NORTH YORK FHT ORGANIZATIONAL QUALITY IMPROVEMENT PLAN

2023-2024

STATUS	QUALITY GOAL	OBJECTIVE	TARGET
ACTIVE IMPROVEMENT	1 **Timely and Efficient Transitions**	To support effective transitions and continuity of care by improving7-day post hospital discharge follow-up by a provider for high-risk conditions (Pneumonia, diabetes, stroke, GI disease, CHF, COPD, and cardiac conditions).	**100 % of patients will be followed up with by a provider within 7 days of being discharged from the hospital for selected acute conditions**
	2 **Falls Prevention**	To prevent falls related complications by increasing falls screening assessment and referral for appropriate follow up.	**30% of people aged 75+ with osteoporosis or osteopenia who have been screened for falls risk** **100% of people aged 75+ with osteoporosis or osteopenia who are at risk for falls (based on screening), have been followed-up for falls risk**
	3 **Patient Experience**	To improve patients' experiences who access NYFHT providers.	**90% of patients who stated that when they see their healthcare provider, 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**
	4 **Sustainable Inhaler Prescribing**	To reduce the number of Meter Dose Inhalers prescribed, and replace those with environmentally sustainable inhalers where appropriate.	**Reduce use of Meter Dose Inhalers by 5%**

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ACTIVE IMPROVEMENT	5 **Advance Care Planning**	To improve awareness and knowledge of how to develop an Advance Care Plan and to initiate patient-provider discussions surrounding Advance Care Planning.	**5% of patients aged 50+ identified within the EMR who have had an Advance Care Plan created**
	6 **Equitable Care**	To support patients experiencing intimate partner violence.	**Collecting Baseline information**
	7 **Timely & Efficient Care**	Improving access to registered dietician (RD) services.	**Reduce waitlist wait time for RD services**

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MAINTAIN	8 HbA1C Testing	To support best practises in diabetes management by providing outreach for patients with diabetes aged 40-80 years old who are overdue for testing (have not received two HbA1C tests in the last 12 months).	**75% of patients with diabetes aged 40-80, who are up to date with HbA1C testing**
	9 Colorectal Cancer Screening	To improve colorectal cancer screening rates.	**85% of eligible patients aged 52-74 years who are up to date with colorectal cancer screening (in the last 2 years will be screened)**
	10 Cervical Cancer Screening	To improve cervical cancer screening rates.	**80% of women aged 25-69 years overdue for a pap smear, will be screened (received a Pap smear within the past three years)**

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MAINTAIN	11 Breast Cancer Screening	To improve the rate of preventative care screening in eligible female patients aged 52 to 69 years who had a mammogram within the past two years.	**80% of eligible female patients aged 52 to 69 years who received a mammogram within the past two years**
	12 Patient Experience	To improve patients' experiences who access central NYFHT services.	**95% of patients accessing central NYFHT virtual services are satisfied with their care.**
	13 Safe Opioid Prescribing	To support safe opioid prescribing practices.	**2.6% of non-palliative care patients newly dispensed an opioid (excluding opioid agonist therapy) within a 6-month reporting period prescribed by any provider in the health care system**

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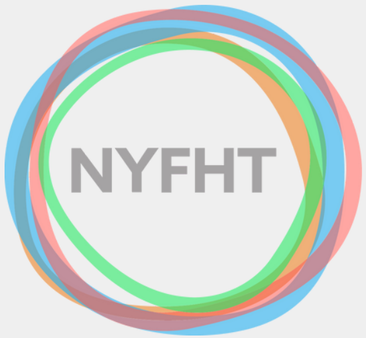
DEVELOPING	14 **Timely & Efficient Care**	Improving access to mental health services.	**Reduce waitlist for Mental Health services.**
	15 **Patient Experience**	Improving care for patients with Chronic Heart Failure (CHF).	n/a
	16 **Equitable**	Increase cancer screening for non-NYFHT patients in community.	n/a
	17 **Provider Experience**	Improve provider experience & engagement.	n/a
	18 **Patient/Experience**	Improve patient engagement.	n/a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