NYFHT Master QI Plan 2019-2020

**Informed by NYFHT, HQO, ARTIC/Choosing Wisely*

**Report to: HQO, MOHLTC, AFHTO D2D, NYFHT*

Quality Goal	Objective	Target	Change Idea/ Methods	Team Involvement	Process Measures/ Outcomes	Comments
1. De-Prescribing	**SECTION A:** To de-prescribe use of sedative hypnotics in patients aged 65+ where risks outweigh benefits and safer alternatives exist.	**A) 20% of target patients will be de-prescribed from sedative hypnotics** Numerator: # of patients who have been de-prescribed from sedative hypnotics Denominator: Total # of people on sedative hypnotics 65+ _____ **B) 70% of target patients who were consulted by a pharmacist and were de-prescribed or achieved dosage reduction from sedative hypnotics** Numerator: # of patients who have been de-prescribed or achieved dosage reduction from sedative hypnotics who were consulted by a pharmacist	• Identify eligible patients at baseline (denominator) and follow these patients until the end of the year. • Updated progress report will be provided at the end of each quarter. • Physician will decide to: o Flag charts o Wait for prescription renewal to review o Follow up with the patient directly o Offer Cognitive Behavioural Therapy for Insomnia (CBT-I) program **and/or** o Refer to pharmacist for de-prescribing • Share de-prescribing resources with physician offices and patients (*Canadian De-Prescribing Network)*	Data Manager Physicians Physician/RN/PA Social Work & Nutrition Pharmacist Medical director	Process Measures Referrals • # of referrals to NYFHT pharmacist • # of referrals to CBT-I program Encounters • # of patients who consulted a pharmacist to taper sedative hypnotics • # of patients who attended the CBT-I Program • # of patients who were consulted by a pharmacist and attended CBT-I sessions. Outcome Measures Overall • Overall #/% of patients de-prescribed off sedative hypnotics. AHP • Overall #/% of patients who saw a pharmacist who were de-	

		Denominator: Total # of eligible patients who were consulted by a pharmacist to de-prescribe sedative hypnotics **C) 5% of target patients who attended the <u>CBT-I program</u> will be de-prescribed or achieved dosage reduction from sedative hypnotics** <u>Numerator:</u> # of patients who have been de-prescribed or achieved dosage reduction from sedative hypnotics who attended the CBT-I program <u>Denominator:</u> Total # of eligible patients currently on a sedative hypnotic and attended the CBT-I program			prescribed or achieved dosage reduction from sedative-hypnotic medication • #/% of patients who attended the CBT-I program who achieved dosage reduction or abstinence from sedative hypnotic medication • #/% of patients who were consulted by a pharmacist as well as consulted the CBT-I program who achieved dosage reduction or abstinence from sedative hypnotic medication.	
	SECTION B: To de-prescribe long term use (>12 months) of PPIs in active patients with significant	**20% of eligible patients de-prescribed from PPIs.** <u>Numerator:</u> # of patients on long term use of PPI (>12 months) who have been de-prescribed from PPIs <u>Denominator:</u>	• Identify eligible patients at baseline (denominator) and follow these patients until the end of the year. • Updated progress report will be provided at the end of each quarter • Physician will decide to:	Data Manager	<u>Process measures</u> • # of referrals to pharmacist • # of patients who received de-prescribing intervention by pharmacist • Qualitative rationale of patients consulted by pharmacist who will never come off PPI	

	safety risk and lack of indicator for ongoing use.	Total # of patients on long term use of PPIs **25% of eligible patients who were consulted by a <u>pharmacist</u> who achieve a dosage reduction or complete abstinence from chronic use of PPIs at the completion of treatment** <u>Numerator:</u> # of patients on long term use of PPI (>12 months) who were consulted by a pharmacist who have achieved a dosage reduction or complete abstinence from PPIs <u>Denominator:</u> Total # of patients on long term use of PPIs who consulted a pharmacist for de-prescribing	○ Flag charts ○ Wait for prescription renewal to review ○ Follow up with the patient directly **and/or** ○ Refer to pharmacist for de-prescribing • A list of patients will be provided to the pharmacist. The pharmacist will review each patient and reach out to the physician office for de-prescribing • Share de-prescribing resources with physician offices and patients (*Canadian De-Prescribing Network)*	Physicians Physician/RN/NP/PA Pharmacist Data Manager Pharmacist Medical director	<u>Outcome Measures</u> Overall • Overall %/# of patients de-prescribed off PPIs. AHP • %/# of patients who were consulted by a pharmacist and have achieved a 50% dosage reduction or complete abstinence from PPIs.	

