Quality Improvement Plan 24/25

Heat Response Strategy Plan – North Toronto OHT

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2024/25**	**Target justification**
Sustainable	Support vulnerable populations in north Toronto during extreme weather conditions	Develop a coordinated response within North Toronto OHT to extreme weather conditions, with a focus on the most vulnerable populations.	There are very few patients who are treated in Sunnybrook's ED for the sole purpose of heat related emergency (3 Cases in 2022-23 and 2 cases in 2023-24) however there is no coordinated heat response in place in North Toronto to prevent heat related injuries. A coordinated response is expected to improve the wellbeing of North Toronto Residents whose conditions may be exacerbated by extreme heat conditions.	Coordinated heat response plan developed for North Toronto OHT	Heat Response Plan approved by March 31st, 2025 The coordinated heat response plan will be created as the initial key deliverable of an overall Heat Response Strategy.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Current State Analysis: Identify existing policies and practices related to heat alerts that are applicable to residents of North Toronto.	1. NT OHT to collect existing heat related policies and practices from NT OHT partners 2. NT OHT / Green Task Force to receive regular updates from TPH regarding the City's heat emergency planning and resources	Build inventory of current heat alert policies, practices and plans.	Completed by August 1st, 2024
Identify critical elements that need to be addressed in heat emergencies for Sunnybrook and the NT OHT	1. NT OHT / Green Task Force to explore opportunities to work with Municipal and	Identify critical elements in heat emergencies	Completed by October 1st, 2024

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
	Provincial emergency management teams on heat emergency planning 2. NT OHT / Green Task Force to identify critical elements that need to be addressed for heat emergency planning		
Develop coordinated heat response plan for North Toronto	1. NT OHT to review and prioritize critical elements that OHT partners can impact in heat emergencies 2. NT OHT partners to identify resources and key contacts for prioritized critical elements 3. Leveraging information and resources available from local, municipal and provincial partners, NT OHT / Green Task Force to develop a coordinated heat response plan for North Toronto 4. Establish Key Performance Indicators to evaluate effectiveness of the plan following extreme weather events 5. Identify an ongoing reporting structure to monitor the execution and impact of the heat response plan to ensure continuous improvement and refinement of the plan	Coordinated heat response plan approved by the NT OHT Executive Leadership Team	Completed by March 31st, 2025

Quality Improvement Plan 24/25

Patient Experience

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2024/25**	**Target justification**
Patient Experience	Establish a Patient Experience measurement audit and feedback program.	Percentage of unit leader engagement with the newly created patient experience measurement dashboards based on the digital patient experience survey results. *The compliance standard is defined as accessing the unit-based dashboards at least once per month. During the initial launch of the digital survey, accessing the dashboards is a form of unit-level engagement.*	N/A Patient Experience measurement dashboards are newly created and therefore there is no baseline rate of engagement.	100% of unit leaders (with access to a unit-specific Patient Experience dashboard) view the dashboards at least once per month, by Q4 2024/25.	This indicator is a process measure. In order for patient experience data to effectively lead to improved patient safety and quality of care, the first step is to ensure that those able to effect change are consistently receiving data and viewing the data.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Create unit-level Patient Experience dashboards.	Creation and implementation will continue to be led jointly by the Office of the Patient Experience's Digital Patient Experience Survey lead and Decision Support (DS). This will require: 1. Ongoing support from DS for creation of the dashboard and determine the data flow for 'free text' responses 2. Engagement with unit leaders to optimize the dashboard functionality to incentivize engagement with the dashboards 3. Engagement with unit leaders regarding optimal workflow for disseminating the dashboards 4. Ensuring meaningful and useful presentation of data via acting on feedback from teams and making iterative modifications to dashboards	Number of units live in Q1 2024/25	1. Have the first iteration of unit based dashboards available by Q1 2024/25 (Apr-Jun) 2. 100% of eligible PCMs engaged

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Create leadership-level Patient Experience dashboard (directors/chiefs)	Creation and implementation will continue to be led jointly by the Office of the Patient Experience's Digital Patient Experience Survey lead and Decision Support (DS) as outlined in the 'Methods' of Change Idea #1.	Number of units live in Q2 2024/25	1. Have the first iteration of Ops Director/Chief based dashboards available by Q2 2024/25 (Jul-Sep) 2. 100% of eligible Ops Directors and Chiefs engaged
Communications Plan/Promotion of Patient Experience measurement dashboards	Awareness and education of the newly created Patient Experience dashboards will be developed in collaboration with Sunnybrook's Strategic Communications team. Awareness and education 'campaign' will include: • Meeting with all unit leaders to introduce dashboards and engage for feedback on how to increase engagement with the dashboards, as well as 'look and feel' of the dashboard • Creation of new 'Patient Experience dashboard' FAQ/informational 'package' for leaders (for sustainability, and ongoing education regarding the utilization of the dashboards with their teams) • Leveraging existing OHA digital survey FAQ by ensuring up to date and relevant** Milestones to highlight include: • Unit-based Patient Experience dashboards 'Go-Live'** • Operations Director/Chief dashboards 'Go-Live'** *** = collaboration with Strategic Communications required*	Completion of Communication plan	Completion of Communication plan by Q3 2024/25 (Oct-Dec)

