Let's Make Healthy Change Happen.

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

De dwa da dehs nye>s Aboriginal Health Centre

3/28/2018

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, Homelessness, and Health Promotion, and Education Services. The Health Centre serves all Indigenous people, regardless of status and offers assistance to outside service organizations to provide care in a culturally appropriate way. The Health Centre has two sites, one in Hamilton and a second in Brantford, with satellite offices in both communities. In addition, the Health Centre provides mental health services in the Niagara Region.
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Describe your organization's greatest QI achievements from the past year

De dwa da dehs nye>s Aboriginal Health Centre hosted a national conference in October 2017 entitled Building on Our Roots ~ Indigenous Health Practice and Research. The conference provided a forum to share opportunities for Quality Improvement, to identify disparities in the care provided to the Indigenous Community and to highlight opportunities for the advancement of improved care.

The conference featured key note addresses from Dr. Malcolm King who addressed the future of Indigenous Health Research. In addition, participants heard from Dr Maureen Lux on the Indian Hospital's in Canada, Dr. Amy Montour with her perspective on learning to practice medicine with an Indigenous world view, Maya Chacaby on the Ethics of Reconciliation and Rick Hill Preparing our Mind and Spirit for Reconciliation. DAHC team members presented several papers focusing on experiences and in program development and evaluation.

The results of the conference evaluations were positive and noted that the sessions highlighted Indigenous Health issues and opportunities for moving forward and collaboration in the development of culturally relevant outcome indicators. Staff of De dwa da dehs nye>s were provided with an opportunity to reflect on the care that we provide and to obtain a greater understanding of the needs of the Indigenous Community.

Resident, Patient, Client Engagement

In December 2017, 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 we will be reviewing comments identified for areas for improvement to identify trends and strategies for Quality Improvement.

Feedback obtained from all sources helps to determine how well we are doing on existing indicators and helps to inform 2018-19 quality improvement activities.

Responses also inform Capital Planning and future space and resources needs of our clients.

The results were summarized and will be presented to the staff and Board in spring 2018

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 has been identified for the Hamilton project and staff have partnered with existing programs in the area as a way to engage the residents of the community. In the spring of 2017, the Healthier YOU program in Hamilton took the lead in opening our medicine garden at the McQuesten Urban Farms. We planted a three sister's garden and a four medicine garden (cedar, tobacco, sage and sweet grass). There was a fire and after the garden opening, there was a medicine walk.

Throughout the month of June 2017, the Aboriginal Patient Navigators (APNs) partnered with the hospitals in the Brantford, Hamilton and Niagara Regions to provide outreach and engagement to the Indigenous Community. In celebration of Aboriginal Day in June, the APNs set up information booths in hospitals across the regions to promote and educate partners on the APN programs and services.

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.

In May 2017 the APN program received a hospital referral for a family of four. The family had recently lost their mother. They were trying to manage their father's illness which had resulted in hospitalization around the same time their mother passed. Both parents were bed ridden and at home for several months before these events. The children were the caregivers. When the mother had passed her one request to her family was that her oldest child (50 years), who has Downs Syndrome, be connected to services. The APN worked with the family it became clear that the family was under a lot of stress as well as grieving the loss of their mother. The youngest son, who was primary guardian and Power of Attorney, was not sure how to proceed. The APN was able to support the family on several levels. The APN was able to organize a family meeting with the hospital to advocate a realistic discharge plan that the family was comfortable with. The APN planned hospital visits with the father to provide cultural support and medicines. The APN also connected with Developmental Services Ontario to organize a meeting to create a plan of care for the oldest son. Overall the APN was able to create a successful relationship with the family while providing support services for each member in their greatest time of need. The family has been and continues to be extremely grateful and the APN is incredibly humble that the family allowed the help in such a stressful and sensitive time in their lives. The APN continues to work with the family.

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

Our Diabetes Education Program works with the Ophthalmology Clinic, run in partnership with St. Joseph's Healthcare Hamilton and Hamilton Health Sciences, to

provide retinal screening for our diabetic patients that are enrolled in the Diabetes Education Program. 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 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. A one day information session was held in June 2017 with the DeGroote Pain Clinic Team to look at the benefits of an integrated Pain Management Treatment clinic. Clinicians have also been provided mentorship opportunities for prescribing opiods. In the 2017-18 fiscal year, the Primary Care program was approached by Dr. Douglas Mack, Pediatric Allergy and Asthma specialist. Dr. Mack is conducting asthma clinics for our rostered primary care patients at our sites. Dr. Mack approached De dwa da dehs nye>s to offer his services as a result of receiving a referral from our Primary Care Clinic.

