Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE — NO EXCEPTIONS!

3/28/2018

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Message from President & CEO, David Musyj.

Windsor Regional Hospital's (WRH) 2018/2019 Quality Improvement Plan (QIP) continues to build on our Vision of Outstanding Care…No Exceptions! The QIP aligns with the Erie St. Clair Local Health Integrated Network (ESCLHIN) priorities, the Health Services Accountability Agreement (HSAA), Ministry of Health and Long Term Care, and Windsor Regional Hospital's Strategic Plan (2016-2020), which reflects the changing landscape of health care delivery with its increased system demands, the ongoing planning for the future of health care in our LHIN, and the continued pursuit of a new state-of-the art single site acute care hospital. On December 1st, 2017 Minister Eric Hoskins announced that the planning for the new Windsor-Essex Hospital System was moving forward.

One of our strategic directions is To Strengthen the Culture of Patient Safety and Quality Care. The QIP is based on a comprehensive assessment of opportunities to improve quality and safety and reflects quality themes that support our vision for a high performing health care system. The QIP builds on the plan from previous years with the ongoing commitment to improve in areas that have been the focus of quality improvement. Moreover, this year's QIP focuses attention on areas that urgently require improvement across the province such as workplace violence and prevention.

The QIP reflects the overall mission to Deliver an Outstanding Patient Care Experience Driven by a Passionate Commitment to Excellence. The work of our 4000 staff, over 550 physicians, and 625 volunteers demonstrates the compassion, commitment and excellence in the pursuit of our vison.
It has been over four years since realignment and the goal remains – to ensure all patients have the same high quality experience. As the President & CEO, I made the commitment to our patients and staff, "At the end of the day, no matter what campus a patient steps onto, their experience will be the same – Outstanding!"

The 2018/2019 QIP was vetted through various process improvement teams, the Executive team, the Patient and Caregiver Council, the Finance Committee, the Medical Advisory Committee (MAC), and the Quality of Care Committee, who made recommendation to the Board of Directors for approval. Our QIP reflects a commitment to optimizing and standardizing practices across our two large acute care sites allowing for consistent and continuous improvement efforts.

Windsor Regional Hospital is committed to making improvements in a substantial way, focusing on 17 indicators: 1 mandatory; 10 priority; and 2 additional indicators, as well as 4 custom/legacy indicators. The 4 custom/legacy indicators remain a part of this year's QIP to improve on the progress to date, sustain improvements made over the past year, and, continue to standardize across our two acute sites.

The 18/19 QIP indicators include:

Mandatory Indicator
•Incidence of Workplace Violence

Priority Indicators
•Medication Reconciliation at Discharge;
•Risk Adjusted 30 Day All Cause Readmission Rate for Patients with CHF (QBP Cohort)
•Risk Adjusted 30 Day All Cause Readmission Rate for Patients with COPD (QBP Cohort)

•Risk Adjusted 30 Day All Cause Readmission Rate for Patients with Stroke (QBP Cohort)
•Home Support for Discharged Palliative Patients
•Patient Experience – Would You Recommend Inpatient Care?
•Patient Experience – Would You Recommend Emergency Department Care?
•Patient Experience – Did You Receive Enough Information When You Left the Hospital?
•Alternative Level of Care (ALC) Rate
•Hospital Readmission for a Mental Illness or an Addiction

Additional Indicators
•90th percentile Emergency Department (ED) Length of Stay for Complex Patients
•Medication Reconciliation at Admission

Legacy/Other Indicators
•Hospital Standardized Mortality Ratio (HSMR)
•Falls with Injury for Patients Admitted to Hospital
•Use of the Surgical Safety Checklist
•Hospital Acquired Infections (HAI) Rate (MRSA, VRE, C-Diff)

These indicators are all transformational and measure important areas for quality improvement, cultivating and supporting a culture of quality within our organization and across the health care system. Our change ideas will result in performance improvement stimulating new ways of thinking about how to improve quality. The QIP stimulates conversation about quality among board members, senior leaders, physicians, individual clinicians and front line staff. Performance improvements are achieved by collaboration among sectors, support from the LHIN, research of best practices, consultation and support with our health care partners, review of our own data, and most notably, feedback from staff, patients, and their families.
In 2014 after realignment, Windsor Regional Hospital initiated the Standardization and Optimization Program (SOP). The consulting firm KM&T provided our leadership team with the necessary oversight to enable SOP to focus efforts on the standardization of services between the two acute care campuses. SOP continues to work collaboratively with teams comprised of patients, front line staff, physicians and the leadership team to understand current practice and process, and re-design them to incorporate best practices from within and outside the organization.

