2017/18 Quality Improvement Plan - Final Draft

30-Apr-17

AIM		Measure						Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective Transitions - To Reduce Potentially Avoidable Emergency Department Visits**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home resident	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	17.3	23	The current blended average for community and veteran residents is 17.3, which includes a portion of eligible convalescent care population. Significant practice changes introduced in 2015/16. Focus is on sustaining current performance and introducing strategic improvements. QIP target of 23 set in 2016/17 is maintained into 2017/18 as we have not yet achieved sustained, actual results at or better than the targeted performance level. Champlain LHIN average = 25.4 (Q3 2015 - Q2 2016).	1) Spread and sustain hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment to all units	1) Rounding logs reviewed weekly by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance by December 31, 2017 for both measures	MoHLTC Priority Indicator Perley Rideau area for moderate action. Data quality remains a challenge for this area. The MoHLTC's formula is set out in such way that quarterly data is not aligned with annualized performance. Internal data is used for quality improvement purposes.
								2) Implement, spread and sustain Palliative and Therapeutic Harmonization approach to care, including Nurse Practitioner completing PATH assessment on all residents transferred back from hospital (excluding convalescent care).	PaTH certified Geriatrician leading team to train staff and implement PaTH tools and approach unit by unit	1) % of residents seen for PaTH assessment by NP upon return from hospital in the Ottawa building 2) % of residents with completed PaTH assessments	PaTH fully implemented across all 12 units by December 31st, 2017	
								3) Continue communication/information sharing with The Ottawa Hospital upon transfer to ED and return from ED.	IDEAS team to continue collaboration with The Ottawa Hospital ED Process Improvement Team. Conduct monthly audits to measure specific initiatives as they are implemented.	TBD	TBD	
Effective	**To Reduce Pain**	Percentage of residents whose pain worsened	% Residents	CCRS, CIHI (eReports) / Q2 FY 2016	18	15	Initial pain management practice changes were implemented in fall 2016 (PainAD assessment for cognitively impaired residents). Only modest metric improvement is expected in the 2017/18 period as changes in practice will not be fully implemented until 2017 and beyond. Due to the delay of CCRS e-report data, it is anticipated that metric improvement will become more visible in 2018 and beyond as the data catches up to the clinical changes implemented. Mid-term goal (3 years) is to meet and exceed provincial average, long-term goal (5 years+) is to achieve established benchmark. Current performance reflects the blended average of veteran and community residents. NOTES: Provincial average = 10.4% (Q2 2016).	1a) Structured pain assessment and screening tools to objectively identify pain and possible interventions - Sustain use of PainAD for cognitively impaired residents	Pain QI team to conduct quarterly chart review in PCC to determine use of PainAD tool	% of residents that have documented pain assessment/screening prior to quarterly care plan meeting	80% compliance by December 31, 2017.	Not included in MOHLTC Priority Indicator List Perley Rideau area for focused action (high priority) Aligns with full implementation of RNAO Best Practice Guideline. Finalize implementation by winter 2017/18 and sustain changes. A sustained decrease in the indicator "percentage of residents who have pain" has been observed. The facility is performing slightly above the provincial average. The team will use this indicator to support decision making as well.
								1b) Structured pain assessment and screening tools to objectively identify pain and possible interventions - Implement, spread and sustain tool for cognitively intact residents	Pain QI team to lead implementation of evidence supported pain assessment tool for cognitively intact residents. Quarterly chart review in PCC to determine use of tool.	1) Timely implementation. 2) % of residents that have documented pain assessment/screening prior to quarterly care plan meeting	1) Practices implemented on all 12 units by June 30th, 2017. 2) 80% compliance by December 31, 2017	
								1c) Structured pain assessment and screening tools to objectively identify pain and possible interventions - Implement, spread and sustain changes for screening process at admission	Pain QI team to lead implementation of pain screening tool at admission to identify pre-existing pain and therapeutic strategies. Quarterly chart review in PCC to determine use of screening tool.	1) Timely implementation 2) % of residents that have documented pain assessment/screening at admission	1) Practices implemented on all 12 units by Sept 30th, 2017. 2) 80% compliance by December 31, 2017	
								2) Implement, spread and sustain structured pain management and monitoring practices (Pain Mapping Tool) to better control resident pain.	Pain QI team to lead implementation of pain mapping tool to identify patterns, triggers and effective pain management strategies for high risk residents. Quarterly chart review in PCC to determine use of Pain Mapping Tool.	1) Timely implementation of pain mapping tool. 2) % of appropriate candidates that have documented pain mapping completed	1) Practices implemented on all 12 units by December 31, 2017. 2) 80% compliance by Dec 31, 2017	
								3) Implement, spread and sustain education and awareness tools including: non-pharmacological intervention list and pain education pamphlet.	Pain QI team to implement communication tools including list of non-pharmacologic interventions and pain education pamphlet to ensure that residents and staff are aware of strategies to effectively manage pain.	1) Timely development of materials. 2) % of residents who receive materials at admission and annual care conference	1) 100% of new admissions receive materials by December 31, 2017. 2) 100% units have the pamphlet on site.	
