Part A:
Overview of Our Hospital’s Quality Improvement Plan

Purpose of this section: Quality Improvement Plans (QIPs) are, as the name suggests, all about improvement. They are an opportunity for hospitals to focus on how and what to improve, in the name of better patient-focused care. As such, they will be unique documents, designed by, and for, each individual hospital. Overall, a QIP should be seen as a tool, providing a structured format and common language that focuses an organization on change. The QIP will drive change by formalizing a plan and facilitating shared dialogue to support continuous quality improvement processes. This introductory section should highlight the main points of your hospital’s plan and describe how it aligns overall with other planning processes within your hospital and even more broadly with other initiatives underway in your hospital and across the province. In addition, this section provides you with an opportunity to describe your priorities and change plan for the next year. Please refer to the QIP Guidance Document for more information on completing this section.

[In completing this overview section of your hospital’s QIP, you may wish to consider including the following information:
• Provide a brief overview of your hospital’s QIP.
• Describe the objectives of your hospital’s QIP and how they will improve the quality of services and care in your hospital.
• Describe how your plan aligns with other planning processes in your organization.
• Describe how your plan takes into consideration integration and continuity of care.
• Describe any challenges and risks that your hospital has identified in the development of their plan.]

Introduction

Health Sciences North/Horizon Santé-Nord (HSN) is an academic health sciences network that is devoted to health, not sickness. Core to our mission is the delivery of the highest quality of patient care, in an environment focused on innovation and research, teaching and learning. The primary focus of our quality and patient safety plan is aimed at ensuring that the population we serve experiences, no needless death; no unnecessary waiting; no needless pain or suffering; no waste; no helplessness in those served or being served and no one left out.

We are a network of integrated facilities and programs working together for the benefit of our patients, communities, physicians, researchers, staff, and learners in the areas of prevention, diagnosis, treatment and care. Based on our core values we actively engage patients; families; staff, physicians and our community partners in finding innovative solutions to the issues and challenges that we face in our service area.

As part of our continued commitment to being open and transparent to the communities we serve and furthering our efforts to provide the best patient care, we are pleased to provide the patients and families we serve with our 2012-13 Quality Improvement and Patient Safety Plan.

How do we plan to improve the quality of services and care in our organization?

Health Sciences North views improving the quality of care and services provided to the population it serves as our primary purpose. This core value is incorporated in our systematic approach to defining our long-term strategic objectives and our annual business planning processes. Our quality improvement/patient safety plan allows us to articulate and execute on our key corporate-wide focus improvement priorities.
The Board and senior team has adopted and uses the IHI Execution framework as described in figure 1.

Figure 1: HSN Execution Framework

The quality improvement focus areas described in our plan are driven by the needs of the patients/families and communities that we serve; a review and analysis of the perceived internal needs of HSN balanced with the external priorities expressed by our LHIN, the Ministry of Health and Long-term Care.

It is the Board and Senior Leadership Team's intent that HSN will be able to:

- Deliver on the system-level aims that are outlined in this plan through the coordination of a defined number of projects that have been aligned with our budgetary strategies.

- Ensure that there is appropriate local management and monitoring of performance to support the achievement and sustainability of our strategic aims across the organization in an environment where staff feel engaged and energized in their daily work.

- Develop and maintain the right mix and number of staff and physician partners who have the capacity and capability to provide leadership for improvement activities and ensure the development of a culture of continuous improvement at all levels of the organization.

To ensure that the organization effectively moves through the process from setting improvement goals to ensuring results the Board and Senior Leadership Team has made the commitment to a rigorous and disciplined approach of:

- Identifying ambitious performance goals for the key improvement opportunities identified;

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• Developing a selection of evidence informed projects to support the realization of each area identified;
• Identifying and deploying the appropriate and necessary resources that will support the execution of the work outlined;
• Establishing an oversight process that will guide, support, monitor the improvement work all levels of the organization.