For 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 on an annual basis the Children's Annual Holiday party. We partner with Brantford Native Housing to deliver this initiative and the service is targeted toward their tenants and our program participants. We rent a large venue and provide a festive meal and a toy for every child that registers. There is a DJ playing music and there is a visit from Santa. This party is delivered only in Brantford to fill a gap that was left when the Friendship Centre closed in 2007. In Hamilton, the Friendship Centre currently provides this service for the Aboriginal community has a long-standing tradition of providing this service thus there is no need for the DAHC to duplicate service. Since 2010, De dwa da dehs nye>s and Brantford Native Housing have been delivering a Children's Holiday Party. It has been interesting to watch it evolve over the years. In the beginning, it was so much more work than it needed to be. The Health Promotions staff cooked all the food for the event and the Clinic staff volunteered to serve it. With city grants the event is now catered. Over the years there have been many tweaks. The learning process has been long, slow and physically daunting; however, we were able to generate new ideas and resources streams and revise process fro running this project more efficiently.

Our 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. Homeward Bound: From Homelessness to Community is now represented at many planning tables and committees in Hamilton. Our team is also involved in providing programming and support, such as talking circles, drumming, traditional dancing, socials, and educational sessions on health and wellness encompassing all four directions of the medicine wheel.

Engagement of Clinicians, Leadership & Staff

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

The Board of Directors has a standing Quality Committee that meets quarterly and reports to the Board. This Committee includes: two Board Members, the Executive Director, Chief Operating Officer, Program Managers, Team Leads and a Community Member with skills and knowledge in Continuous Quality Improvement.

The Committee monitors the Centre's performance through review of the quality indicators on our Balanced Scorecard as well as the MSSA indicators. Compliance with regulatory requirements such as Occupational Health and Safety training are also monitored by the Committee and all of this information is summarized for submission to the Board. 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, Team Lead's discuss issues that could cross departments where collaboration would be useful. Team leads are also demonstrating an increased undertstanding 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.

The representation on the Committee helps to facilitate two way communication around quality issues and initiatives and helps to ensure that there is understanding by staff, Leadership Team, the Committee and the Board related to the priority objectives selected for the annual Quality Improvement Plan.

Population Health and Equity Considerations

DAHC services the Urban Indigenous Populations in Hamilton and Brantford. With investments by the Hamilton Niagara Haldimand Brant Local Health Integration Network we have been able to extend our reach into the Niagara Region by providing Adult Mental Health and Patient Navigation Services.

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 in the DAHC. This number will differ from what is internally generated from our Electronic Medical Record as we only have our internal data.

Relationships are an important part of the Indigenous culture and of the DAHC. It is important for our staff to develop and cultivate relationships with our clients in order to create an environment that is culturally safe. 91% of our staff has completed Indigenous Cultural Sensitivity 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 in our

capital planning process, there will be a greater demand for services from DAHC. 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. 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."

DAHC 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 is a transportation program for seniors and those with chronic mobility issues. to attend programs and services that will improve their physical, mental, emotional, and spiritual health. Due to the prevalence of chronic disease in the Indigenous population, early on-set aging is experienced at a higher rate.

- Access to Care - We have one evening clinic per week at each site 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 question of a systemic bias toward not admitting native children?

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

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.

Homeward Bound: From Homelessness to Community
In April 2015, De dwa da dehs nye>s received funding from the City of Hamilton through the Housing First initiative, to provide services to the chronically and episodically homelessness Indigenous persons in the City of Hamilton. This program addresses issues with 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, work with them to develop goals, and walk beside them on their journey.

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

At the end of the third quarter, the Homeward Bound team has housed 30 indigenous individuals this fiscal year.

In January 2017, the Homeward Bound Program received a new participant. The client originated from a reserve in southern Ontario, where there is a high rate of unemployment and poverty. Having family in the Hamilton area, the client moved to Hamilton to be closer to his daughters and grandchildren. When he came to Hamilton, he had no permanent housing and was couch surfing between his children's residences, all the while holding a job as a mover. With a bit of assistance from the Homeward Bound Program, the participant was able to find housing and to receive a housing allotment toward his rent. He was extremely happy to have his own place with some financial help! He is well on his way to a very independent and successful future. He mentioned he might even be able to save for his own car with the money he's saving.

Access to the Right Level of Care - Addressing ALC

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 Aboriginal Patient Navigators 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 are success stories of the APN impact on the Brantford, Hamilton and Niagara communities:

Brantford Success Story:
The APN program encountered a community member who was struggling to live a healthy lifestyle. He was at risk of becoming injured or even homeless. He had been fighting past traumas and alcohol abuse his whole life. He was disconnected from his family and his culture. He was the victim of abuse, robbery, assault and had many falls down stairs as he lived in an upper apartment. With case management and some services in the community we were able to create a plan for him to live a healthier lifestyle with both main stream and Aboriginal. He just needed to see that people cared for his well being. With services in place he is now more out going and seems happier, it has definitely lifted his spirit.

