Quality Priorities 23/24

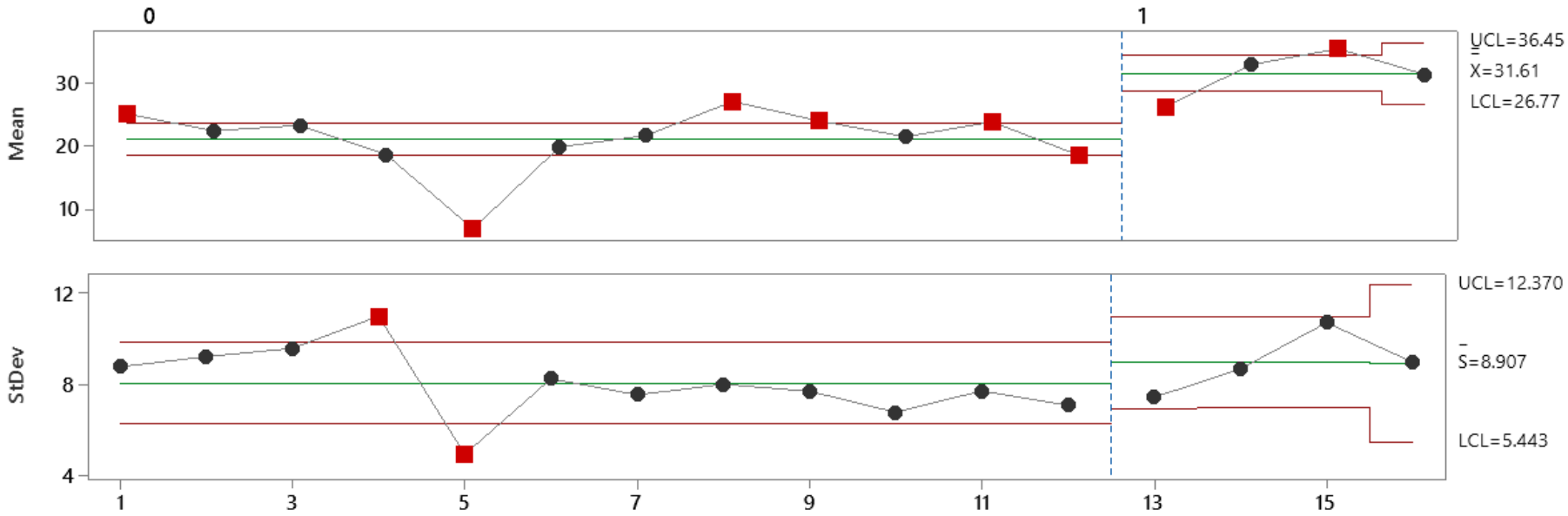
Emergency Department (ED) Admitted Patient Occupancy

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2023/24**	**Target justification**
Seamless	Ease occupancy pressures in the Emergency Department (ED) by reducing the number of admitted patients in the ED	Average number of admitted patients in the Emergency Department (ED) at 07:00, reported by quarter for the QIP. *Indicator includes patients admitted as EMRG, EMCC, and EMMH, and patients admitted in Transitional Care Unit (TTCU).*	Baseline period: FY 22/23 YTD January Baseline performance: Average of **32** admitted patients in ED daily at 07:00	Average of **21** admitted patients in ED daily at 07:00 in Q4 23/24	Reducing the volume of admitted patients in ED requires a long-term approach. This target is a 34% improvement from baseline and is based on the anticipated impact of the change ideas. It represents the initial phase of work to reduce volumes back to levels maintained from FY 19/20 to 21/22, with the aim of further reduction with future work.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
1. **Optimize use of C-Ground Transitional Care Unit (TCU) space to support organizational flow in long-term** (Lead: C. Convery)	a) With S. Gandhi, explore optimization of Oncology Urgent Care clinic (ONUC) to support increased diversion of medical oncology patients from ED b) Identify optimal use of C-Ground (TCU) space in long-term to support ED occupancy and organizational flow	*a) Indicator to be identified when interventions confirmed* *b) Indicator to be identified when interventions confirmed*	*a) Target to be identified when indicator confirmed* b) *Target to be identified when indicator confirmed*
2. **Identify strategies for services to reduce ED occupancy** (Lead: C. Convery)	a) Identify how the ED is used as a care space by different services, and develop strategies for services to support reduction of ED occupancy. Explore potential approaches, including: alternate care pathways to access urgent care without an ED visit, enhancement of ambulatory care, etc.	a) *Indicator to be identified when interventions confirmed*	a) *Target to be identified when indicator confirmed*
3. **Expansion of ED One Team (ED1T)** coverage through partnership with community organizations to safely reduce inpatient	a) Increased Physiotherapist coverage (evenings / weekends) to increase assessment and treatment of both ED patients for potential discharge requiring PT	Overall indicators for change idea:	Targets for overall indicators for change idea: i. 13 patients