What are the Objectives for the Health Sciences Quality Improvement/patient Safety Plan

Figure 2 summaries the four (4) improvement priority areas that the Board and Senior Leadership Team have selected to focus on for this 2012/13 Quality and Patient Safety Plan. Figures three (3) through six (6) provide a high-level overview of the initiatives that the organization will pursue in order to improve its performance in these key areas and how the Board and Senior Leadership team intends to provide oversight of the execution of the improvement initiatives from the Macro to Micro levels of the organization.

Each figure describes the key strategic and focus measures that will be reviewed to monitor performance and progress towards goals. The figures also provide an overview of the key tactics or evidence informed change ideas that the organizations plans to test and execute over the next fiscal year.

HSN Building the Enabling Foundation for Excellence

In order to successfully execute the improvement initiatives delineated in this plan we must reinforce and strengthen our foundational approaches to quality and process improvement. To this end we will create and maintain rigorous performance monitoring systems to ensure that:
• All gains achieved related to Accreditation Canada standards and required organizational practices are maintained and we continue in a “survey ready” state.
• We integrate Lean Systems thinking into our strategic and business planning processes.
• We design and consistently use a defined organization-wide approach to performance (process) improvement and that staff, physician, care partners and board members will all be knowledgeable of this approach and the tools/techniques appropriate to their role in the organization.
• We design and consistently use a management system for improvement.

These approaches are aimed at assisting HSN to realize two key states that are pre-requisites in creating the type of organization that can achieve the performance agenda that we outlined in this plan:

• 1) A truly patient-centered organization where patients and families are engaged in meaningful ways that allow each patient/family to be involved in their own health care and have a health system that is responsive to their needs, is respectful and works with them in a collaborative manner; that engages them as strategic partners in governance and engages them in the design, delivery and evaluation of health care programs and services

• 2) Quality of work-life for all staff.

<table>
<thead>
<tr>
<th>What we will measure to know that we are moving towards our desired state?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For staff and physician partners: <strong>Turnover and retention rates, overtime hours, work life pulse survey, staff satisfaction; annual patient safety culture survey, utilization of employee family assistant program.</strong></td>
</tr>
<tr>
<td>For Organizational Health: <strong>Financial and risk management data</strong></td>
</tr>
<tr>
<td>For Patients and Families: <strong>See Priority Focus Area #3</strong></td>
</tr>
</tbody>
</table>

Guide to the priority area maps:
Figure 3: Priority Focus Area 1

AIM: Zero Harm to Patients as a Result of Care

Reduce Adverse Events

Compliance with evidence informed care bundles for VTE, Reduction of Adverse Drug Events (Medication Reconciliation); Sepsis and Surgical checklist

Reduce harm by reducing the prevalence & incidence of Healthcare Acquired Infections

Program and Unit Level: Rate and Process Indicators for Adverse drug events; Medication Reconciliation at admission and discharge, VTE, Prohibited Abbreviations, compliance with the surgical checklist, Incidence of HAI - MRSA, Clostridium difficile, VRE, central line blood stream infections, surgical site infections, ventilator associated infections, compliance with hand hygiene

Strategic Level: HSMR (Hospital standard mortality ratio) will be at or below 100 by 4\textsuperscript{th} quarter FY 2012/13

Glossary: HSMR = Hospital Standardized Mortality; MRSA = Methicillin-resistant Staphylococcus aureus; VTE = Venous thromboembolism; C-Diff = Clostridium Difficile Infection; VRE = Vancomycin Resistant Enterococcus; VAP = Ventilator Associated Pneumonia; HAI = Hospital Acquired Infections

(See Part B: for our improvement targets and details of the associated planned initiatives)
What we will measure to know that an improvement has occurred?

