

Excellent Care
For All.



2011-12

Quality Improvement Plan

(Short Form)

Bluewater Health
April 1, 2011



This document is intended to provide public hospitals with guidance as to how they can satisfy the requirements related to quality improvement plans in the *Excellent Care for All Act, 2010* (ECFAA). While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and hospitals should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, hospitals are free to design their own public quality improvement plans using alternative formats and contents, provided that they comply with the relevant requirements in ECFAA, and provided that they submit a version of their quality improvement plan to the OHQC in the format described herein.

ontario.ca/excellentcare

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 organizations 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 organization. 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 organization. In addition, this section provides you with an opportunity to describe your priorities and change plan for the next year.

Please refer to **Appendix D** in the [QIP Guidance Document](#) for more information on completing this section.

1. Overview of our quality improvement plan for 2011-12

The mission of Bluewater Health is “We create exemplary healthcare experiences for patients and families every time” and our vision is “Exceptional Care-Exceptional People-Exceptional Relationships”. From experience, we know that the development of a quality improvement plan ensures that we remain on track to meet these high standards and expectations.

Through the engagement of our staff, physicians, and community partners, we will achieve excellent outcomes in all of the quality dimensions:

- Safety - Improved hand hygiene practices by staff, a reduction in patient falls, and improved medication reconciliation.
- Effectiveness - Improved financial management.
- Access - Reduced Emergency Department wait times and faster access to surgery for patients with cancer.
- Patient-Centred - More patients recommend Bluewater Health to their friends and families.

2. What we will be focusing on and how these objectives will be achieved

Bluewater Health has developed quality improvement plans around “priority 1” measures, or those measures that have the highest priority because they align with our local and strategic priorities or accreditation priorities, are supported by external funding, or demonstrate an opportunity for us to improve from our current performance. Specifically, by March 31, 2012, we will:

- Improve the percentage of times staff clean their hands before coming into contact with a patient or patient environment (room) from 45% to 75% by:
 - Training staff champions, delivering targeted education, and establishing a feedback and recognition system.
- Reduce the number of patient falls that cause permanent or temporary minor harm/damage by 10% from 169 to 152 by:
 - Weekly reviews of falls data and identification and implementation of improvement/prevention strategies through rapid improvement cycles and adoption of one standard from the Calgary Falls Program.
- Improve the percent of medication reconciliations completed within 24h of inpatient admission from 62% to 75% by:
 - Developing a patient education pamphlet, implementing an improved documentation system, and further education and evaluation.
- Improve Bluewater Health's percent by which total revenues exceed total expenses from -.28% to 0% and achieve a balanced budget by:
 - Benchmarking with peer hospitals, closely monitoring and managing expenses, and developing action plans for budget shortfalls.
- Reduce the time admitted patients spend in the Emergency Department (ED) waiting for an inpatient bed by 10% from 19.4h to 17.5h by:
 - Participation in an organized ED Process Improvement Program (PIP), increasing the number of patients discharged by 11am, implementation of the Releasing Time to Care© Admissions/Discharge process module, and continued monitoring and development of the Daily Access Reporting Tool (DART).

- Improve the percent of patients able to access surgery for their breast, bowel, or prostate cancer diagnosis within the guidelines for priority access timeframes from 78% to 90% by:
 - Implementing a patient navigator, implementing a central booking system for cancer surgery, implementing Diagnostic Assessment Pathways (DAPs), and establishing diagnostic assessment clinics.
- Improve the percent of patients who would “definitely” recommend Bluewater Health following an inpatient stay from 68.4% to 75% which is well beyond the Ontario Community Hospital Average score of 69.4%. Given “attitude of care providers” constitutes a major reason for patients not “definitely” recommending the hospital, we will accomplish this improvement by:
 - Developing action plans for the top 3 priorities linked to staff engagement, implementing focused Team Renewal activities on designated patient units to improve communication, improve engagement in problem solving, and support the ongoing identification of issues, and continue to spread the Releasing Time to Care© program to all inpatient units.

