92212	CB	CB	45.20	We do not report on this indicator

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At this time we do not report on this indicator, we report on a similar indicator.		

ID	Measure/Indicator from 2019/20	Org Id	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
14	Proportion of patients with a progressive, life-limiting illness who were identified to benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment. (Proportion; All patients; Most recent 6 month period; Local data collection)	92212	CB	CB	CB	

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A review of the EMR data for this indicator will take place.		We are waiting for a report from our Data Management Support to identify progress on this indicator.

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

2/10/2020

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 improving the health and well-being of Indigenous individuals, families and communities through wholistic Indigenous, Traditional and Western health care.

"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 once again been used to support the development of the Quality Improvement Plan for the 2019-20 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:

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

De dwa da dehs nye>s has 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.

Emergency Room (ER) Use:
- 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. This is demonstrated in the following success story:

During the second quarter the APN worked with an individual who was struggling with social and emotional supports. The individual had some family support, however due to family related trauma; the family was in no position to provide the support this individual required.

Previous to completing my initial intake with the client, as the client had been hospitalized for four months and discharged to an Independent Living home. Once hearing the client’s story it was clear that the individual needed several referrals to community services, advocacy with Ontario Disability Support Program and assistance with transportation as the client is wheel chair bound. As a result of these barriers the APN also recognized the client was beginning to experience serious mental health and suicidal ideations due to the lack of social interaction with community, proper medication and emotional support.

Over the course of a few months the APN was able to advocate on the clients behalf to receive appropriate transportation through ODSP. The APN accompanied the client to doctor appointments to have required forms completed and medication examined and adjusted to what the client needed. Once transportation was approved the APN

advocated with Red Cross to have a transportation account set up as well with the local Taxi company.

With transportation now being covered, the APN referred the client to the Indigenous Diabetes Health Circle to connect with Elders, The Niagara Falls Community Health Centre for community support programs and the Aboriginal Health Centers Mental Health Counselor for emotional support. While the client still struggles to work through some mental health issues, they now have access to community and emotional supports. The APN consults with the PSW in the Independent Living Home regularly and schedules home visits every other week to check in with the client. Once the client is in a good mental health space, the APN believes they have the support and access to services the client was not previously receiving.

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.

Indigenous 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.

The example below provides a snapshot of the services offered through our Housing Services Program.

Through collaborative case management support of Indigenous Housing Services (IHS), a client who was couch surfing and living on the streets was provided accommodations within a temporary supportive rooming house 10 months ago. This client resided within this setting with the determination of obtaining his own

apartment that would be a permanent place to call home. At the end of September, this individual was ready to take the next step to independence and was able to obtain his own one bedroom housing while staying connected with IHS for continuous case management supports.

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

In October 2019, De dwa da dehs nye>s hosted its 5th 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 last year's gala was Howie Miller. Howie is an Indigenous Comedian that highlights current day issues with a humorous approach to promoted education and awareness of current Indigenous issues.

Backpack Events
De dwa da dehs nye>s Aboriginal Health Centre hosted two very successful back to school backpack events(one in Brantford at 36 King Street and the other in Hamilton at 678 Main Street).

Brantford received approximately 194 backpacks, while Hamilton received approximately 216.

The event was designed to encourage the students to come and "shop" for their back to school needs, this allowed them to choose the items and colours (where appropriate) for what they wanted and/or needed. De dwa da dehs nye>s provided the students with back to school essential items appropriate for kindergarten and all the way through to high school. Our partnership with Save the Children, PVH and Korn Ferry provided the backpacks. A previous donation from PVH allowed us to combine a small back to school clothing section that included winter hats and scarves, cardigans, shoes and socks. Due to the need and success of this addition in Brantford, it was expanded for the event in Hamilton with a call to staff to include gently used clothing and coats.

Overall, both events were very successful and many community members were supported with their back to school needs. We continue to provide backpacks with supplies available to those who have reached out and were not able to attend the events.