**Strategic Level:** *Reduce the Average Length of Stay in ER for Admitted Patients by 10% by the 4th quarter FY 2012/13.*

**Program and Unit Level:** *Process Indicators to monitor the flow of patients through the emergency department, numbers and flow of patients through the diagnostic imaging department, number and time it takes for patients to receive their hip and knee replacements*

*(See Part B: for our improvement targets and details of the associated planned initiatives)*
Figure 5: Priority Focus 3

<table>
<thead>
<tr>
<th>What we will measure to know that an improvement has occurred?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Level:</strong> Increase the result for the NRC Picker question, “Overall, how would you rate the care and services you received at the hospital?” by 10% improvement by 4th quarter of FY 2012/13.</td>
</tr>
<tr>
<td><strong>Program and Unit Level:</strong> Using NRC Picker, a series of corporate wide patient experience surveys, with special focus on the Emergency department scores and other key items e.g. overall satisfaction with care and by department, pain management (See Part B: for our improvement targets and details of the associated planned initiatives)</td>
</tr>
</tbody>
</table>
**Figure 6: Priority Focus 4**

**AIM:** Reduce Avoidable Admissions/Readmissions to Hospital

- Improve transitions along the continuum of care
- Improve the care provided to patients living with long-term (chronic) conditions (Diabetes, Congestive Heart Failure; Chronic Obstructive Pulmonary Disease)
- Implement evidence informed population based care models (i.e. inpatient and outpatient components) for conditions (Diabetes, Congestive Heart Failure; Chronic Obstructive Pulmonary Disease)
- Use standardized protocols and/or Order Sets

Enhanced admission assessment for post-hospital needs; with a focus on creating a "Senior Friendly Hospital" Patient and Family Centered handoff communication; Post-Hospital discharge followup, including "Virtual Ward"; Collaborate with the LHIN and CCAC and other key external partners to improve discharge planning and the transfer of information at discharge.

**What we will measure to know that an improvement has occurred?**

<table>
<thead>
<tr>
<th>Strategic Level:</th>
<th>Increase enrollment in the CHF and COPD Chronic Disease Management Clinics by 25% for high risk patients by the 4th quarter of FY 2012/13 and Implement the care transition service by the 4th quarter of FY 2012/13.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program and Unit Level:</td>
<td>ALC (Alternate Level of Care days, Readmission rates within 30 days for selected high volume CMGs, Process measures for key long-term conditions. (See Part B: for our improvement targets and details of the associated planned initiatives)</td>
</tr>
</tbody>
</table>
How does this plan align with Other HSN Planning Processes?

As HSN progresses in realizing its academic mandate the leadership team is adopting the principles of quality as a business strategy. There are eight criteria that HSN has integrated into it overall strategic and business planning processes as displayed in figure 7, including:

A. Understanding and clearly articulating the purpose of the organization
B. Viewing the organization as a system
C. Measurement of the system
D. Developing a system to obtain information
E. Planning for improvement
F. Managing improvement efforts
G. Using an improvement methodology
H. Developing a management system for improve

Figure 7: HSN Approach to Strategy Deployment

Health Sciences North’s Strategy Deployment Model to Drive Sustainable Results

The consistent use of this process ensures that the organization takes in consideration all related external and internal factors that impact their ability to provide the care and services of the population that they serve including:

- Hospital Service Accountability Agreement (HSAA)
- Multi-Sector Service Accountability Agreement (M-SAA)
- Partner hospitals, community providers and the Northeast Community Care Access Center (NECCAC).
- Requirements related to the Excellence Care for All Act (2010) and the Public Hospital Act.
What are the challenges and risks that have been considered in the development of this plan?

In the developing this plan, the Board and Senior Leadership has been guided by their review of the context of care delivery for HSN in Northern Ontario, the changing environment in the entire Ontario healthcare system; including the current changes underway to the funding structures.

The key risks and/or challenges that have been identified are:

A. The population of Sudbury and the Northeast is aging and with this aging population the proportion of frail elderly in the population is expanding and thus increasing the demand for acute and community-based services.

B. There are an increasing number of persons living in Sudbury and the Northeast diagnosed with long-term conditions that can be resource intensive, especially when there aren’t enough of community-based services to support them and enable them to better self-manage their conditions.

C. Like many organizations across the province we struggle with the consistent compliance with standard work and policy, a need to develop more capability and capacity around performance improvement.