								4) Spread and sustain hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment to all units	1) Rounding logs reviewed weekly by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance by December 31, 2017 for both measures	
								5) Review and revise the care plan library to align with best practice and ideal process in the facility	1) Team will review and test the care plan library regarding the focus of pain, to facilitate best practice in the frontline 2) The final library will be rolled out together with other care plan library changes identified	1) Revision of care plan library completed by February, 2017 2) Completion of the roll out by March, 2017	100% Completion	
Resident-Centred	**Domain 1: "Having a voice" and being able to speak up about the Home.**	Percentage of residents who responded positively to the statement: "What number would you use to rate how well the staff listen to you". (NHCAHPS)	% Residents	In-house survey / July 2016 (or most recent 12mos)	N/A	N/A	There is no direct question comparison on the InterRAI QoL survey used at Perley Rideau. Based on international benchmarking data from the interRAI survey, the Home's performance currently sits within the international benchmark range for "Staff act on my suggestions".	1) Implement, spread and sustain Palliative and Therapeutic Harmonization approach to care, including Nurse Practitioner completing PATH assessment on all residents transferred back from hospital (excluding convalescent care).	PaTH certified Geriatrician leading team to train staff and implement PaTH tools and approach unit by unit	1) % of residents seen for PaTH assessment by NP upon return from hospital in the Ottawa building 2) % of residents with completed PaTH assessments	PaTH fully implemented across all 12 units by December 31st, 2017	MoHLTC Priority Indicator Perley Rideau area for moderate action PaTH aligns with listening to and acting on residents suggestions
	Domain 2: "Having a voice" and being able to speak up about the Home.	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (InterRAI QoL)	% Residents	In-house survey / July 2016 (or most recent 12mos)	81%	81%	Not an area of focus for 2017/18. Based on international benchmarking data from the interRAI survey, the Home's performance currently sits above the international benchmark.	N/A	N/A	N/A	N/A	
	Domain 3: "Overall Satisfaction"	Percentage of residents responding positively to: "I would recommend this site or organization to others" (interRAI QoL)	% / Residents	In-house survey / June to July 2016	88%	85%	Based on international benchmarking data from the interRAI survey, the Home's performance currently sits above the international benchmark. The focus for 2017/18 is to maintain our consistently high performance in this area, while introducing strategic improvements as needed.	1) Expand the Family Advisory Program to Resident and Family Advisor Program and increase the number of advisors	1) Collaborate with the Friends and Family Council and Resident Councils to raise awareness and participation in the Advisor Program. 2) Include Family and/or Resident Advisors on QIP teams	1) Number of formally trained resident and family advisors 2) Number of projects/initiatives with Family/Resident Advisor	1) 10 Advisors by Dec 31st 2017 2) 100% of QIP teams include Family and/or Resident Advisors by Dec 31st 2017	
								2) Undertake food services review	Director Food Services to engage with residents and staff on benchmarking best practices, redesigning menu and recommending/implementing changes to food services system.	1) Number of benchmarking sites 2) Timeliness of review and recommendations 3) % Resident satisfaction with food on 2018 InterRAI QoL survey	1) Minimum 3 sites benchmarked by June 30th, 2017 2) Review and recommendations completed by Dec 31st, 2017 3) 10% improvement in resident satisfaction with food by 2018	

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Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Safe	**Medication Safety - To Reduce the Inappropriate Use of Anti psychotics in LTC**	Percentage of residents on antipsychotics without a diagnosis of psychosis	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2016	15.6	9	Significant improvement has been observed since 2012 Q3. Although not an area of focus for 2017/18, the Home will continue to monitor performance in this area. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial average = 25% (Q2 2016).	1) Review diagnosis documentation to ensure accuracy	Director of Nursing to review diagnosis information in PCC with most responsible physicians to ensure accuracy	Completion of data review	Data review completed by September 2016.	MoHLTC Priority Indicator Perley Rideau area for moderate action Participating in Seniors' Quality Leap Initiative improvement collaborative. May lead to additional actions.