Empowering front line staff to learn skills to drive continuous quality improvement within their own departments is another outcome of this work.

For 2018/2019, the SOP projects are focused on:
•Patient Flow Improvement
•Quality Based Procedures (QBP) Pathway Improvement
•Standard Unit

The Patient Flow Improvement project uses best practices, Lean/Six Sigma methodology and project management tools, to improve the current patient flow process. Led by a cohort of WRH employees trained in Lean/Six Sigma Green/Yellow Belt training, the goal of the patient flow project is to improve the patient experience and improve efficiency overall related to length of stay, overall occupancy and capacity, readmission rates, and the reporting structure.

Leveraging best practices, the Quality Based Procedures (QBP) Pathway Improvement project will integrate and standardize Order Sets, Clinical Pathways and Patient Experience Pathways, increasing their adoption by the care teams, patient and families. This project seeks to improve the patient experience and improve

efficiency related to length of stay, cost per case, readmission rates, and improving and expanding on the current reporting structure.

The third SOP project will focus on the Standard Unit where processes are developed and implemented to reduce or eliminate patient harm by following 'best practices', creating an environment where the patient receives the same care at both campuses, and creating an environment where all nurses have the assurance that basic practices will reduce patient harm and these practices are known, understood and practiced by all medicine and surgical nurses. Nursing staff receive specialized 'Model of Care' training where 8 'bundles" or standardized processes and practices, in place on the Standard Unit are taught. This includes: care rounds; in-room patient white boards; performance boards; shift to shift report, transfer of accountability; leadership rounding; safety huddles; and comfort rounds. In 2018 we will be introducing the ninth bundle – Mobility, utilizing best practice content from the provincially endorsed MOVE mobility program.

Model of Care training is a major part of quality improvement at WRH and was introduced as a result of post realignment standardization and the decision to have RN's and RPN's working together across most clinical areas at both acute care sites. This was a shift from the RN only nursing model at one of our sites. Developed and led by our CNE/COO, the roll out of Model of Care two years ago, focused not only on the change in practice, but also ensuring that nursing staff had the necessary tools and appreciation for working as a team delivering a best practice model. A multifaceted approach to staff education was developed that supported the skill mix changes being implemented at one campus and the enhancement to the scope of practice at the other site. The Model of Care training continues in 2018/2019.

Describe your organization's greatest QI achievements from the past year

The 2018/19 QIP sets aggressive targets that are based on theoretical best or best elsewhere, with planned improvement initiatives to build on the successful processes and best practices of previous years. The objectives identified in this year's QIP continue to reflect a multiyear strategy that support the tenets of an operating model for the two acute sites. This is important as we move forward with the planning for a new single site acute care hospital.
WRH continues to:
•Optimize capacity and re-balance activity across both acute care sites;
•Adopt a community-wide approach to patient quality and safety;
•Facilitate and implement best practices and models of care and standardization of both clinical
and non-clinical processes and practices;
•Explore operational efficiencies with a higher critical mass of activity;
•Explore opportunities for improved operating efficiency through economies of scale in
administrative and support services;
•Improve coordination and consistency in service delivery;
•Support the single unified professional staff, unified medical departments and a single Medical
Advisory Committee (MAC) to facilitate improved inter-site access to clinical consultation
services and clinical technologies;
•Allow the administration/professional staff to make day to day operational decisions and the Board
to govern with the vision of the future.

Strategies to reduce patient falls with injury remain a focus for improvement and have produced very positive results. As we have in past years, we operationalized the falls indicator so that it relates to acute care and is reflected as the rate of inpatient falls with injury per 1000 patient days. The Fall Prevention Program at the Metropolitan campus has achieved impressive outcomes in the prevention of falls and falls with injury achieving a fall with injury rate of .04/1000 patient days since its launch. Following realignment, the goal was to accomplish the same level of success at the Ouellette Campus, and in the four years since introducing the Fall Prevention Program to the Ouellette Campus, the fall with injury rate has decreased from .79/1000 patient days in 2014 to .04/1000 patient days today. Setting an ambitious target and maintaining these results remains a priority for Windsor Regional Hospital and so it is represented as a legacy (other) indicator. Since introducing our new Discharge Policy in 2016 that brought acute care and LHIN/CCAC services together in a coordinated response to discharge planning, WRH has experienced a major reduction in the number of patients designated ALC (Alternate Level of Care). In 2015, our ALC rate was 16.6%, in 2016 it was 13.2% and in 2017, it was 8.3%.