D. As described in the report; “Enhancing the Continuum of Care” which was submitted to the Ministry of Health and Long-term Care in November 2011, “Ontario’s current funding structures do not provide hospitals with strong incentives to invest in improved care transition processes to reduce patient readmission, once a patient is discharged, the hospital is no longer technically accountable for their care.” This fact drives home the need for better integration and ease of flow for patients as they attempt to navigate across the disparate parts of the health system. The mechanisms to support this need are still evolving.

Our key approaches to mitigating these challenges and risks are:

A. To create an organization that is flexible and that is deeply rooted in the ability to provide evidence informed consistent care to the population that we serve.

B. To find intentional ways to engage our patients/families and community partners as active decision makers in the design and delivery of care services provided

C. To engage patients and families especially those living with long-term conditions to design and deliver the most cost-efficient and effective care delivery models of self-care.

D. To advocate and collaborate with the LHIN and other community partners who provide care along the continuum to truly move towards reducing the barriers and lowering the boundaries between parts of the “system” so that patients are able to move along the continuum of care in a more efficient and cost effective way and care can always be provided in the most appropriate place to the patient’s care needs. To use Quality as our Business Strategy; which requires us to have a rigorous ongoing process for monitoring our progress towards goals, allows us to more easily identify any new potential risks in our environment and is driving us towards the realization of organization that; (1) is fiscally responsible; (2) provides care that is satisfactory to the patients served and that reflects the best science; and (3) engages staff, physicians and other care partners in a way that will support innovation and a culture of continuous improvement.
Part B:
Our Improvement Targets and Initiatives

Purpose of this section: Please complete the “Part B - Improvement Targets and Initiatives” spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to HQO (QIP@HQOntario.ca), and to include a link to this material on your hospital’s website.
### PART B: Improvement Targets and Initiatives - 2012/13

#### Dimension: Safety

##### Objective

- **Reduce Central Line Blood Stream Infections (CLI)**
  - Dec. 2011, consistent with publicly reportable patient safety data.
  - RLHC = 0.56
  - OPC = 0
  - RLHC = 0.013

##### Outcome Measure/Indicator

- **Rate of central line blood stream infections per 1,000 central line days**: Total number of newly diagnosed CLI cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of central line days in that reporting period, multiplied by 1,000. Average for Jan-Dec. 2011, consistent with publicly reportable patient safety data.

##### Methods and Process Measure

- **Hand hygiene compliance before patient contact**: The number of times hand hygiene was performed before initial patient contact multiplied by 100. Jan-Dec. 2011, consistent with publicly reportable patient safety data.

##### Goal to Change (2012/13)

- **Theoretical Best**: 99.7%
- **Target Justification**: Theoretical Best applied to applicable areas outside of the OR; (4) Focus on each target group (physicians, nurses, etc.) addressing specific barriers to hand hygiene in staff work groups; (5) lesser management support and commitment to stand-alone hand hygiene as organisational priority; (6) Parallel engagement; (4) Environmental changes and system supports in alcohol-based hand rubs (99% compliance); (5) Ongoing monitoring and evaluation of hand hygiene practices, with feedback to health-care providers; (3) Commitment to make hand hygiene an organizational priority.; (4) Senior management support and addressing specific barriers to hand hygiene in staff work groups.; (4) Senior management support and addressing specific barriers to hand hygiene in staff work groups.; (4) Senior management support and addressing specific barriers to hand hygiene in staff work groups.; (4) Senior management support and addressing specific barriers to hand hygiene in staff work groups.

##### Comments

- **Moving toward Target**: Hand hygiene practices observed, with feedback to appropriate groups.
- **On Target**: Ongoing monitoring and evaluation of hand hygiene practices, with feedback to health-care providers.