Save the Children and Scholastic
We would like to thank our valued partner Save the Children and Scholastic for their contribution in support of De dwa da dehs nye>s child/youth and family education initiatives. In support of literacy and most importantly Indigenous children and youth, families and communities, Save the Children Canada and their donor Scholastic has contributed 400 Scholastic child and youth books and 400 Klutz kits! The Scholastic books and Klutz kits will be delivered in late February 2020. We will distribute the books and Klutz kits during our child /youth and family programs and events in Hamilton, Brantford and Niagara.

Message from Save the Children:
"Thank you for all the hard work you are doing to promote health and education and literacy for children in your communities. We appreciate the opportunity to contribute to your efforts and help and supporting children's education".

PS Suites Electronic Medical Record
In October 2019, De dwa da dehs nye>s transitioned to a new Electronic Medical Record (PS Suites) from Nightingale on Demand. PS Suites is more user friendly and staff are embracing the new electronic medical record. Ongoing training for staff is occurring.

2019-2022 Strategic Plan
In March 2019, the Board of Directors approved a new three year strategic plan. The strategic plan has three priorities: Developing People, Enhancing Performance and Cultivating Partnerships. As part of the Enhancing performance priority, De dwa da dehs nye>s is working toward accreditation through the Canadian Centre for Accreditation. The site visit has been scheduled for November 2021.

Our capital projects for new community wellbeing centres in Hamilton and Brantford continue to be a priority for the staff and Board. In Hamilton, De dwa da dehs nye>s has expanded its current partnership with Niwasa Kendaaswin Teg, Ontario Aboriginal Housing Services, and the McQuesten Planning Team to include the McMaster University's Department of Family Medicine to provide Primary Care Services to the Non-Indigenous population in the McQuesten Neighbourhood. In addition, it is providing an opportunity for Medical Residents to practice in a culturally safe environment.

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 a hospital longer than required is not in the best interest of the patient. 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:
The APN received a call from the chaplain at BGH about an Indigenous patient looking for support. The APN went to the hospital to see the patient at their request. They live in Brantford and are Anishnawbe. They have been diagnosed with cancer and it is in the later stages. We talked for a while about their feelings and their plans, they said they kind of already knew, and they are dealing with it quite well but their fear is their children. They know that they will be taking it hard. They asked me to be present as they told their children about the diagnosis and their plan.

Week after week the APN would go see them and bring them the papers, care pack, coloring, etc. I listed as they told me about their week and speak of their children, they love them so much. They said they really enjoyed my coming to see them as it gave them comfort.

They slowly started to decline and got moved to palliative care and their children started coming in more and staying through the nights. It gave them some peace

knowing they were close by. They got to spend one on one with each of their children before they passed which was one of their wishes. I told the oldest daughter that was what they had wanted and some of the other things they had wished for. It was nice to see it all come together as they requested and for everyone to put their feelings aside and abide by their wishes.

They lasted three and half weeks in the palliative care unit and passed peacefully with family by their side, and their favorite songs being sung and drummed. The family's request was to do a cedar bath for them as they slowly wanted to reconnect back to their roots. This was unplanned but thought it would be so special. They didn't think it could be done on such short notice, so gave a call to the social worker to see how long we had to arrange.

I ran and searched for some fresh cedar. I laid down tobacco and got it boiled up and transported back to the hospital for the family to do the cedar bath. There were more and more people who got there to help bring them and the patient on their journey.

A smudge took place and then the cedar ceremony and bath. It was so peaceful for them and their family to witness. The singing and the drumming was so touching. I was glad they asked me to stay to be a part of her end of life celebration.

Hamilton:
A client of AHC contacted this APN for support during the death of a family member. The family member was held in Toronto and the family needed to get the body to their home reserve in the North.

After consulting with AHC to inquire if there was such a fund to assist community members with this particular situation, APN was informed there were no funds to support the family.