Patient Flow has been a major area of focus for WRH this past year. In October 2017, after much research and planning, we launched our new Patient Flow Improvement Program for Medicine, concentrating on improving patient flow for admitted patients, since medicine patients represent the majority of patients admitted from the emergency department. One key component of the Patient Flow Improvement Program has been the introduction of Command Centers located at both our sites – a central hub for systems communication, escalation and operational decision making involving the admission, discharge and overall flow of patients is central to this improvement program. Four daily huddles (2 System Level and 2 Unit Patient Flow) briefly review the availability of beds, overall capacity, specific patient issues and discharge delays. Additionally Assessment Bays located on the Medicine Units were introduced to pull patients from the Emergency Department in a timely manner. The results have been dramatic with respect to patients admitted and waiting in the Emergency Department and the time to an inpatient bed. Last year, patients admitted to the medicine program waited an average of 11 hours before being transferred to an inpatient bed. Since the launch of the Patient Flow Improvement Program, the average wait time was 3.6 hours at our Metropolitan Campus and 5.9 hours at our Ouellette Campus.

Resident, Patient, Client Engagement and relations

Patient engagement is fundamental to the QIP's core objective of continually improving the care experience of our patients and their families. The Patient and Caregiver Council reviewed the QIP and provided feedback. The belief that partnerships among patients, families and health care providers are mutually beneficial to all parties is at the core of WRH's Patient and Caregiver Council (PCC). Involving patients and their families in the care provided is embedded in the culture at WRH. The Patient and Caregiver Council provide insight to professional staff, nurses, and other health care providers to ensure that the highest level of care is delivered.

The goals of the Council are:
- Improve patient safety and the delivery of quality of care;
- Promote improvements in processes and services;
- Enhance communication with patients among hospital personnel;
- Improve navigation through and within the health care system.

WRH standardization and optimization team includes patients as an important part of their process improvement initiatives. Patients provide important input in areas such as: mapping sessions to identify current process gaps, opportunities to redesign processes to eliminate 'waste'; creating patient experience surveys for immediate feedback about process changes; redesigning patient education materials; attending hospital celebrations highlighting work done to date; sharing their involvement in newsletters / website / videos; and, testing new approaches through engagement in improvement team meetings.

When health care is perceived though the eyes of the patient and family and/or caregivers, research shows that the quality of care rises, costs decrease, provider satisfaction increases and the overall patient care experience improves. Patient satisfaction is one of the more difficult indicators to improve upon and can take years for an initiative focused on patient satisfaction to demonstrate improvement. It is important to consider both patient experience and patient satisfaction, and use the information gathered to design care and services that consistently and reliably deliver an ideal patient experience. Patient satisfaction surveys were once the traditional method of filling out a paper based questionnaire and then mailing back the completed survey to NRC Health. In 2018/2019, we will continue to use the email version of our patient satisfaction surveys, allowing patients to provide their email address at the time of admission.

Several other initiatives at WRH demonstrate our commitment to engaging our patients. Every patient admitted to the hospital receives a Welcome Letter from the President and CEO, where patients are welcomed and provided with my personal phone number. Of the phone calls received, the majority (over 90%) are from grateful patients wanting to share their stories of gratitude about the care and compassion they received.

Service Recovery is a program that strives to 'makes things right when they go wrong'. When services have failed, it is about doing what we can to satisfy our patients and their loved ones. Our patients have praised us for responding to their issues and resolving their complaints and concerns. Coffee cards, parking passes, etc. are provided to patients as tokens of our commitment to this endeavor.
Our 'Well-Come Mat Program' continues to receive positive feedback from patients and their families across both sites of Windsor Regional Hospital. Volunteers visit every newly admitted patient to provide an orientation to the hospital, including information on patient directories, food services, parking, television services, and other patient related information.