Quality Priorities 24/25

Enhance Safe Senior Care

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2024/25**	**Target justification**
Safe	Enhance Safe 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 2023/24 Delirium Rate = 30%	≤ 25% in Q4 2024/25	Quarterly rates of delirium (generated by the GEMINI algorithm) since 2020/21 have fluctuated 2-3% each quarter. An absolute reduction of 5%, sustained over at least 2 quarters would reflect a true improvement over time and is considered a stretch target given staffing pressures and high patient acuity.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Achieve the Institute for Healthcare Improvement (IHI) ***Age-Friendly Designation***	Elevate the profile of Safe Senior Care and celebrate teams committed to ongoing delirium prevention, by seeking Level 1 Age Friendly Designation from the Institute for Healthcare Improvement. Complete IHI Level 1 application outlining hospital commitment to incorporating 4 M's (Medication, Mentation, Mobility and What Matters) into practice Engage the Strategic Communications Department to develop a plan to foster greater engagement in safe senior care as a corporate priority though ongoing communication & profiling of this initiative.	Submission of application for Level 1 Designation	Approval of Level 1 IHI Designation by Q3 2024/25
Mobilization: Enhance daily mobilization of patients according to evidence-based guidelines	**Continue audit & feedback of mobility data**: data will be shared with teams regularly at Quality Conversations to discuss opportunities to improve mobilization of patients.	% patients up at mealtimes Baseline = 26.4% (2023/24 YTD to Nov)	33% overall proportion of patients up at mealtimes in Q4 2024/25

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
	Review and ensure mobility standards are defined: To continue updating physician order sets to ensure mobility expectations are ordered for 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.		(target based on highest performing unit at baseline)
Mentation: Improve knowledge and capacity of staff and physicians related to delirium prevention best practices	1. **Enhance quality and quantity of Behaviour Care Plans developed for at-risk patients.** Arrange for identified high risk units to work with QI Specialist to co-design a team based work flow to proactively identify patients with high risk behaviours and implement a Behavioural Care Plan (BCP) prior to a code white and alert. 2. **Delirium Order Sets:** Review unit current practices related to use of the Delirium Order Set (usage in eligible patients). Develop an awareness campaign and forcing functions (where applicable) to increase use of delirium order sets, which support the ordering and application of senior friendly / prevention best practices. 3. **Micro Learning:** Create a library of Senior Friendly Micro Learning including: • Best Practices in Behaviour Support • Person Centred Language (PCL) • Mobility (ABC's) • Pharmaceutical Approaches to Delirium • Delirium Prevention Tools (CHASM, Sleep Hygiene) 4. **Identify at-risk patients**: Pilot a method to identify elective surgical patients at higher risk of post-	1. % of patients under constant observation with a Behaviour Care Plan 2. % of patients with delirium reported at discharge (eDischarge) with a delirium order set completed 3. Completed Micro Learning modules 4. % of at-risk patients with a perioperative bundle of delirium reduction	1. 80% of patients with a BCP in Q4 2024/25 2. 80% of patients with delirium have a Delirium Order Set completed during their admission in Q4 2024/25 3. 5 Micro Learnings to be completed and available to staff by January 31st, 2025 4. Target TBD once baseline identified.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
	operative delirium in the Anesthesia Pre-operative Clinic. • Develop a check list or electronic screening tool to facilitate systematic assessment of risk factors for POD during pre-operative evaluations • Implement interdepartmental team meetings to discuss complex cases and develop individualized prevention and treatment plans for patients at high risk of post-operative delirium • Implement regular educational workshops/online modules to educate healthcare providers on evidence-based strategies for preventing/managing post-operative delirium	interventions (pharmacologic and non-pharmacologic)	
Medication: Understand details regarding overuse of sedative-hypnotic medications in seniors.	In partnership with the Pharmacy Department and Choosing Wisely Steering Committee, detailed analyses of prescribing practices will be conducted for specific high risk medications for seniors (e.g. sedative-hypnotics, neuroleptics) on select units (high users). We will co-design an intervention with relevant services and Interprofessional teams that aims to reduced overuse of high risk medications identified in the analyses.	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
What Matters: Patient Family Education	Establish regular "check-in" meetings with patient partners, patients and residents to discuss what is going well and what could be improved. Offer Senior Friendly Care education/resources as appropriate.	SF monthly unit check-ins meetings (across all Sunnybrook programs / campuses)	Creation of monthly check-in meeting on 6 units by September 30th, 2024
Develop Senior Friendly Champions	Develop Champion Framework to engage and provide unit staff with Senior Friendly expertise in the areas of senior friendly care, delirium prevention (4Ms), management of high risk behaviours, and promote overall safe senior care.	Number of staff with training in the areas of Delirium Prevention and Behaviour Support (meeting Senior Friendly Champion 'designation').	10 Senior Friendly Champions trained & active by Q4 2024/25