The family was then referred to Social Services in Toronto and Canada Pension Plan. APN provided the number for Social Services and printed the document for Canada Pension Plan. A phone call was made to the First Nations where the family was from and they sent an application for the family to apply for consideration. The application was printed and provided to the family.

The package contact information was provided if the family required assistance with filling out the application. The contacts included APN. The family did call and was supported via telephone to complete the application.

The family was successful with getting their loved one back to their original homeland. The family was able to work together and support each other during the journey to join their ancestors.

The family later called to express their gratitude for the support of the Health Centre that assisted them with the emotional, spiritual and mental wellness when they need their community.

Niagara:
The APN Niagara has recently been working with a client who struggles with complex mental health in addition to several social and economic barriers. With little to no family support this client was left to navigate the health system on their own.

A referral came into the APN through the mental health department at the St. Catharines Hospital site. The client had been in the mental health department for

about three weeks. The referral was to ensure the client did not fall through the cracks once they were discharged back into community.

Since the referral and discharge into the community, the APN has been working very closely with the client as many areas needed to be addressed. The client was placed in a community living group home in Crystal Beach, which made and continues to make accessing services very difficult. Regular contact with the ODSP worker has alleviated some of this stress. In prioritizing the clients most immediate needs the APN had to strongly advocate for a community psychiatrist as the client was using the emergency department for medication refills; the client now has regular appointments with community psychiatrist. As the client is also involved with the court system, the APN advocated and connected client to the CMHA court support services where the client will receive additional mental health supports and is currently awaiting a referral to Developmental Services Ontario. To address the social needs of the client, The APN has referred the client to the internal mental health counselor and schedules weekly home visits to ensure the client feels supported. At the request of health care providers and the client, the APN also attends all appointments: psychiatrist, injection clinic, mental health etc., and arranges transportation to and from appointments.

To date, the client has only had two short hospital admissions. Compared to previous months, this number has dropped substantially as the client was presenting at the E.R regularly for a variety of reasons. With continued support and connection to services, the hope is the client will build a community that meets the needs in all areas of their well-being.

Diabetes Education Program
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.

Pain Clinic
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 2019, clinicians from the Pain Clinic have 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 fall of 2019, De dwa da dehs nye>s was invited by the Ministry of Health to submit a proposal for a pain clinic.

Geriatric Care
In the 2019-20 year we also continued 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.

Healthy Living
At the end of the third quarter (Q3) the Healthy Living Department delivered two community events for children and their families in both of our catchments of Hamilton and Brantford. The Children's Holiday Party in Brantford is an event that has been happening for the last nine years. It was hosted at the Civic Centre and 280 participants attended. All the participants received a holiday meal and

children aged 0 to 16 received a gift from Santa. The gifts were provided by the Dawn Adams gift program, which is a program sponsored by the employees of RBC. Santa made an appearance at the dinner, as well as the Old Mush Singers, to add some cultural music into the event. This successful event was hosted in partnership with Brantford Native Housing, Niwasa Kendaaswin Teg and the Brantford Regional Indigenous Support Center. The event took place on December 19, 2019.

On December 21, 2019, the Fetal Alcohol Spectrum Disorder (FASD) and Children's Nutrition Program hosted an event at the Steelworker's Hall in Hamilton. Approximately 120 participants attended this event. Not only was a holiday meal provided, in addition, a toy bingo was organized for any child that was in attendance.

Indigenous Housing Services
Our Indigenous 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 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. In May 2019, the City of Hamilton has taken possession of the property to hold for De dwa da dehs nye>s. In addition, we have been meeting with the other Indigenous agencies in Hamilton and current programs offered on the site to develop the Biindigen Wellbeing Centre. Biindigen is an Anishnawbe 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.

Urban Farm
Over the fall and early Winter of 2019-20, the City of Hamilton and De dwa da dehs nye>s have entered into discussions for De dwa da dehs nye>s to take over the operations of the Urban Farm effective February 2020. The urban farm is adjacent to the proposed Biindigen Wellbeing Centre.