Collaboration and Integration

The realignment of programs and services across Windsor's two acute care hospitals in 2013 provided the necessary first step toward the future of healthcare in our community and a new single site acute care hospital. For care to be truly patient centered, it must be coordinated, collaborative and integrated. The realignment of services across acute and sub-acute care has provided the opportunity for greater integration between sectors. The goal is for healthcare in our community to operate within an integrated healthcare system that will help ensure that patients move from one care setting to another with fewer barriers. Healthcare is delivered by various providers including primary care, acute care hospitals, tertiary or sub-acute hospitals, long term care homes, public health and community health service providers. The realignment provided an opportunity for formalized connections to support coordinated and efficient care across the continuum for residents in the Erie St. Clair LHIN. In this community, partnerships continue to be forged to

create a complete system of care that is inter-connected and works for every patient. The realignment also reinforces government supported initiatives toward more community-based care changing the demands and requirements of the acute health care service delivery system.

Windsor Regional Hospital is a key partner and a leader with its community partners, maintaining strong relationships with health care providers across the Erie St. Clair (ESC) region, across Ontario and in Michigan.

Engagement of Clinicians, Leadership & Staff

To ensure sharing of quality improvement goals and commitments, WRH has embedded several innovative strategies to ensure our focus remains on our core corporate indicators, while engaging clinical staff and the broader leadership in leading the way with our patient safety, patient flow and quality initiatives.
Monday Morning Huddle (MMH) brings both clinical and non-clinical leadership together every week to review real time data (previous week's results) and makes the necessary changes to ensure goals are achieved. Weekly results are displayed across all inpatient units, openly displaying quality indicators to ensure staff are aware of their performance and can celebrate their successes and recognize opportunities for improvement.

Clinical Red Green and Financial Red Green Meetings are monthly meetings held with the senior team and leadership and board representatives, examining the quality improvement process in more detail and working collectively to develop action oriented plans. Every corporate process improvement initiative has a Vice President and Director Lead and is supported by management and front line staff; allowing important improvements to stay at the forefront.

The Quality of Care Committee of the Board holds monthly meetings. All clinical, non-clinical programs and support services report biannually. Senior administration, management and front line staff are present and participate in this presentation. Their report focuses on their program scorecard and addresses program area strengths and weaknesses. Patients and their families supported by the hospital's Patient Advocate are invited to participate to communicate their positive and negative patient care experiences. Staff and leadership from the identified areas are present to respond to process improvements, questions and concerns.

Leadership Rounding was re-introduced in 2016 with standard work developed across both campuses. This continues to be rolled out in 2018. Leadership Rounding helps to demonstrate to our staff, the organization's commitment to patient centered care. When leadership takes the time to speak to patients, they understand that their perceptions are important. Leadership rounding occurs in all inpatient and outpatient areas. Every operational leader rounds on patient/families daily. The goal is to visit every inpatient at some point in their stay and reach 10% of the outpatient population.
WRH recognizes the importance of supporting staff in their quality improvement efforts. With a strong investment in education and training, WRH encourages front line staff, physicians and leadership to present at conferences. WRH fosters a learning environment that provides the necessary tools and knowledge to support staff to achieve their own personal and professional goals. In turn, this helps to promote a positive work environment with a focus on quality improvement.

WRH's staff recognition program called 'Above and Beyond' recognizes staff for going the extra mile. The program operates with recognition being submitted on-line or by email by other staff, patients, families and visitors. The Patient Experience

Committee reviews the letters of recognition and awards staff a certificate and a token identifying the act of care and compassion. The tokens can be turned in for gift certificates. Our recognition goes one step further; those recognized for Above and Beyond are photographed for banners, posters and promotional material. Many can be found on the 'Wall of Fame" at each campus.

Population Health and Equity Considerations

Responsible stewardship combined with innovative thinking pushes us to make the best use of limited resources and implement improvement strategies that drive value and effectiveness in the provision of health care for our citizens.