Quality Improvement Plan 24/25

Choosing Wisely- Using Labs Wisely

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2024/25**	**Target justification**
Sustainable Safe	Reduce unnecessary repeat short interval laboratory testing for select patients where testing is not indicated.	Proportion of patients with repeat interval testing of thyroid stimulating hormone (TSH), serum protein electrophoresis (SPEP), and lipid profiles (whole panel).	Performance in 2023: • 27% of SPEPs (n=1,047 / 3,885) were re-ordered within 90 days. • 26% of TSH (n=6,203 / 23,951) were reordered within 28 days • 15% of lipid panels (n=1,822/12,233) were repeated within 12 weeks	Target for repeat TSH, and SPEP, and lipid profile testing = < 5% at 28 days (TSH) and 90 days (SPEP and lipid panel) by March 31st 2025.	Rationale for this target comes from similar work relating to unnecessary aspartate aminotransferase (AST)/ alanine aminotransferase (ALT) and Blood Urea Nitrogen (BUN)/Creatinine testing that was performed at Sunnybrook Health Sciences Centre https://qualitysafety.bmj.com/content/28/10/809.long

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Conduct Current State Analysis of SPEP/TSH/Lipid panel testing for clinical areas where repetition is not clinically indicated	Based on data provided by the lab, we will conduct a root cause analysis to identify drivers of inappropriate care	Current state analysis completed	Complete by July 1st, 2024
Co-design interventions with target clinical areas to reduce rates of repetitive SPEP/TSH/Lipid Panel testing (ie. Hard stop from the lab processing, prompts to alert prescribers that the test had been recently completed)	Based on results of the root cause analysis, collaborate with target clinical teams to determine specific interventions	Reduced proportion of repeat testing sent within 28d (TSH)/90d (SPEP, Lipids) respectively.	All repeat TSH (within 28d), SPEP (within 90d) and Lipids (within 90d) will be targeted by this change idea. The aim is to reduce repeating testing such that less than 5% of tests are repeated within the aforementioned intervals by March 31st, 2025.
Communicate new re-testing standards.	Engage Strategic Communications team to help establish an internal campaign to raise awareness, present at grand rounds to disseminate ideas and rationale. Educational campaign to inform clinicians of new change ideas and rationale for such. Provide clinicians with re-testing data to support change management.	Number of education sessions provided on intervention implementation and new retesting standards	Complete one presentation at grand rounds by March 31st , 2025
Present findings to Choosing Wisely Canada's Using Labs Wisely (ULW) National Consortium on findings of work to disseminate findings and to solicit feedback	Educational campaign to inform other institutes of new change ideas and rationale for such. Provide clinicians with re-testing data to support change management.	Number of sessions at ULW provided on intervention implementation and new retesting standards	Complete one presentation to ULW by March 31st 2025.

Quality Improvement Plan 24/25:

Reducing the number of admitted patients in the Emergency Department (ED)