3. How the plan aligns with the other planning processes

Bluewater Health’s strategy map (below) highlights that the dimensions of quality healthcare are fundamental to our strategic priorities and strategic plan. The quality improvement plan (QIP) is also very much linked to the following:

- H-SAA (Hospital Service Accountability Agreement) - ED Wait Times, Readmissions, Cancer Surgery Wait Times, Margin, Pressure Ulcer Incidence, ALC days.
- Bluewater Health’s Safety Plan and Accreditation Canada Required Organizational Practices - C. Difficile rates, Ventilator Associated Pneumonia (VAP) rates, hand hygiene compliance rates, Central Line Infection (CLI) rates, fall rates, and medication reconciliation completion rates.

The majority of indicators are also monitored through balanced scorecards reported to our Medical Quality and Utilization Committee and Quality and Performance Committee and many are also reported on our website for the public to access (<http://www.bluewaterhealth.ca/>). Similarly, many are reported on the Ontario Hospital Association (OHA) website (<http://www.myhospitalcare.ca>) or Ministry of Health and Long-Term Care website (<http://www.health.gov.on.ca/en/public/programs/waittimes/> or http://www.health.gov.on.ca/patient_safety/). Bluewater Health has committed to depicting the QIP (and other) indicators in a more visual and graphical format on our website in the near future.

The QIP serves not only as a means of communicating our plans to improve and deliver high quality healthcare experiences at Bluewater Health, but also as an indication of our commitment to accountability and transparency to our community, patients, and staff.

4. Challenges, risks and mitigation strategies

Changes and improvements are not always easy to implement and are even more difficult to sustain¹. The following are some potential challenges that Bluewater Health may encounter in working on our Quality Improvement Plan (QIP) activities and strategies to mitigate these challenges:

Potential Challenges:	Mitigating Strategies:
<ul style="list-style-type: none"> • Competing priorities: local and organizational needs and priorities versus ECFAA QIP measures 	<ul style="list-style-type: none"> • Strategic plan devised based on balanced scorecard perspectives to ensure efforts remain balanced in achieving quality care, exceptional relationships, inspired people, and outstanding performance. • Limit improvement efforts and plans to target a manageable number of priority 1 measures (7). • Optimize alignment between ECFAA QIP measures and strategic priorities. • Develop “energy grid” to monitor and plan for optimal use of human resources.
<ul style="list-style-type: none"> • Not all changes lead to improvement in outcome measures 	<ul style="list-style-type: none"> • Develop leadership skills in continuous quality improvement, including measuring and monitoring outcomes.
<ul style="list-style-type: none"> • Not all ideas from other organizations can be adapted locally 	<ul style="list-style-type: none"> • Continue spread of Releasing Time to Care © program which teaches continuous quality improvement skills and engages frontline staff in idea generation, problem solving, and decision making.