	SECTION C: To track the % of non-palliative care patients newly dispensed an opioid within a 6-month period.	**To track NYFHT physician opioid prescribing patterns over a 3-year period (2017, 2018, 2019, 2020).** <u>Numerator:</u> # of patients newly dispensed an opioid during the 6-month reporting period <u>Denominator:</u> # of patients assigned to a primary care physician	• Identify non-palliative care patients newly dispensed an opioid within a 6-month period. • Compare opioid prescribing patterns over a 3-year time period using My Practice Report data. • Provide education and share resources to physicians • Creation of a formalized process for tapering patients on long term, high dose opioids incorporating a coordinated multidisciplinary collaboration	Data Manager Physicians/Pharmacist Medical Director & Physicians Physicians, Addictions Counsellor, Pharmacists, Psychiatrist	<u>Process Measures</u> • # of patients newly dispensed an opioid within a 6-month period via EMR. <u>Outcome Measures</u> • %/# of eligible patients with reduced dose aligned with prescribing guidelines	**Based on opioid prescribing patterns, reduce # of patients that have been newly dispensed an opioid within a 6-month period aligned with prescribing guidelines.** *Numbers are based on HQO's My Practice: Primary Care Report

2. Timely and Efficient Transitions	**SECTION D:** % of patients who have had a 7-day post hospital discharge follow-up by a primary care provider for the following conditions: Pneumonia, diabetes, stroke, GI disease, CHF, COPD, and cardiac conditions.	**40 % of patients will be followed up with by a primary care provider within 7 days of being discharged from the hospital for an acute condition.** <u>Numerator:</u> # of discharges where the patient was followed-up with in person or via telephone by a primary care provider within 7 days of discharge for selected conditions. <u>Denominator</u> # of acute care discharges for an episode of care in which one of the mentioned conditions is recorded in the first hospitalization of the episode.	• Identify eligible patients who require a follow-up after hospital discharge • Follow-up with patient (In person or via phone) using standardized discharge template. • Schedules follow-up visit with Physician (as needed).	Physicians/NP/PA RN RN/Reception	<u>Process measures</u> • # of patients requiring post hospital discharge follow-up. <u>Outcome Measures</u> • %/# of eligible patients followed up with by a primary care provider within 7-day post hospital discharge where timely discharge (within 48 hr) notification was received.	

3. HbA1C Testing	**SECTION E:** To improve the frequency of HbA1C testing for patients with diabetes aged 40-80 years old who are overdue (have not received two HbA1C tests in the last 12 months).	**25% of patients with diabetes aged 40-80, previously identified as overdue, who are now up to date with HbA1C testing** Numerator: # of overdue patients with diabetes aged 40-80 who are now up to date with HbA1C testing (received two or more HbA1C tests in the last 12 months) Denominator: Total # of overdue patients with diabetes aged 40-80	• Identify eligible patients at the beginning of each quarter and follow these patients until the end of each quarter. • Updated progress report will be provided at the end of each quarter • Follow up with patient	Data Manager Physicians/RN/PA	Process measures • # of patients identified Outcome Measures • %/ # of identified overdue patients with diabetes aged 40-80 years who have had two or more HbA1C tests done in the last 12 months.	

4. Falls Prevention	**SECTION F:** To increase the number of patients 75+ who are screened for falls risk, assessed, and referred for appropriate follow up	**80% of people aged 75+ who have been <u>screened</u> for falls risk**. <u>Numerator:</u> # of patients aged 75+ screened for falls risk in the past 12 months. <u>Denominator:</u> # of patients aged 75+ that have been seen by an RN. **100% of people aged 75+ who have been <u>followed up</u> for falls risk.** <u>Numerator:</u> # of patients aged 75+ screened to be at risk for falls who received follow up <u>Denominator:</u> Total # of patients aged 75+ screened to be at risk for falls	• Identify eligible patients at baseline (denominator) and follow these patients until the end of the year. • Updated progress report will be provided at the end of each quarter. • Follows up with patient, making external referrals as needed	Data Manager Physician/RN/PA	<u>Process measures</u> • Number of identified patients • Number of patients who were screened • Number of patients screened to be at risk for falls • Number of patients 75+ followed up with as appropriate <u>Outcome Measures</u> • #/ % of people aged 75+ who have been screened for falls risk in the past 12 months. • #/% of people aged 75+ who have been followed up for falls risk.	