Safe	**To Reduce Worsening of Pressure Ulcers**	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2016	5.8	4.8	Pressure Ulcer Quality Improvement Team kicking off in early 2017, aligned with RNAO Best Practice Guideline implementation. Due to the delay in CCRS e-report data, significant metric improvement will likely not be visible until 2018 and beyond. Impact of implementation of comfort care rounds home-wide may be visible by the end of 2017/18 period. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 3.3% (Q2 2016).	1) Design, test, implement and spread pressure injury assessment tools and processes, aligned with the work of the Quality Improvement Team.	Methods to be determined as quality improvement project progresses.	Process and relevant tools designed and implemented. Specific measures to be determined as project progresses.	Goals to be determined as quality improvement project progresses.	MOHLTC Additional Indicator Perley Rideau area for moderate action Aligns with full implementation of RNAO Best Practice Guideline
								2) Streamline and support staff in wound care product selection to ensure a standardized approach to caring for wounds, appropriate resource utilization and excellent care to residents.	1) The Pressure Injury prevention team to develop standard protocols (SOPs) for the management of different categories of wounds. (process measures to be determined) 2) Education and capacity building resources secured through Skin and Wound Assessment Team, onsite dermatologist and wound product vendor	1) Process and relevant tools designed and implemented. Specific measures tbd 2) % staff receiving training on SOPs and product selection 3) Cost of wound care supplies	1) Process and tools implemented on all long-term care units by December 31, 2017. 2) 80% of nursing staff receiving training on SOPs and product selection by Dec 31st, 2017 3) 20% reduction in cost of wound care supplies by December 31, 2017	
								3)Hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment	1) Rounding logs reviewed weekly by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance by December 31, 2017 for both measures	
								4) Review and revise the care plan library to align with best practice and ideal process in the facility	1) Team will review and test the care plan library regarding the focus of wound care, to facilitate best practice at the frontline 2) The final library will be rolled out together with other care plan library changes	1) Revision of care plan library completed by February, 2017 2) Completion of the roll out by March, 2017	100% Completion	
Safe	**To Reduce Falls**	Percentage of residents who fell in the past 30 days	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2016	20.6	19.5	Key practice changes were substantially implemented in 2016 (e.g. Scott Fall Risk Assessment). However, only modest metric improvement has been achieved in 2016 due, in part, to lack of timely CCRS e-report data (data lags by approx. 2 quarters) and impact of rolling four quarters. It is anticipated that metric improvement will be more visible in 2017 and beyond as the data catches up to the clinical changes implemented. Mid-term goal (2 years) is to meet and exceed provincial average, long-term goal (4 years+) is to achieve established benchmark. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 15.0% (Q2 2016) (unadjusted for risk). Focus for 2017/18 is to sustain and spread changes implemented across the Home in 2016/17.	1) Sustain fall risk assessments on admission, quarterly and following significant change in condition (using Scott Fall Risk Screening Tool)	1) Falls QI Team to conduct monthly chart review in PCC of new admissions to determine if Scott Fall Risk Assessment completed and appropriate interventions put in place. 2) Falls QI Team to conduct monthly chart review in PCC for all residents up for quarterly review to determine if Scott Fall Risk Assessment completed.	1) % of residents with Scott Fall Risk Assessment completed on admission 2) % of residents with Scott Fall Risk Assessment completed prior to quarterly review	80% compliance for both process measures by December 31, 2017.	MOHLTC Additional Indicator Perley Rideau area for focused action (high priority) Aligns with full implementation of RNAO Best Practice Guideline. Finalize implementation in Spring 2017 and sustain changes.
								2a) Implement, spread and sustain team communication tools including: - Fall risk to be discussed at ALL quarterly interprofessional care plan meetings	Falls QI Team to conduct monthly chart review in PCC to determine if Falls were discussed at care plan meeting for all residents up for quarterly review.	% of care plan meeting tools demonstrating evidence that falls discussion occurred.	80% compliance by December 31, 2017.	