Quality Based Procedures (QBP) are a major area of focus and as a source of revenue, they are reviewed and compared to benchmarks on an ongoing basis. A QBP Steering Committee acts as the executive champion to spearhead change management across the organization and provide oversight to project governance. In 2018/2019 we will continue to focus on achieving our QBP targets and maintaining the required quality outcomes. The Standardization and Optimization Program (SOP) as part of their QBP Pathway Improvement Plan will focus on another 5 QBP's, in addition to the 5 focused on in the previous year. They include:
Wave 1 – 2017/2018
•Ischemic Stroke
•Congestive Heart Failure
•Hip Fracture
•Chronic Obstructive Pulmonary Disorder (COPD)
•Community Acquired Pneumonia

Wave 2 – 2018/2019
•TIA (Combined with Ischemic Stroke)
•Hemorrhagic Stroke
•Hip Replacement
•Knee Replacement
•Knee Arthroscopy

Three (3) of these QBP's (CHF, COPD, and Stroke) are highlighted in this year's QIP with the 30 day readmission rate indicator. The QBP teams work in collaboration with the Decision Support Case Costing team and the Finance department to develop common pathways and support services to help patients transition between hospitals, and, between hospital and community services.
From December 2017 to March 2018, WRH, was not unlike other acute care hospitals in the province, experiencing a surge in occupancy, going beyond 100%. The spike in influenza cases compared to the previous year increased the demand overall resulting in OR cancellations, patients admitted to unconventional and overflow areas, and a drain on our nursing resources. WRH continued to work with our community partners and our LHIN developing a system wide surge protocol to respond to the increasing demand on acute care services.

The challenges to patient flow this year were met with some significant positive influences with the introduction of the Patient Flow Improvement Program in October 2017. While our wait time in ED and inpatient medicine units did increase as compared to "normal" times since the launch of the new patient flow processes, these wait times were significantly better than the previous year. All the elements of the Patient Flow Improvement Program: Command Center, System and Unit Patient Flow Huddles, Assessment Bays, Care Rounds, etc. have led to these positive results creating more capacity and reducing wait times.

Health care equity focuses on the health system's ability to provide equitable health care services. In 2014, Windsor Regional Hospital collaborated with Henry Ford Health System in Detroit, Michigan, and implemented AIDET training. AIDET (Acknowledge, Introduce, Duration, Explanation and Thank you) is a program that teaches staff to communicate with patients and their families as they do with one another and to be sensitive to cultural/social differences and reinforcing communication with vulnerable populations. This valuable training continues in 2018/2019. Since its introduction, over 2000 front line staff, leadership team, volunteers, security and physicians have received this training.

In addition, the Patient Experience Task Force ensures that patient and caregiver knowledge, values, beliefs as well as cultural backgrounds are incorporated into care planning that help inform decision making. WRH is committed to reducing the health inequities for Indigenous People and improving access to health services. Through Cancer Care Ontario (CCO), members of the WRH leadership team participated in the online Aboriginal Relationship & Cultural Competency course to strengthen knowledge of First Nations, Inuit and Metis history and culture to improve health outcomes and person centered care.

Access to the Right Level of Care - Addressing ALC

In 2016, WRH launched a revised Discharge Policy bringing acute care and LHIN/CCAC services together in a coordinated response to discharge planning, most especially for those identified as Alternative Level of Care (ALC). We have witnessed a major reduction in the number of patients designated ALC as a result and so continued collaboration with LHIN/CCAC and other community partners like Assisted Living Southwestern Ontario (ALSO) play an important role in supporting patients outside of hospital by reducing the number of ALC patients in acute care. Team work, earlier engagement by LHIN/CCAC and other community providers, screening all patients at admission for complex discharge issues, face to face complex discharge rounds with community providers, regular and repeated family meetings involving the family, hospital (including social work and the patient advocate) and LHIN/CCAC coordinating Intensive Hospital to Home (IHH) services, and Emergency Department diversion protocols, are just a few strategies that we deliver daily to ensure that patients are in the right bed at the right time, and services are coordinated to meet their needs post their acute care stay. Since introducing our collaborative discharge policy, WRH has experienced a steady decline in our ALC rate. In 2015, our ALC rate was 16.6%, it decreased to 13.2% in 2016, and in 2017, was 8.3%.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Opioids are at the center of a public health crisis. A recent Health Quality Ontario report ranked the Erie St Clair LHIN as the highest LHIN in the province for the number of people who filled an opioid prescription (18 per 100 people), and the second highest LHIN for the number of opioid prescriptions filled (100 prescriptions filled per 100 people). Accurate data collection on overdoses is a vital part in evaluating this issue and in developing strategies. New reporting to CIHI identifies patients presenting to our Emergency Departments, when an opioid antidote is given and a positive response occurs, or, when an Emergency Department physician documents "opioid overdose".