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
admissions through connection to care in community (Leads: B. Wagner, D. Cass)	specific skill set and admitted seniors to help decrease LOS in hospital and optimize disposition. b) Expand Team Lead role to weekends to increase identification of patients eligible for care by the ED1T. c) Recruit community-based Occupational Therapist (OT) to assist with home assessment, etc. d) Add Patient Support Worker (PSW) resource 8h/day (SPRINT) to assist with settlement, supporting ED1T patients e) Establish pool of funds for immediate ED1T patient services (home care services; transportation)	i. Average number of patients seen per weekday ii. Average number of patients seen per weekend day iii. % patients discharged after being seen by ED1T iv. 7 day return rate for patients seen by ED1T	ii. 10 patients iii. > 63.5% (from FY 21/22) iv. < 6.8% 7 day return rate
4. North Toronto OHT Collaborative QIP: Reduce ED visits as first point of contact for mental health and addiction (MHA) care by increasing access to community mental health and addiction services (Lead: K. Liu)	a) Understand Mental Health and Addictions patient population needs within the NT OHT community to inform service design and delivery b) Improve patient access to Inter-Professional Health Provider (IHP) Mental Health and Addictions resources within select primary care clinics. c) Expand access and pathways related to MHA for primary care in North Toronto through SCOPE and other methods to improve access to MHA resources	Overall indicator: Number of individuals for whom the Emergency Department was the first point of contact for mental health and addictions care per 100 population aged 0 to 105 years with an incident MHA-related ED visit	In 2023/24, the NT OHT has set a maintenance target of 24.6 for ED first point of contact for MHA care. This target will provide our OHT the opportunity to improve our understanding of available data within our partner organizations and primary care. We will develop targeted and local tests of change that are sustainable and can be scaled within our OHT and our partners.

Control Chart of Average Number of Admitted Patients in ED at 07:00, by Quarter (FY 19/20 – 22/23 YTD January)



Stage	Subgroups	Average Subgroup Size	Mean	StDev(Within)	StDev(Overall)
0	12	91	21.172	8.0814	9.4920
1	4	76.5	31.608	8.9812	9.7208

Control limits use StDev(Within)

Quality Priorities 23/24

Early Warning Scores

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2023/24**	**Target justification**
Safe	Improve Escalation of Care at Sunnybrook via the implementation of an Early Warning Scores (EWS) system	Complete the Sunnybrook EWS pilot and expand to 5 additional acute care units (6 units total)	40% complete EWS Pilot (QIP 2022/23) NOTE: the pilot project included development of all technical aspects of the EWS system, and implementation on 1 pilot unit. The start of the pilot and required EWS Scoring Simulation have been impacted due to technical complexities and availability of required resources. Full pilot implementation is anticipated by Q1 2023/24.	Complete the EWS pilot and expand to 6 units total by March 31st, 2024.	Due to technical complexities and availability of required EWS system development resources, the EWS pilot (QIP 2022/23) is extended into Q1 2022/23. The further expansion of EWS to 6 units in total is considered a reasonable target based on technical & clinical requirements for adoption and spread.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Complete 2022/23 Quality Priority Action Plan: Pilot and evaluate Sunnybrook's EWS solution on the initial unit and then expand to 2 additional units.	Implementation will continue to be lead jointly by Sunnybrook's Project Management Office and the EWS Clinical Lead. This will require: 1. Will include ongoing engagement and support from EWS Advisory Group and Working Group 2. Will require coordination and resource support from Philips Canada, Biomedical Engineering, SunnyCare, Telecommunication and Decision Support. 3. Will integrate learnings from the EWS scoring simulation activity	1.% EWS scoring completed during routine vitals collection 2. Completion of the evaluation of EWS algorithm performance and daily alert frequency 3. % reduction code blue events, cardiac arrests and deaths	1. 95% completed EWS during routine vitals collection 2. Completion of EWS pilot by October 1st 2023/24 3. Target % reduction in code blue events, cardiac arrests and deaths to be determined based on baseline rates (to