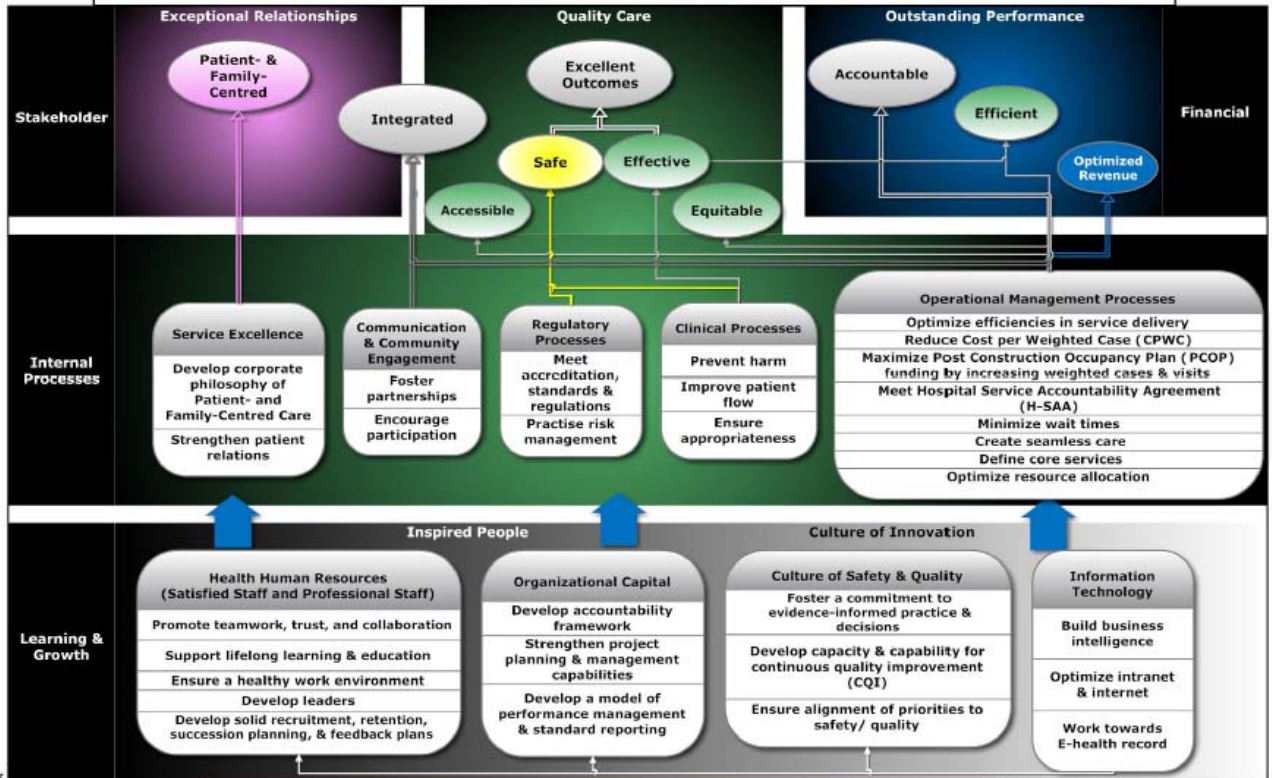
¹ Ontario (January 2011). Quality Improvement Plan Guidance Document. Available online: Ontario.ca/ExcellentCare

Strategy Map

v. Jan 27 2011

Vision: Exceptional Care - Exceptional People - Exceptional Relationships

Mission: We create exemplary healthcare experiences for patients and families every time.



Values: Compassion, Accountability, Respect, Excellence (CARE)



*Adapted from Institute of Medicine, Ontario Health Quality Council, Ontario Hospital Association



Part B: Our Improvement Targets and Initiatives

Please complete the "[Improvement Targets and Initiatives – Part B](#)" spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to the OHQC (QIP@ohqc.ca), and to include a link to this material on your hospital's website.

Part B: Improvement Targets and Initiatives as follows:

PART B: Improvement Targets and Initiatives



[Bluewater Health | 89 Norman St., Sarnia, ON N7T 6S3]