								2b) Implement, spread and sustain team communication tools including: - Medication cheat sheet for PSWs	PSW and Pharmacy to review most common medications that contribute to Falls and develop and test a "cheat sheet" to identify action and length of action.	Number of cheat sheets available for use on the unit	100% of PSW care plan binders have medication cheat sheets available by April 2017	
								2c) Implement, spread and sustain team communication tools including: - Fall risk logo	Develop and test a new transfer logo process designed to reduce waste. Process revisions will include the following: Standardize language used in transfer logos to match RAI language and improve the workflow associated with changing transfer requirements in order to maintain accuracy.	% of transfer logo audits in the resident's room that match the care plan	Implementation by July 2017: 100% of transfer status requirements match the care plan	
								2d) Implement, spread and sustain team communication tools including: - Resident communication tool	PSWs and Residents to develop a fall prevention poster to be used as a visual cue for residents and families. Staff can also use the tool as a cue to provide fall prevention education to residents and families	Number of Posters available in resident rooms	100% of resident rooms have a falls prevention poster (exclusion residents who do not want a poster) to be implemented by April 2017	
								3) Implement, spread and sustain post fall huddle (root cause analysis) conducted by clinical team immediately following each fall	Falls QI Team to conduct monthly chart review to determine how many post fall huddles were completed. Information to be pulled from PCC or paper chart (TBD based on identified method for documenting post fall huddle)	% of falls with documented post fall huddle	75% compliance by December 31, 2017.	
								4) Spread and sustain hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment to all units	1) Rounding logs reviewed weekly by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance by December 31, 2017 for both measures	
								5) Review and revise the care plan library to align with best practice and ideal process in the facility	1) Team will review and test the care plan library regarding the focus of falls, to facilitate best practice in the frontline 2) The final library will be rolled out together with other care plan library changes	1) Revision of care plan library completed by February, 2017 2) Completion of the roll out by March, 2017	100% Completion	

AIM		Measure						Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Target for process measure	Comments
Safe	**To Reduce the Use of Restraints**	Percentage of residents who were physically restrained (daily)	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2016	5.3	5.5	The Home has achieved significant improvement in this area as a result of changes implemented in 2012/13, with performance improving over time from 22.1% to 5.3%. Improvements appear to be sustained, and the Home's performance is currently better than provincial average (5.7% as of Q2 2016). Target of 5.5% remains unchanged from 2016/17 as most recent data has not consistently been at or better than the identified target of 5.5%. No focused activity expected in 2017/18, however, the home will continue to monitor restraint practices at the Home. NOTES: Current performance reflects the blended average of veteran and community residents.	1)Conduct audit of restraint use at the Home.	RAI RPNs to conduct an audit of restraint use and compare to existing documentation in PCC. Documentation to be amended to reflect clinical practice.	Restraint use	<6%	MOHLTC Additional Indicator Perley Rideau area for continued monitoring
								2)Hourly comfort care rounds by PSWs to assess pain, positioning, toileting needs, personal environment to all units	1) Rounding logs reviewed weekly by PSW Supervisors to determine if hourly rounds are documented by PSWs on all shifts. 2) Nursing leaders to validate PSW rounding practices through shadowing	1) % hourly rounds documented on rounding log 2) % of staff shadowed on day and evening shift that meet rounding expectations	90% compliance by December 31, 2017 for both measures	
Safe	**To Reduce Responsive Behaviours**	Percentage of residents whose behavioural symptoms worsened	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2016	20.9	19.3	The Home implemented a number of key practice changes and training initiatives in 2016 including Behaviour Mapping and post incident reviews (ABC meetings). However, only modest metric improvement is expected in the next reporting year due both to the complexity of responsive behaviour management and the lack of timely CCRS e-report data (data lags by approx. 2 quarters). It is anticipated that metric improvement will become more visible in 2018 and beyond as the Home continues to refine how it identifies and manages responsive behaviours. Mid-term goal (3 years) is to meet and exceed provincial average, long-term goal (5 years+) is to achieve established benchmark. NOTES: Current performance reflects the blended average of veteran and community residents. Provincial Average = 13.1% (Q2 2016).	1) Sustain structured assessment and screening tools (Behaviour Mapping) to objectively identify risk factors, and assess residents for delirium, depression, dementia and abuse.	Develop audit process and tool for sustainability of behavior mapping	Run quarterly report on Behaviour mapping summary note and cross reference with "Criteria to initiate behavior mapping" which includes: identified high risk new admission, escalation in physically responsive incidents, change in condition or other (as identified or assessed by registered	80% of residents by September 2017	Not included in MOHLTC Priority Indicator List Perley Rideau area for focused action (high priority) Aligns with full implementation of RNAO Best Practice Guideline. This work will also align with PaTH.
								2) Test, implement and spread a process for the management of high risk residents (high risk meetings)	Manager of Resident Care Gatineau to spread process facility wide starting with R1S. First meeting to be scheduled in January 2017. Gatineau manager to attend and will monitor and evaluate process.	Ensure that high risk meetings are conducted monthly on each unit (once trained) by auditing meetings, as well as ensuring high risk notes are put in 24 hr reports after each meeting and auditing content of notes.	100% implementation of high risk meetings facility wide by end of 2017.	