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
			be calculated during statistical simulation)
Complete 2023/24 Actions: Expand Sunnybrook's EWS beyond the pilot unit to 6 additional priority acute care	An EWS Implementation Work Plan will guide the expansion of EWS beyond the pilot unit to 6 units total 1. Each program will receive EWS system training and go live support. EWS workflow will align with current medical coverage models and be co-designed by medical service and unit team. Impact will be evaluated post go live. 2. This will require coordination and continued resource support from Philips Canada, Biomedical Engineering, SunnyCare, Telecommunication and Decision Support. 3. This will integrate learnings from the EWS Pilot	1. % EWS scoring completed during routine vitals collection 2. Completion of the evaluation of EWS algorithm performance and daily alert frequency 3. % reduction code blue events, Cardiac arrests and deaths	1. 95 % completed EWS during routine vitals collection 2. Complete the EWS pilot and the expansion of EWS to 6 units total by March 31st, 2024. 3. Target % reduction in code blue events, cardiac arrests and deaths to be determined based on baseline rates (calculated during data simulation)
Promotion of EWS to generate momentum for system expansion and to strengthen staff awareness of EWS as a Patient Safety & Escalation of Care resource at Sunnybrook	Interest and awareness of EWS will be cultivated through collaboration with Sunnybrook's Communication Department and Professional Practice to plan and execute a communication campaign highlighting: • The EWS Pilot Go-Live launch, including profiling a kickoff event. • Ongoing updates regarding impact on patient outcomes and patient and staff experience • EWS Expansion Kickoff events	Completion of the EWS communication campaign	The full EWS communication plan to be completed by Q3 2023/24 (timing of the EWS communication campaign elements will be aligned with EWS pilot implementation milestones

Quality Priorities 23/24

Enhance Senior Friendly Care

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2023/24**	**Target justification**
Safe	Enhance Senior Friendly Care	Reduce delirium rate for patients with Length of Stay (LOS) > 2 days and age ≥65 The Delirium rate is generated by the GEMINI Research Group using a computerized algorithm. Continuous validation of the algorithm is underway.	Q2 2022/23 Delirium Rate for patients with LOS > 2 days and age ≥65 = 28.9%	23%	Quarterly rates of delirium (generated by the GEMINI algorithm) since 2020/21 have fluctuated 2-3% each quarter. An absolute reduction of 5% would reflect a true improvement over time. 5% is a stretch target given current staffing and high patient acuity.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Enhance mobilization of patients according to evidence-based guidelines	**Implement and evaluate regular tracking of patient mobility:** Q&PS have initiated manual *mealtime mobility audits* on 13 acute care units. Continue partnership with Decision Support to refine mobility dashboard in Power BI (go-live in January 2023) and information dissemination to unit leadership. **Complete audit & feedback process with mobility data**: data will be shared with teams regularly at Quality Conversations to discuss opportunities to improve mobilization of patients. **Review and ensure mobility standards are defined**: To continue updating physician order sets to ensure mobility expectations are ordered each program/ patient population. **Identify and Engage units:** To develop 'bite-sized' tips & education for clinical staff to continue building mobilization know-how and to identify low-effort & highest outcome interventions to trial.	% patients up at mealtimes Baseline = 22.5% (June – Dec 2022)	45% overall proportion of patients up at mealtimes in Q4 2023/24 (target based on highest performing unit at baseline) Given current staffing challenges and high patient acuity and the need to reengage units this is a stretch target.
Increase the use of person-centred language (PCL) by health care providers when caring for individuals living with dementia and responsive behaviours	Senior Friendly team members have completed baseline audits of documentation and are supporting partner TAHSN sites in completion of their data collection. A multi-method education and coaching program has been developed and will be implemented to support the implementation of PCL guidelines targeting interprofessional health care providers in acute care. Organizational strategies and resources continue to be implemented to sustain and spread the use of PCL.	1. % increase in use of PCL when describing responsive behaviours in persons with dementia in health care provider documentation 2. % increase in knowledge of importance and applicability of	1. Target to be defined once baseline confirmed (estimated to be approximately 15%).