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2024/25**	**Target justification**
Seamless	Improve organizational patient flow to ease occupancy pressures of admitted patients in the Emergency Department (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, EDSH, and EMMH, and patients admitted in the Tory Transitional Care Unit (TTCU).*	Baseline period: FY 23/24 YTD February Baseline performance: Average of **31** admitted patients in ED daily at 07:00 Source: RPT250 Occupancy Sandbox	Average of **22** 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 30% 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**
Explore opportunities to improve Patient Transport and Environmental Services (EVS) turnaround time (TAT) after hours	a) Conduct current state analysis b) Identify top opportunities to reduce turnaround time – focus in high priority areas (e.g. ICU beds)	Reduce time from request to cleaning complete	TBD based on baseline
Reduce turnaround time (TAT) for completion of transfer orders from ICU to ward	a) Complete current state analysis (underway) b) Develop a procedure to ensure timely access to transfer orders across high priority services (with longest turnaround time) c) Identify potential electronic trigger to facilitate prompting of transfer orders	Reduce time from ward bed available to patient arrived (influenced by timely orders and transfer of accountability)	TBD based on baseline
Explore barriers to weekend discharges (i.e. access on weekends to medical imaging, allied health, MDs/NPs, etc.)	a) Quantitative and qualitative data analysis to identify key barriers to weekend discharges, understand root causes, and identify strategies for improvement. b) Prioritize strategies based on greatest potential for impact on weekend discharge rate.	Identification and SLT approval of 1-2 key strategies for improving weekend discharges	Approval of 1 new strategy by March 31st, 2025

Quality Priorities 2024/25

Early Warning Scores

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2024/25**	**Target justification**
Safe	Improve Escalation of Care at Sunnybrook via the implementation of an Early Warning Scores (EWS) system	Complete implementation of the Sunnybrook EWS system on remaining acute care units.	70% complete implementation on first 6 units (QIP 23/34 Goal)	Complete implementation on remaining 8 acute care units by March 31st, 2025.	The expansion of EWS to the final units is considered a reasonable target based on technical & clinical workflow requirements for adoption and spread.

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Complete implementation of the EWS System across remaining acute care units	Go live and evaluate Sunnybrook's EWS system on the final waves of acute care units. Implementation will continue to be lead jointly by Sunnybrook's Project Management Office and the EWS Clinical Lead, under the oversight of the EWS Advisory Group. Each go-live period will include staff, physician and trainee education, daily coaching and support, and capture of key performance metrics including: capture of vital signs at the point of care, number of pages, and follow up on each page sent.	1. % EWS scores completed during routine vitals collection 2. Go-live complete on target units	1. 95% completed EWS during routine vitals collection 2. Complete full implementation by March 31, 2025
Evaluation of impact on outcomes	A mid-point evaluation will be conducted to determine impact on patient outcomes following the implementation of the EWS system. This data will be used to make key decisions about the use of the algorithm, inform the EWS model in our future HIS and evaluate overall impact of this important patient safety initiative.	1. % reduction in code blue events, cardiac arrests and deaths 2. % of pages resulting in action (based on go-live sample)	1. Target reduction is TBD based on baseline level of variation from quarter to quarter (variation can be significant due to rare nature of these events) 2. Target TBD based on combined baseline across services – no external benchmark available

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Sustainable Training Model to be developed	A sustainable model for training of all incoming staff, trainees and physicians must be developed to ensure ongoing awareness of the crucial practice expectations in relation to Early Warning Scores. A model will be co-developed with the EWS Advisory Group, including electronic Learning Management System modules and other tools to ensure ongoing awareness of roles & responsibilities across professions.	Completion of all EWS training materials	The full suite of EWS training resources to be completed by the end of Q3 2024/25.

Quality Improvement Plan 24/25

Equity: Language Concordant Care

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2024/25**	**Target justification**
Safe	Improve access to care in patient's preferred language	Percentage of admitted acute care patients on the Bayview Campus with language preference documented in SunnyCare / Quadramed	35% of Bayview acute care patients and 59% of General Internal Medicine patients had language preference documented in SunnyCare (Q3, 2023/24)	Preferred language documented in Quadramed / SunnyCare in Q4 2024/25 for 60% of all acute care inpatients on the Bayview campus.	Peer Toronto Academic Health Science Network (TAHSN) hospitals are achieving this and higher levels of language documentation. This target represents a long journey for some areas and a small step for GIM but improvement in all areas. There is a planned implementation of a forcing function within Quadramed organization wide in June 2024 which will require preferred language to be documented at the time of patient registration. While the forcing function will be in place the quality of the data entered into the new field will be have to be monitored in the early days to confirm that the data matches the patient needs.
Safe	Improve access to care in patient's preferred language	Use of professional interpretation services (phone and video) per month	**Baseline Jan 2022 – Oct 2023:** Average access to phone interpretation services* = 184/month *Data from 18 clinical units + ED at Bayview Campus.	Increase the number of times a professional Interpreter is used to 276 times per month by Q4 2025.	Based on the clinical experiences of providers at Sunnybrook, professional interpretation services are significantly underutilized at Sunnybrook. The new Sunnybrook policy for professional interpretation use lists a number of critical care points when professional interpretation should be used (e.g., new consultation, goals of care conversation, consent discussions, discharge counselling etc.,). Thus, a 50% increase in professional interpreter use across all of Sunnybrook's Bayview campus is a reasonable goal for Q4 2024/25