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**Note**: Provincial Average (October to December 2011)  
- VAP (Ventilator Associated Pneumonia): 1.26  
- CLI (Central Line Blood Stream Infections): 0.48
### Province: Effectiveness

#### Objective
- **Improve Access to Care**
- **Zero Harm to Patients**

<table>
<thead>
<tr>
<th>AIM</th>
<th>Measurement</th>
<th>Description</th>
<th>Achieve Performance</th>
<th>Baseline 2011/12</th>
<th>Target 2012-13</th>
<th>Target justifiable</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td><strong>MRI Wait Times:</strong></td>
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<td><strong>IP Admits @ 0700 hours:</strong></td>
<td><strong>(2nd Quarter) Sept 2012)</strong></td>
<td><strong>(Q3 2011/12)</strong></td>
<td><strong>(April 2012)</strong></td>
<td><strong>Planned Improvement Initiatives (Change ideas)</strong></td>
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<td><strong>2.</strong></td>
<td><strong>Percentage of Surgical Patients with Timely Prophylactic Antibiotic Administration:</strong></td>
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<td><strong>(May 2012)</strong></td>
<td><strong>(April 2012)</strong></td>
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<td><strong>Methods and Process Measures:</strong></td>
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<tr>
<td><strong>3.</strong></td>
<td><strong>Medication Readbacks &amp; Reconciliation at Admission &amp; Discharge:</strong></td>
<td><strong>Medication Readbacks &amp; Reconciliation at Admission &amp; Discharge:</strong></td>
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<td><strong>(April 2012)</strong></td>
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<td><strong>(April 2012)</strong></td>
<td><strong>Goal for Change Ideas (2012/13):</strong></td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td><strong>Provincial Orthopeadic Scorecard:</strong></td>
<td><strong>Provincial Orthopeadic Scorecard:</strong></td>
<td><strong>(May 2012)</strong></td>
<td><strong>(April 2012)</strong></td>
<td><strong>(April 2012)</strong></td>
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#### Objective: Access

- **Linear候期 in the ED**
- **MRI Wait Times:**
- **CT Wait Times:**

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#### Objective: Effectiveness

- **Provincial Orthopeadic Scorecard:**

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<td><strong>(April 2012)</strong></td>
<td><strong>Contents:</strong></td>
</tr>
</tbody>
</table>

#### Note:
- Revision baseline for Q3 2012/12 as per Decision Support. Original value: 14.3
- * Revised Baseline for Q3 2011/12 as per Decision Support. Original value: 14.3
**AIM:**

**Measure:**

Continue with the implementation of the Chronic Outcome Measure/Indicator Baseline Ontario Average Current Performance

**Goal:**

(1) Increase the voice of the patient and family in the methodology

**Methodology/Process Measures:**

Quality Dimension/Alignment with Admissions/Readmissions

**Performance:**

Improve the Patient Experience

**Performance:**

Improve the Patient Experience

**Note:**

AIM: Performance

1. NRC Picker: Percent of patients who received answers they could understand when they asked important questions from a nurse in the hospital, and (b) doctor in the hospital; (c) NRC Picker: Percent of patients who were able to understand explanations about test results received on discharge from the hospital; (d) Other measures TBD.

**Performing**

Note: HSN Recognizes that to effectively implement the planned improvement initiatives described here, HSN is partnering with our LHIN and will work with providers across the system. Unless otherwise indicated, data collected locally at least monthly is reported to the Quality Performance Committee at least quarterly. Note: HSN Recognizes that to effectively impact these two initiatives, they must work with providers across the system. This is partnering with our LHIN and HCSS, the Community Care Access Centre, and long-term care providers to improve access to post acute care. Unless otherwise indicated, data collected locally at least monthly is reported to the Quality Performance Committee at least quarterly. Note: HSN Recognizes that to effectively impact these two initiatives, they must work with providers across the system. Unless otherwise indicated, data collected locally at least monthly is reported to the Quality Performance Committee at least quarterly.

**Comments:**

Monitor all the program level and report at least quarterly to the Quality Performance Committee.
Part C: The Link to Performance-based Compensation of Our Executives

The purpose of performance-based compensation related to ECFAA is to drive accountability for the delivery of quality improvement plans (QIPs). By linking achievement of targets to compensation, organizations can increase the motivation to achieve both long and short term goals. Performance-based compensation will enable organizations to ensure consistency in the application of performance incentives and drive transparency in the performance incentive process.