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
		PCL of patients with high risk responsive behaviours	2. 20% increase in knowledge of importance and applicability of PCL
Formalize the role of Resource Team Patient Support Partners (RT-PSP) and enhance the role of Clinical Externs & Internationally Educated Nurses (and others as appropriate) in supporting teams to proactively address patient safety concerns and prevent/manage delirium and high risk behaviours.	Pilot units will participate in modified *Eyes On Safety* program that engages specialized RT-PSPs to provide regular touchpoints for patients exhibiting high risk behaviours, to reinforce CHASM delirium prevention and overall safety interventions. These PSPs will also support nursing staff in completing basic patient care. Q&PS in partnership with Interprofessional Practice and the resource team clinical leadership to roll-out streamlined *Eyes on Safety* program across all acute care units to enhance the role of Clinical Externs.	1. % of patients receiving RT-PSP support 2. Staff feedback / experience with the Eyes on Safety program and RT-PSP / Extern support	Goal to be determined based on baseline once staffing numbers for the RT-PSP pool have been established.
Improve identification and training rate of staff requiring enhanced delirium and dementia care training.	Q&PS with nursing education to develop flagging protocol to identify units that would most benefit from enhanced delirium and dementia care training. Behaviour Support Advisory Group, with relevant clinical and corporate stakeholders, to develop short and medium term direction for coordinating appropriate delirium and dementia care training for staff.	1. % of clinical staff on priority units who report competence / confidence in ability to manage behaviours due to dementia & delirium 2. % of required staff (staff on flagged units) trained	1. Creation of process to identify priority units and determination of baseline staff confidence. Target % increase in staff confidence report to be defined once baseline is confirmed. 2. Calculation of baseline rate and determination of increase in training target. Target % increase in staff training to be defined once baseline is confirmed.
Align high risk behaviour training curriculum with TAHSN network partners	In coordination with the TAHSN Senior Friendly Community of Practice and the TAHSN Capacity Building in Behavioural Care Working Group, identify and align / standardize delirium and dementia educational resources across the network.	Identification of common resources	By December 30th, 2023.
Understand prescribing practices related to high risk medications for seniors, on high use units (building on 2022/23 antipsychotic prescribing change ideas)	Analyse pharmacy data to understand current prescribing practices for specific high risk medications for seniors (e.g. sedatives, hypnotics, neuroleptics) to identify high use units for root cause analysis. Complete a root cause analysis for identified high use units, to better inform a tailored approach to reducing prescribing of high risk medications for seniors.	Individual improvement targets to be set based on unit and medications identified during the analysis	Targets to be set based on improvements identified and baseline calculated.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Flagging of high risk cardiac patients	In partnership with the PROMOTE study leadership (S. Choi, L. Kaustov) and the D3 team, flag cardiac patients who screen as high risk for perioperative cognitive decline during their pre-surgery assessment. Develop a process to relay at-risk patients to the D3 interprofessional team for additional delirium prevention precautions in their post-operative care.	% of high risk patients with documented evidence of delirium prevention practices	95% of high risk patients have documented evidence of delirium prevention practices in place in Q4 2023/24.
Order Set Modifications (to improve ordering of senior friendly best practices)	Complete order set review with initial programs (Medicine, Cardiology, Orthopaedics, Trauma) through to order set approval. Collate, modify, and review order set changes with programs with highest remaining rates of delirium (neurosurgery, stroke, radiation oncology).	Number of order sets reviewed and revised to improve ordering of senior friendly best practices.	20 order sets reviewed for senior friendly revisions by March 31st, 2024.

Quality Priorities 23/24

Supply Room Cart Redesign

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2023/24**	**Target justification**
Sustainable	Reduce the volume of medical surgical supplies purchased through improvements in purchasing, consumption, and organization of supplies.	Total volume of medical surgical supplies per 1,000 patient days purchased per supply room in participating units (n = 7)	Combined baseline for 7 units = 43,419 widgets per 1,000 patient days Units include B4ICU/Ward, C5, CRCU, CVICU, D2, F2, K3E Baseline period is FY 2022/23 (with projected Q4 data).	5% reduction in volume of supplies by Q4 2023/24 (≤ 41,248 widgets per 1,000 patient days)	This target is based on early observations of the FY 22/23 Supply Waste Management Project. An annual 5% reduction will be based on the composition of the units scheduled for supply room re-design (some in greater need than others). In addition, as this greening initiative represents a significant cultural shift, this work will require strong partnership and collaboration with busy clinical staff and measurement is complex.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
1. Re-design Clean Supply Carts Tours completed of patient care units (PCU) identified supply rooms that are disorganized and overstocked resulting in obsolesce, product waste, and inefficiencies to staff workflow. This initiative plans to re-configure supply rooms to organize and optimize space. This process will be led by the Supply Chain Services Team and will be coupled with a standardized cart review to balance PCU supply budgets. This initiative will be rolled out over a 2 year period with 7 units expected to be completed in FY 2023/24.	• Develop work plan to re-design clean supply carts in collaboration with Nursing and PSP staff, Patient Care Managers, Process Improvement Specialist, Supply Chain Services, Stores, Infection Prevention & Control, and ACART vendor • Apply a Lean framework to ensure the reduction of supply waste, space optimization, and sustainability of supply management practices. • Measure qualitative satisfaction of end users with respect to supply associated activities (pre and post implementation) • Implement storage solutions and new inventory organization model	% of staff reporting a positive impact on their daily work life Complete re-design of supply rooms across 7 units in FY 23/24	85% of staff reporting a positive impact on their daily work life 100% of participating units have completed the supply cart re-design by Q4 2022/23