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), pre-operative clinics and/or arrival on the patient care unit	Engage patient care managers (PCMs) in the ED, OR, and patient care units in development of processes for patient administrative associates (PAAs) to consistently collect preferred language – with the ultimate goal of making the collection and documentation of preferred language a mandatory step in patient registration	# units with a defined process map for collection of language preference	a. Target 6 units including the ED and pre-admissions clinic. b. 60% of discharged patients have their preferred language documented in SunnyCare/Quadramed in Q4 2024/25
Implement unit-level tools designed to enable the utilization of interpretation services	a. Audit units to identify hardware requirements (phones/tablets) for accessing Interpretation Services b. Implement language identification tool (tool that translates a phrase asking patients their preferred language into the top 15-20 most commonly requested languages at Sunnybrook) c. Develop posters for units in alignment with implementation and communications strategy so that teams know how to access interpretation services	a. # units with hardware (telephone and tablet or laptop) available to facilitate interpretation services b. # language identification tools delivered to units c. # posters delivered and displayed on units	a. 100% units have a phone and tablet available for interpretation services b. 100% of units receive language identification tool c. 100% of units receive poster
Conduct education and training to build awareness and capacity among frontline staff for using interpretation services	a. Embed language concordance as a topic in Quality Rounds; b. Engage units in micro-learning sessions	a. # MD Quality Rounds focused on language concordance b. # units that have been engaged in micro-learning sessions	a. 10 Rounds by March 31, 2025 b. 1 micro-learning session per unit in 2024/25 at the Bayview campus.

Quality Improvement Plan 24/25

Nurse Practitioner-Led Outreach Team (NLOT)

AIM		MEASURE			
Quality dimension	**Objective**	**Indicator**	**Current performance**	**Target for 2024/25**	**Target justification**
Seamless	Avoid unnecessary hospital admissions for residents from North Toronto Long-Term Care Homes (NT LTC)	Number of Nurse Led Outreach Team encounters that contributed to an avoided Emergency Department transfer	Q3 2023/24 = 4 transfers avoided	20 avoided transfers in 2024/25	Opportunity to increase avoided transfers by 25% given NLOT was able to support 4 avoided transfers in Q3 as a newly established team (increase from 4 avoidance per quarter to 5 per quarter for a total of 20 avoided transfers in 2024/25)

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
Support transitions of Long Term Care (LTC) patients to hospitals and repatriation back to LTC home	1. NLOT to work with Decision Support to create standard notification to NLOT when residents from NT LTC homes arrive at the Sunnybrook ED 2. NLOT to solicit feedback from Sunnybrook clinical teams to determine what background information regarding the resident should be shared to facilitate care 3. NLOT to develop standard work and establish protocols to facilitate 2-way information sharing and support subsequent resident repatriation in a safe and timely manner	NLOT involvement in repatriation from hospital to LTC	NLOT involved in at least 80% of hospital admissions of NT LTC home residents by March 31st, 2025
Facilitate timely transfers of Sunnybrook ALC patients who have accepted beds in North Toronto LTC homes	1. NLOT to work with Home and Community Care Support Services (HCCSS) and NT LTC homes to ensure NLOT is notified when a patient at Sunnybrook awaiting a Long Term Care bed has been accepted with transfer pending to a NT LTC home 2. NLOT to solicit feedback from LTC homes to determine what background information regarding the resident	NLOT involvement in new LTC placements from Sunnybrook (NT LTC only)	NLOT involved in at least 80% of transfers to NT LTC homes by March 31st, 2025

CHANGE			
Change Ideas	**Methods**	**Process Measures**	**Goal for Change Ideas**
	should be shared to facilitate smooth transition of care to LTC setting 3. NLOT to coordinate with the LTC home and facilitate 2-way information sharing and support subsequent resident transfer in a safe and timely manner		
Continue to strengthen relationships with LTC physicians and staff to provide supports to residents, to improve resident care and experience	1. NLOT to conduct capacity building events with NT LTC home staff, based on opportunities identified by NT LTC homes and resident needs 2. NLOT to strengthen connections with LTC homes and also internal ambulatory services at Sunnybrook to facilitate access for NT LTC residents	Number of total encounters with NT LTC home residents: • Number of staff encounters for capacity building • Number of clinical assessments conducted (including interventions) • Number of connections to specialists and navigation support	10% increase in the total number of encounters with NT LTC homes (Baseline = 754 per quarter)