Please refer to Appendix E in the QIP Guidance Document for more information on completing this section of the QIP Short Form. The guidance provided for executive compensation is also available on the ministry website.

Manner in and extent to which compensation of our executives is tied to achievement of targets

The Excellent Care for All Act, 2010 requires that the compensation of the Chief Executive Officer, Chief of Staff, Chief Nursing Executive and any senior executive who reports to the CEO be linked to the achievement of performance improvement targets laid out in an organization's Quality Improvement Plan (QIP). The following table details positions included and how the executives' compensation is linked to performance.

<table>
<thead>
<tr>
<th>Position</th>
<th>Percent of Salary at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive Officer</td>
<td>5% of base salary</td>
</tr>
<tr>
<td>Chief of Staff</td>
<td>5% of base salary</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>2.5% of base salary</td>
</tr>
<tr>
<td>Chief Nursing Executive</td>
<td>2.5% of base salary</td>
</tr>
<tr>
<td>Vice President Research</td>
<td>2.5% of base salary</td>
</tr>
</tbody>
</table>

Performance Allocation Plan for 2012/13

<table>
<thead>
<tr>
<th>General Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) All measures listed below are equally weighted</td>
</tr>
<tr>
<td>2) The indicators apply equally to all affected members of the Senior Management Team</td>
</tr>
<tr>
<td>Priority Area 1: Zero Harm to Patients as a Result of Care</td>
</tr>
<tr>
<td>A. <strong>Effectiveness:</strong> Achieve a HSMR (hospital standardized mortality ratio) to equal or below 100 by 4th quarter of FY 2012/13</td>
</tr>
<tr>
<td>Priority Area 2: Improve Access to Care and services</td>
</tr>
<tr>
<td>B. <strong>Access:</strong> Reduce the Average Length of Stay in ER for Admitted Patients by 10% by the 4th quarter FY 2012/13</td>
</tr>
<tr>
<td>Priority Area 3: Improve Patient Satisfaction</td>
</tr>
<tr>
<td>C. <strong>Patient-centered:</strong> Increase the result for the NRC Picker question, “Overall, how would you rate the care and services you received at the hospital?” by 10% improvement by 4th quarter of FY 2012/13</td>
</tr>
<tr>
<td>Priority Area 4: Reduce Avoidable Admissions/ Readmissions to Hospital</td>
</tr>
<tr>
<td>D. <strong>Integrated:</strong> Increase enrollment in the CHF and COPD Chronic Disease Management Clinics by 25% for high risk patients by the 4th quarter of FY 2012/13</td>
</tr>
<tr>
<td>E. <strong>Integrated:</strong> Implement the care transition service by the 4th quarter of FY 2012/13</td>
</tr>
</tbody>
</table>

Approach for Incentive Payout

| Minimum threshold achieved (same as previous year) | 50% |
| Improved over previous year (but target not achieved) | 80% |
| 2012/13 target achieved | 100% |

Note: This section is presented as a DRAFT only as the HSN System for Executive Compensation and Performance Pay is under review. Any changes to the specific measures or method for calculation will be completed and posted by the end of the first quarter of FY 2012-13.
Part D: Accountability Sign-off

[Please see the QIP Guidance Document for more information on completing this section.]

I have reviewed and approved our hospital's Quality Improvement Plan and attest that our organization fulfills the requirements of the *Excellent Care for All Act*. In particular, our hospital's Quality Improvement Plan:

1. Was developed with consideration of data from the patient relations process, patient and employee/service provider surveys, and aggregated critical incident data
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in and extent to which, executive compensation is tied to achievement of QIP targets; and
4. Was reviewed as part of the planning submission process and is aligned with the organization's operational planning processes and considers other organizational and provincial priorities (*refer to the guidance document for more information*).

Russell Boyles  
Board Chair

Nicole Everest  
Quality Committee Chair

Dr. Denis-Richard Roy  
Chief Executive Officer

Health Sciences North
Horizon Sante-Nord