Quality Priorities 23/24

Improving Safety Monitoring Process

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2023/24**	**Target justification**
Safe	Improve Safety Monitoring Processes	# of total safety reports with documented follow up in the Safety Event reporting system	81% in Q3 2022/23	≥ 88% in Q4 2023/24	The target of ≥ 88% was selected as this was the highest performing quarter in the last 2 years. To achieve this, while also encouraging increased reporting overall, represents a stretch target.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Investigating High Risk Precursor Safety Events Identify precursor safety events that did not result in serious harm, but have high potential for recurrence and harm for follow up.	• Define criteria for "high risk" precursor safety events. • Develop a flag in the Safety Event Reporting system to identify eligible safety reports • Risk Management to flag events during their routine review of all events • Patient Safety Team to screen flagged events and identify the appropriate action (based on a spectrum of possible analysis tools) and collaborate with area leadership to identify possible change ideas for implementation. • Patient Safety and the clinical area team to document investigation and follow up in the safety reporting system (for review by submitters)	# Precursor Safety Events (PSEs) co-investigated with the Patient Safety Team	6 – 12 by end of Q4 2023/24 (TBD based on how many meet the criteria for review, and the nature / scope of the follow up required, hence a range is provided)
Improve Documentation of Serious Safety Event (SSE) Follow Up	• Risk Management to summarize System Review and investigation outcomes in the Safety Event Reporting system to ensure transparency for submitters • Clinical Leaders involved in System Reviews will be prompted to provide additional follow up commentary in the system • Emails to be sent to submitters (automated through the system) when the file is closed so they can review the commentary	% of SSEs with detailed follow up documentation safety event reporting system	95% of SSEs with detailed follow up by June 30th, 2023
Track closure of Safety Event Reports to identify areas requiring further support with safety event follow up	• Create an internal report to track closure of Safety Event Reports (with no follow up) each month • Identify areas for improvement • Provide localized support and coaching as needed, in alignment with the principles of the Accountability for Patient Safety Policy	Internal report generated monthly	Process in place by May 1st, 2023.
Enhance area leader documentation of event follow up	• Precursor Safety Events and Near Miss Events rely primarily on area leaders for investigation, follow up and closure. • Conduct refresher training regarding the Accountability for Patient Safety Policy and the steps involved in investigating and documenting follow up after a safety event • Where possible, provide leaders with data regarding the closure of their safety event reports and coaching around Patient Safety best practices.	% increase in safety event reports with documented follow up at the time of closure	Target TBD once baseline determined

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Strengthen leader Patient Safety competencies (training)	• Review existing training materials for leaders • Identify new approaches to building patient safety **competency** – including a focus on: strengthening safety culture behaviours, normalizing conversations about safety, appropriate responses to safety reports and moving to action • Integrate into existing orientations for new leaders and supplement with additional primer education sessions where possible	# of area leaders (with responsibility for safety event follow up) who are trained	Target to be determined once process and baseline are established
Celebrate strong Safety Culture	• Implement a recognition program to appreciate and acknowledge the actions of Sunnybrook staff who are able to help prevent safety incidents from occurring by recognizing the potential for harm and using the appropriate channels (e.g. the RL Safety Reporting System) to alert the right teams to rectify the safety threat. • Risk Management and Patient Safety to identify core examples of "good catches" through the routine safety event report review processes • Work with clinical teams to capture their story, the event follow up and resolution, for publication on SunnyNet	# of Good Catches recognized on SunnyNet	4 Good Catch Awards celebrated on SunnyNet by March 31st, 2024.