Please do not edit or modify provided text in Columns A, B & C

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Safety	Reduce clostridium difficile associated diseases (CDI)	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	0.22	0.34 (ON)	3					
	Reduce incidence of Ventilator Associated Pneumonia (VAP)	VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	0	0 * 1.46 (Q3,ON)	3					* Inserted provincial rate for information
	Improve provider hand hygiene compliance	Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - 2009/10, consistent with publicly reportable patient safety data	45% (09/10)	75% * 65.73% (ON)	1	Increase rates of hand hygiene compliance before patient/patient environment contact to 75% or better for nurses within 2 targeted areas by August 2011 (specific strategies contained within improvement plan). Through the implementation of a detailed action plan and campaign specific to each target group (Nurses, Physicians, and Support Staff). This plan includes job specific education, intervention auditing in addition to other actions. As well Hand hygiene is added as a core measurement for Releasing Time to Care® units (RTC ©).	* Compliance rates Hand hygiene champions * Targeted education delivered * Feedback and recognition mechanism established	* Increase rates of compliance amongst nurses to 75% or greater within the targeted areas	Bluewater Health will meet or exceed the Ontario hospital average in 2011/12. The targeted compliance rate will be increased in subsequent years to reach our long-term goal of 100% compliance. The hand Hygiene Plan will be implemented within the 2 targeted areas first (Surgical In-Pt and Rehab) and then spread to other areas within the hospital in 2011/12. The initial areas were selected based on a review of hospital acquired infection rates, surgical site infection rates, and hand hygiene compliance.	Linked to CEO, COS, and Executive compensation.
						Increase rates of hand hygiene compliance before patient/patient environment contact for <u>support staff</u> within 2 targeted areas to 75% or better by August 2011	* Compliance rates * Targeted education delivered * Feedback and recognition mechanism established	Increase rates of compliance amongst support staff to 75% or greater within the targeted areas		
Increase rates of hand hygiene compliance before patient/patient environment contact for <u>physicians</u> within 2 targeted areas to 75% or better by August 2011						* Compliance rates * Targeted education delivered * Feedback and recognition mechanism established	Increase rates of compliance amongst physicians to 75% or greater within the targeted areas			
Reduce rate of central line blood stream infections	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 being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2010, consistent with publicly reportable patient safety data	0	0 * 0.75 (Q3, ON)	3					* Inserted provincial rate for information	

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	Avoid new pressure ulcers	Pressure Ulcers: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - FY 2009/10, CCRS	5.0%(Sarnia) 7.8% (CEEH)	4.2% (ON)	2					*Unadjusted Rates
	Avoid falls	Falls: Percent of complex continuing care residents who do not have a recent prior history of falling, but fell in the last 90 days - FY 2009/10, CCRS * Definition: Percent of residents who fell in the last 30 days from their MDS(Minimum Data Set) assessment's reference date - Q3 2009/10 - Q2 2010/11, CCRS. The unadjusted rates will be used. Each Patient in Complex Continuing Care has one MDS assessment completed per quarter and their reference dates are all different.	11.8% (Sarnia) 11.0% (CEEH)	6.5% (ON)	2					*Unadjusted rates

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Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	Avoid falls	Organizational falls for Level 2 and 3: Severity Level 3 - Event/error results in permanent harm/damage. Additional monitoring, prolonged stay and extensive follow-up required - total reported events for 2010. Severity Level 2 - Event/error results in temporary minor harm/damage. Additional monitoring or follow-up required - total reported events for 2010	165 (level 2) 4 (level 3) (Jan-Dec 2010)	10% reduction in Level 2 and 3 falls (comb.)	1	<p>Spread releasing Time to Care (RTC ©) to 9 inpatient units in 2011-2012 with patient falls as a core measurement and implementation and weekly reviews of safety crosses in all 9 units. Interpretation and understanding fall results on safety crosses to identify risks and opportunities for improvement.</p> <p>Subsequent implementation of 2 specific strategies to reduce falls within the Acute/Palliative/ Telemetry Medicine program (project charter and measures will be determined through data analysis in 11/12)</p>	<p>* Falls data is posted daily on the targeted units</p> <p>* Audit will demonstrate weekly meetings to review falls data</p> <p>* Days between falls</p>	* Weekly review of safety crosses in 100% of 9 designated RTC © spread units.	RTC © pilot completed in December 2010. an organization commitment to spread RTC © to all inpatient units in 2011-2012 and to establish falls measurement and focus as a core measurement. Integration of falls prevention work into existing processes at the departmental levels through Releasing Time to Care activities supports achievement of an organizational reduction in level 2 and 3 falls of 10%.	
						Participation in the LHIN Ontario-wide Falls Prevention Program (1 standard from the Calgary Falls Program will be chosen and implemented LHIN-wide)	To be developed when project is rolled out	*Participation and implementation of 1 standard as applicable to hospital care.	LHIN-wide strategy is set to roll-out for implementation in 11/12. Our participation will ensure a consistent approach to system improvement related to falls prevention work being undertaken within our LHIN. Commitment to target ensures forward movement of a Regional initiative.	
	Improve reliability with medication reconciliation process	Medication Reconciliation: % complete within 24hr of admission	62.2% (Q3)	75%	1	Implementation of action plan to improve compliance with medication reconciliation process.	<p>* Action plan complete with evaluation methods established</p> <p>* Education program related to medication history assessment completed and rolled out</p> <p>*Patient education pamphlet completed and distributed</p> <p>* Implementation of improved documentation module</p>	<p>*Improve compliance to 75% or better within acute medicine and the telemetry medicine units in Q4 2011/12.</p> <p>*80% of applicable staff will have completed the education component</p> <p>*Patient/visitor brochure complete and circulated</p>	Incremental improvement plan will be administered over a 2-year period to bring compliance to 90% or better. Teams will focus on achieving a 75% or better compliance rate in 2011/12 and that this target will increase to 90% for 2012/13. It is anticipated that the latrics project (computerized documentation) will have significant impact.	Linked to CEO, COS, and Executive compensation.