Additionally, in 2017 we introduced Naloxone Administration as a new indicator on our Corporate Quality Scorecard. Naloxone - an opioid antagonist, is used for the complete or partial reversal of opioid overdose. If naloxone is removed from our automated medication dispensing system on a patient that received a narcotic within

6 hours, the chart is flagged and sent to the pharmacy department and the clinical area for review. If naloxone was administered because of the narcotic, the patient is included in the count. The intent is to identify situations where as an organization we could have made different decisions in the administration of narcotics from a medical/nursing perspective.

Workplace Violence Prevention

Windsor Regional Hospital has a zero tolerance approach to workplace violence and is committed to providing safe, healthy and secure work environment where the dignity and worth of every person is respected. WRH's 'Creating a Safe Workplace' Program is comprised of policies and procedures that address violence and include: Creating a Safe Workplace, Code White/Management of Aggressive and/or Violent Individuals; Flagging Patient Behavior Policy; Intimate Partner/Domestic Violence Policy and the Professional Staff – Creating a Safer Workplace Policy. These policies as well as de-escalation techniques are introduced at all Hospital Wide Orientation sessions and reinforced with the Safe Workplace mandatory e-learn for all staff. We created Safe Workplace Bundles that are unit specific and focus on assessment, prevention, investigation, and debriefing and utilize safety huddles and care rounds to communicate to staff in real time. Additionally, WRH created our own workplace violence risk management form, utilizing our existing risk management software, providing an easy and accessible electronic form and alerting system for all staff.

This past year, staff from selected areas such as the Emergency Department, Mental Health and Security, received new Nonviolent Crisis Intervention Training. The training emphasized early interventions and nonphysical methods for preventing or managing disruptive behavior. Additionally, at one of our acute care sites, all staff, leadership and physicians wear a personal safety device that is a pressure activated and sends an alert when protection is needed, so security will know who, where and when to send help when it is most needed.

Performance Based Compensation

To achieve system-level performance senior leaders and the board established solid performance measures and adopted specific aims that we committed to. We know that as leaders, what we pay attention to will get the attention of the entire organization. Ten (10) quality improvement indicators were selected for the performance based compensation and given a weighting. The indictors include:

- Hospital Standardized Mortality Ratio;
- Risk Adjusted 30 Day All Cause Readmission Rate for Patients with COPD;
- Risk Adjusted 30 Day All Cause Readmission Rate for Patients with CHF;
- Risk Adjusted 30 Day All Cause Readmission Rate for Patients with Stroke;
- 90th percentile Length of Stay for Complex Patients;
- Hospital Acquired Infection Rate;
- Patient Falls with Injury for Admitted Patients;
- Alternative Level of Care Rate;
- Patient Experience –Would you recommend inpatient care?;
- Patient Experience – Would you recommend the emergency department?

The performance indicators are incorporated into the Board, Corporate, Program and Service Scorecards and are updated monthly with ongoing monitoring.

In the first year (2011) of the QIP, performance based compensation resulted in the non-union staff achieving 60% of this bonus. This increased to 70% in 2012, even though several targets stretched beyond regional and provincial targets. In 2013, the compensation resulted in achieving 63% of the bonus, again with ambitious targets set. In 2014, following the October 2013 realignment, the compensation resulted in achieving 48% of the bonus. In 2015, the compensation resulted in 43.5%, and in 2016, 60%. In 2017, 4 years post realignment, the performance based compensation resulted in 83% of the bonus.

The 2018/2019 QIP is once again linked to performance based compensation for all non-union staff, consistent with the Excellent Care for All Act. This link to performance establishes how leadership will be held accountable for achieving the targets set in the QIP. The performance based compensation allows all non-union staff to have an opportunity to earn up to a 2% bonus and the CNE, COS and CEO up to a 5% bonus.

Contact Information

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Other

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Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Board Chair Lynne Watts _____ (signature)
Quality Committee Chair Dan Wilson _____ (signature)
Chief Executive Officer David Musyj _____ (signature)
Other leadership as appropriate Karen McCullough _____ (signature)