Quality Priorities 23/24

Nitrous Oxide reduction

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2023/24**	**Target justification**
Sustainable	Reduce environmental impact of Nitrous Oxide (N2O) waste	Reduce the consumption of Nitrous Oxide (N2O) gas by at least 75% through the reduction of waste by March 31, 2024 **(Nitrous oxide purchase data will be used to identify how much nitrous oxide is consumed annually from all sources.)**	Annual average of 5,433 Kg Nitrous Oxide purchased annually (32,599 Kg over the last 5 years) This 5 year consumption is the equivalent of driving over 38 million kilometers in a car and offset would require planting 160,630 trees and letting them grow for over 10 years.	75% decrease in N2O purchased by Q4 2023/24 (Reduce purchase to 340Kg or less per quarter)	Nitrous Oxide waste reduction projects in Lothian (Scotland) and Providence Health Care in Oregon reduced consumption by 75-98%, so this is a feasible target. The largest users of N2O are dentistry, and they already use efficient tanks for delivery, so a further reduction below 75% may not be feasible.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Decommission the large nitrous oxide tank used to support the hospital	Engage the appropriate vendor to pump down the large N2O tank, and switch to a system of K tanks (Large K size 29kg tank) to support the hospital gas delivery valves Address any contracts which need to be changed as a result of the new Sunnybrook process.	Switch to K tank completed	Completed by September 31st, 2023.
Decrease the pressure for the K tanks to minimize N2O waste during refilling process	Have anesthesia, dentistry and plant operations work to evaluate the K tanks and define the minimal pressures required to provide care, so tanks can be returned to vendor for refilling with the minimal volume possible, as this is vented to atmosphere before refilling. Ensure policies and procedures are revised / documented as required to embed the new process. Complete communication of new standard procedures across all staff impacted, to ensure awareness.	All tank gauges and manifolds switched to the minimal pressure.	Completed by December 31st, 2023.

Quality Priorities 23/24

Language Concordant Care

AIM		MEASURE			
Quality dimension	Objective	Indicator	Current performance	Target for 2023/24	Target justification
Safe	1. Increase documentation of patient's preferred language in SunnyCare from 60% to 80% by March 2024	% of patients with language preference documented in SunnyCare at the time of discharge by Q4 2023/24	In Q1/Q2 2022/23, 3136 patients admitted to Sunnybrook; 1748 (59%) had preferred language documented in SunnyCare	Increase documentation of preferred language in the designated language field SunnyCare to 80% (from baseline of 59%), measured by % of discharged patients with language preference documented in SunnyCare by Q4 2023/24	Other TAHSN hospitals involved in a multi-site collaboration to improve language concordant care have achieved language preference documentation rates > 95%.

CHANGE			
Change Ideas	Methods	Process Measures	Goal for Change Ideas
Standardize the collection of language preference data at the time of registration in the emergency department (ED), the operating room (OR) and/or arrival on the patient care unit	Engage patient care managers (PCMs) in the ED, OR, and patient care units in development of process for patient administrative associates (PAAs) to participate in consistent collection of data on preferred language use Explore with Information Services the possibility of enhancing visibility of preferred language in SunnyCare	# of units with documented processes for collecting language preference	80% of discharged patients have their preferred language documented in SunnyCare by Q4 2023/24
Create contact cards for the language line (including access codes for D2, C4 and C6) and save them onto the GIM staff, resident and student smartphones	At the time of new trainee orientation on the GIM service, contact cards will be sent to all new residents and students by the chief medical resident to be saved on their smartphones	% GIM residents and students with the language line contact card saved on their smartphones. (determined by periodic surveying)	100% of GIM residents and students will have the language line contact card saved on their smartphones November 2023.
Update policy for Interpretation services at Sunnybrook.	Working with Information Services (IS) and Department of Equity and Social Accountability, update interpretation services policy, including new processes for preferred language data collection and recommended use of professional interpretation services	Policy is updated and approved by Sunnybrook Senior Leadership Team (SLT)	Policy is updated and posted on Sunnynet.ca June, 2023
Develop policy implementation plan, including a communication strategy to ensure information about interpretation services is accessible to patients and families, and that staff have knowledge of the policy and processes for acquiring language interpretation.	In partnership with the Department of Equity & Social Accountability, Communications & Stakeholder and Patient council members, create patient information materials, and develop a process for distributing this information to patients at the time of their hospital admission (+/- posters with QR	% admitted patients who receive information about interpretation services.	100% of admitted patients receive information about interpretation services

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
	codes that links to same information online in multiple languages, digital screens). Develop communication materials to ensure information about the policy and processes is accessible to all staff.	% of PCMs and Team Leaders who report being very confident they could facilitate a request for interpretation services	%100 percent of PCMs and Team Leaders report being very confident they could facilitate a request for interpretation services