								3) Develop, test, implement and spread screening and assessment / reassessment practices	Review current MMSE process, create new electronic version of MMSE and educate staff on new tool. Develop process to link new MMSE process with PaTH protocols.	Percentage of MMSEs completed within 7 days of admission.	1) Revised MMSE tool developed by end of June 2017. 2) 80% of residents with MMSE completed within 7 days admission by December 2017.	
								4) Full implementation of the RNAO BPG related to the assessment and care of delirium, dementia and depression, aligned with other efforts of the Responsive Behaviours QI Team.	As per above the Responsive behaviours team along with BPSO lead are currently working on the screening tools specifically related to the assessment of dementia in 2017/18.	Percentage of MMSEs completed within 7 days of admission.	1) Revised MMSE tool developed by end of June 2017. 2) 80% of residents with MMSE completed within 7 days admission by December 2017.	
								5) Review and revise the care plan library to align with best practice and ideal process in the facility	1) Team will review and test the care plan library regarding the focus of "behaviours", to facilitate best practice in the frontline 2) The final library will be rolled out together with other care plan library changes	1) Revision of care plan library completed by February 2017 2) Roll out completed by March 2017	100% Completion	
Enabling	**Build a Culture of Safety**	N/A	N/A	N/A	N/A	N/A	Capacity building	1) Enhance modified root cause analysis tool and process for rapid review and learning following incidents and near-misses.	Performance Improvement Consultant and small team to evaluate current process and implement changes as appropriate.	1) Modified RCA tool evaluated and changes recommended and implemented 2) Frequency of use of RCA tool	1) Tool evaluated and enhanced by Sept 30, 2017 2) 1 modified RCA/quarter	Not included in MOHLTC Priority Indicator List Perley Rideau area for moderate action Aligns with Accreditation Canada expectations
								2) Implement changes resulting from the Accreditation Canada Culture of Safety Survey. "Safe to Speak Up" likely an area of focus.	Performance Improvement Consultant and small team to analyze survey results and identify top 2-3 areas for action. Team to develop and implement associated action plan.	Process measures tbd following survey analysis and selection of focus areas	TBD	
								3) Implement IPAC enhancements including refreshing hand-hygiene auditing and data reporting program.	Progress to be monitored by Manager, Infection Control and IPAC committee.	1) New hand hygiene auditing program developed and implemented 2) Number of hand hygiene observations conducted monthly 3) Hand hygiene compliance rates	1) New auditing program implemented by March 31st 2017 2) 450 observations per month 3) 80% compliance	
Enabling	**Build QI Capacity**	N/A	N/A	N/A	N/A	N/A	Capacity building	1) Continue to train and educate leaders and front line staff in quality improvement through internal and external programs. Leverage existing external program (IDEAS, etc.) and incorporate QI training into internal educational opportunities (LDIs).	Focus efforts on QI training for staff involved in QIP teams. Senior Leaders to continue identifying front line staff, supervisors and managers to attend external QI educational opportunities.	1) QI content delivered at Leadership Development Institutes in 2017. 2) QI content delivered at QIP team training sessions 3) Number of front line staff/supervisors attending external QI educational opportunity	1) QI education provided at ≥1 Leadership Development Institute(s) in 2017 2) ≥10 3) >10	Not included in MOHLTC Priority Indicator List Perley Rideau area for moderate action

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Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
								2) Plan and implement changes to RAI MDS process, including enhancements to clinical informatics and decision support.	RAI MDS Coordinator, Performance Improvement Consultant and team to implement enhancements to PCC; documentation practices; RAI coding and process; analysis and decision support activities	1) Timely implementation of PCC structural changes 2) % staff receiving training on new RAI process 3) Timely implementation of new RAI process 4)% resident RAI and care planning process following new procedure 5) Decision support measures tbd following development of plan	1) PCC structural changes implemented by May 31st, 2017 2) 100% staff trained on new RAI process by Oct 31, 2017 3) Full implementation by Dec 31, 2017 4) All residents on new process by Jan, 2018 5) TBD	
								3) Continue with RNAO Best Practice Spotlight Organization activities	Through BPSO Liaison and Champion, continue implementation of Best Practice Guidelines and supporting activities to build quality capacity with staff working at the point of care.	Contract deliverables to be achieved annually	100% of contract deliverables to be completed on time	