Hamilton Success Story:
The APN was contacted by AHC reception to accompany a participant to appointments as the participant frequently missed important appointments and follow up. The patient was in need of hearing aids as tested by Connect Hearing. The participant missed follow up appointments so no hearing aids were ever discussed, chosen or ordered. The APN was able to connect with the participant and book a new hearing test. The APN arranged transportation with the Wheels for Seniors Program. The APN accompanied the participant to appointment; hearing was re tested, moulds created

for hearing aids and best style discussed. Connect Hearing was able to have devices fully covered through Non-Insured Health Benefits (NIHB).

The APN accompanied the participant to the follow up appointment and hearing aids were received. The participant is very happy to hear better/clearer and APN is feeling pleased that the participant's hearing needs were met with a bit of assistance.

Niagara Success Story:
During the third quarter the APN and Adult Mental Health Counselor were invited to a lunch and learn with Bethesda Community Services and Twin Lakes Clinical Services to share information about programs and services. A few weeks following the meeting an individual involved with Bethesda Community Services was referred to the APN program for supports and services. Upon meeting the individual, it was clear that she was in serious crisis and had no supports in place to address the very basic needs required to sustain any sort of well being. A 27 year old female with developmental delays was bouncing from shelter to shelter over a 6 month period with no money and no plan. As the APN began to work closely with the participant, the APN also began to suspect that the participant was experiencing financial abuse from her husband and family. Due to circumstances with Family and Children Services, the participant was not allowed to dwell in the family home, where her 19 month old son also resided, thus leaving the client homeless. According to the participant the plan was to rent an apartment of her own with her husbands help. This did not happen.

After recognizing the complexity of the situation, the APN called in community supports. It was two weeks leading up to Christmas and the client had nothing. The participant was invited to a Women's Appreciation Diner at the Niagara Regional Native Centre, where the APN introduced her to a support circle (Healing and Wellness Coordinator, Health Outreach Coordinator, and Abbey House Outreach Worker). Prior to the dinner the participant was apprehensive and unsure, however during the social, after the dinner, the women's hand drum group played an honor song. The participant immediately felt comfortable and stated that she belonged there. Since this initial meeting with the community the participant opened up and agreed to move into Abbey House, a transitional home for Indigenous women and children. The participant is currently taking parenting classes and is setting healthy boundaries with her husband and family. The participant can recognize that what was happening was not right and that she needs to take care of herself so she can be with her son.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

In 2017-18, Nurse Practitioners scope of practice was expanded to include opioid prescribing for the treatment of pain. To support the primary care clinicians at De dwa da dehs nye>s Aboriginal Health Centre received training from Michael G DeGroote Pain Clinic operated by Hamilton Health Sciences. The training was a full day session that spoke to the importance of complementary and alternative treatments for pain along with opioid management.

Following this discussion, the primary care clinicians received a lunch and learn session with Dr. Hariton on the practical approaches to prescribing opioid and ways to monitor patient compliance with medication.

We are in continued discussions with Hamilton Health Sciences to provide additional support to the primary care clinicians at De dwa da dehs nye>s.

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. The training has been updated to include the requirement of Bill 132. All Board, Staff and Volunteers will receive the revised training.

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

Annually, all staff are required to take WHMIS training.

Contact Information

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

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

The following are the Quality Improvement Contacts for the organization:

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

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

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

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

Other

De dwa da dehs nye>s Aboriginal Health Centre is continuing to grow at a rapid pace. With a renewed Strategic Plan, accreditation and Capital Planning Processes underway for 2 new sites, there continues to be a strong commitment to integrating the Call to Action from the Truth and Reconciliation Commission into our daily operations. To support our quality improvement we are making strides in obtaining quality data. The addition of the Business Intelligence Reporting Tool (BIRT) on to our EMR in the 2017-18 fiscal year and has simplified the data mining process so that information from the EMR.

Refining and articulating our model of care deliver is the foundation up which culturally appropriate and relevant indicators can be identified for our Quality Improvement Plan.

Resource challenges continue to threaten our ability to meet our Indigenous Community's need; however, the strength of commitment of all our staff and our ability to work collaboratively with internal and external partners enable us to exceed targets and sustain our gains.

Through the hosting of our national conference, De dwa da dehs nye>s is being looked upon as a credible voice for advocating for culturally safe and appropriate care for the Indigenous Community.

We anticipate that the 2018-19 year will continue to build on the momentum 2017-18 will continue to build on the momentum of the last fiscal year. We will continue our efforts towards Accreditation and for the progression of our two capital projects.

Sign-off

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

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

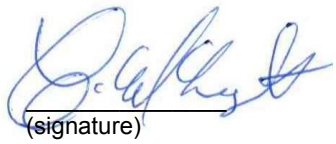
Board Chair Pat Mandy

(signature)

Quality Committee Chair or delegate Lina Rinaldi

(signature)

Executive Director / Administrative Lead Constance McKnight



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