5. Colorectal Cancer Screening	**SECTION G:** To improve colorectal cancer screening by targeting individuals aged 50-74 years who are overdue with screening (not tested in the last two years).	**25% of patients aged 50-74 years who have not had colorectal cancer screening in the last 2 years will be screened** <u>Numerator:</u> #/% of overdue patients, aged 50-74 years, who are now up to date with colorectal cancer screening. <u>Denominator:</u> Total # of patients aged 50-74 years who have not had colorectal cancer screening in the last two years.	• Identify eligible patients at baseline (denominator) and follow these patients until the end of the year. • Updated progress report will be provided at the end of each quarter • Follows up with patient	Data Manager Physicians/RN/NP/PA	<u>Process measures</u> • # of patients overdue for screening <u>Outcome Measures</u> • #/ % of patients aged 50-74 years old who were previously identified as overdue, who are now up to date with colorectal cancer screening	

6. Cervical Cancer Screening	**SECTION H:** To improve cervical cancer screening by targeting women aged 21 to 69 who are overdue with Papanicolaou (Pap) smear (last 42-months).	**30% of women aged 21-69 years overdue for a pap smear, will be screened** Numerator: # of women aged 21-69 years overdue for a pap smear who are now up to date with cervical cancer screening. Denominator: Total # of women aged 50-74 years who did not complete a pap smear in the last 42-months.	• Identify eligible patients at baseline (denominator) and follow these patients until the end of the year. • Updated progress report will be provided at the end of each quarter • Follows up with patient	Data Manager Physicians/RN/PA	Process measures • Number of identified patients overdue for screening Outcome Measures • #/ % of women aged 21 to 69, previously identified as overdue, who are now up to date	
7. Patient Experience	**SECTION I:** To improve patients' experiences who access central NYFHT services.	**85% of patients accessing central NYFHT services satisfied with their care.** Numerator: # of patients who completed the survey who report being satisfied with the care they received Denominator: # of patients who completed the survey.	• Survey patients accessing central NYFHT Services. • Feedback results of survey to all team members to enhance performance.	Central NYFHT staff Data Manager/Clinical Manager	Process measures • Number of patient experience surveys sent • Number of completed patient experience surveys Outcome Measures • #/% of patients accessing central NYFHT services satisfied with their care.	

8. Advance Care Planning	**SECTION J:** To provide participants with the awareness and knowledge of how to develop an Advance Care Plan and to initiate patient-provider discussions surrounding Advance Care Planning.	**A)30% of participants who have initiated taking steps towards developing and/or completing their Advance Care Plans** <u>Numerator:</u> # of participants who have initiated taking steps towards developing and/or completing their Advance Care Plans. <u>Denominator:</u> # of participants who attended each Advance Care Planning session per year.	• Distribute needs assessment survey to incorporate into the overall structure/content of the sessions • Offer sessions to different community populations every 3 months • Receive consent to follow-up with participants after 6 months • Follow-up with patients at 6 months (via e-mail/telephone) to assess participant's new awareness and knowledge regarding ACP and steps toward preparing an Advance Care Plan	SW/RN/Physicians SW QIDSS QIDSS	<u>Process Measures</u> • Number of assessment surveys completed • Number of sessions held • Number of participants (each session and total) • Number of completed follow-up surveys <u>Outcome Measures</u> • #/% of participants who have initiated taking steps towards developing and/or completing their Advance Care Plans	

		B) 60% of patients identified within the EMR as having had a discussion with the RN about Advance Care Planning Numerator: # of patients that have had a discussion regarding ACP with the RN. Denominator: # of patients identified as benefiting from an ACP discussion as per: -*Surprise Question -*Serious Chronic Illness -Clinical Judgement	• Identify eligible patients requiring ACP discussion using: -*Surprise Question -*Serious Chronic Illness -Clinical Judgement • Initiate ACP Discussion with Patient • Refer to NYFHT Case Worker (As Needed) • Refer patient to educational resources: - SPEAK UP campaign - NYFHT/NYGH community ACP sessions	Physician/RN/NP/PA RN	Process Measures • # of RNs receiving ACP education • # of ACP conversations initiated • # of Case Worker ACP follow-ups Outcome Measures • # of patients that have participated in an ACP conversation	***Surprise Question: "Would I be surprised if this patient were to be alive in 2 years?" (Source: CCO, Dana-Farber Cancer Institute).** ***Serious Chronic Illness (Meta-LARC ACP Study:)** **End stage chronic kidney disease, COPD, CHF, dementia, cancer.**
9. Data Clean-Up	**SECTION K:** To improve the quality and accuracy of EMR data (i.e. Patient lists)	**100% of member FHT physicians will update their patient list in the EMR.** Numerator: # of member FHT physicians who have updated their patient list with the appropriate status Denominator: Total # of member FHT physicians (88)	• Sends list of all active patients to physician offices that have had 0 visits within the last 4 years. • Review/Clean the list	Data Manager Reception/Physicians	Process Measures • # of active patients that have not had a visit within the last 4 years Outcome Measures • # of patients with an up-to-date patient status (i.e. changed from "active" to "inactive" OR "deceased" OR "moved away")	