Patient/client/resident partnering and relations

Patient/Participant Feedback
In December 2019, 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.

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 2020-21 quality improvement activities. Responses also inform Capital Planning and future space and resource needs of our clients.

Patient/Participant Testimonials
Testimonial #1:
This is a really great centre. I am so thankful for all the programs and services offered to me here. Thank you very much!

Testimonial #2:
Nya:weh/Thanks All. Good care. Good job!! I feel I am in best of care at DAHC!

Testimonial #3:
I like coming here; I feel like I belong which is wonderful.

Testimonial #4:
Best place for me willing to always look at alternative solutions. EXCELLENT!

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 taken seriously and investigated. Findings of investigations are communicated to all parties involved.

Annually, all staff are required to take WHMIS training.

Alternate level of care

The concept of "taking care of each other amongst ourselves" is essential to what we do. Although we do not have a program targeted towards the reduction of ALC, many of the programs and services we provide are naturally aligned to reduce the incidents of ALC patients among the Indigenous Community.

The Wheels for Seniors program provides medical transportation to Indigenous Seniors (and those with early on-set aging), as well as those with complex physical

disabilities, to access door to door service for medical appointments and to other agencies that support the individuals social determinants of health (i.e. supermarket and cultural ceremonies). Additionally, we support Indigenous Peoples (often the poorest and most marginalized) to access Health Promotions programming, and Traditional Healing Services such as Sweat Lodges, Ceremonies, etc. on reserve lands, in rural areas, and in differing cities. The transportation program provides greater access to care for Indigenous Seniors and reduces the social isolation.

Our Aboriginal Patient Navigators also work very closely with senior individuals and their families to navigate the health system to ensure proper supports are available for Indigenous Seniors to be able to return to home.

Virtual care

We currently do not participate in virtual care; however, this is an area that we are open to explore further.

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

Chief Executive Officer:
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

Sign-off

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

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

Board Chair _____ (signature)
Quality Committee Chair or delegate _____ (signature)
Executive Director/Administrative Lead _____ (signature)
Other leadership as appropriate _____ (signature)

2020/21 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, L8M1K2

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 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*					1)				We have no way to capture this data as the last Practice Profile report has released in 2017. We are working on old data.
	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 2019 - March 2020	92212*	30.16	31.70	With the addition of Same Day Access and Walk-in Clincs we find that patients/participants are not answering this question appropriately. We will review the question being asked to ensure the information gathered will be an accurate measure of this indicator.		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)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)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 2019 - March 2020	92212*	89.95	94.50	We dropped a bit in this indicator over the last few fiscal years 2018-19 so we are keeping the target by 5%.		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.	

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
		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	% / Patients	In-house survey / 2019-20	92212*	98.5	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.	
		Percentage of screening eligible patients up-to-date with Papanicolaou (Pap) tests	C	% / Patients	EMR/Chart Review / 2019-20	92212*	55.71	58.50	We have not met the target as of the end of the third quarter of the 2018-19 fiscal year. As a result, we are keeping the target the same.		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.	
Theme III: Safe and Effective Care	**Effective**	Proportion of patients with a progressive, life-limiting illness who were identified to benefit from palliative care who subsequently have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion / All patients	Local data collection / Most recent 6 month period	92212*	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 through a comprehensive and wholistic assessment.	
		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 / 2019-20	92212*	72.48	76.10	We did not achieve the target in the 2019-20 fiscal year. We have identified a modest increase of 5% in 2020-21.		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	Percentage of non-palliative patients newly prescribed an opioid by a provider in your organization within a 6-month reporting period.	P	% / Patients	EMR/Chart Review / most recent data point or end of calendar year	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.	

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
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 survey / 2019-20	92212*	3755	8500.00	We have kept the target the same in 2020-21 as we had staff vacancies that impacted the results for this target.		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.	