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Effectiveness	Reduce unnecessary deaths in hospitals	HSMR: number of observed deaths/number of expected deaths x 100 - FY 2009/10, CIHI	101	<100	2					
	Reduce unnecessary hospital readmission	Readmission within 30 days for selected CMGs to any facility: The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2010/11, DAD, CIHI	18%	14%	2					
	Reduce unnecessary time spent in acute care	Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q2 2010/11, DAD, CIHI	7.27%	< 9%	3					
	Improve organizational financial health	Total Margin (consolidated): Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2010/11, OHRS	-0.28%	0%	1	Refine global Cost Per Weighted Case (CPWC) measurement and reporting to subdivide into Program targets for direct care. Direct CPWC measured and monitored for Surgery; Medicine; and Maternal Infant Child Programs. Cost per Diem measurement and monitoring used for Mental health; rehabilitation; and Complex Continuing Care. Individual programs closely monitor budgets and action plans are developed when needed. Measurements reported at all levels up to the Board. Improvement mechanisms identified and implemented to reduce costs. Strategies include: e.g. comparing activities to peer hospitals, revenue generating activities, prospective planning, Identifying core business activities, Releasing Time to Care.	We are limiting capital spending to improve working capital deficit. We are monitoring program variances from budget. Programs that are exceeding budget must develop a back to budget plan. We utilize balanced scorecards incorporating activity and dollars spent to help identify problem areas.	Targeting to achieve between a 0.5% and 0.5% Margin for 2011/12 fiscal year.	Range of -0.5 to 0.5 taken from the Hospital Service Accountability Agreement. Our organization needs to begin to eliminate our working capital deficit. As we are improving on our Cost per Weighted Case, we anticipate further efficiencies in operations which should generate small surpluses going forward.	Linked to CEO, COS, and Executive compensation.

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2010/11, NACRS, CIHI	19.9hr Sarnia; 6.8hr CEEH; 19.4hr (comb.)	17.5h(comb.) * 8hr prov target; 32.2hr prov avg	1	Improve access and patient flow through continued participation in the Emergency Department Process Improvement Program (ED PIP). ED PIP is designed to support improvements to hospital flow and build capabilities within hospitals for long term sustainable change.	* Data collection process complete for number of patients discharged by 1100 * Action plan developed for at least 1 strategy (as determined based on data analysis)	* Data entry of the in-patient indicators in process within the Daily Access Reporting Tool (DART) by May 1, 2011 * Early morning DART review with Emergency Department (ED) and Inpatient teams (IP) in place and operational by March 2012.	Bluewater Health is pending approval for wave 4 ED PIP effective April 1, 2011. as an organization in this program for the first year, a planned 10% reduction in wait times in 11/12 and further review and analysis to further reduce wait times in future years.	Linked to CEO, COS, and Executive compensation.
						The Releasing Time to Care © (RTC ©) in -patient team will develop and implement a standardized admissions/discharge process to improve patient flow for all 9 units involved in the spread plan.	* In-patient team established * Components identified * Action plan completed with timelines for implementation	*Completion of an organization-wide admission/discharge process (as yet to be determined) through the RTC © admission/discharge module over 2 years. Year one – achieve full implementation and application of admission/discharge process in 6 of the 9 spread units. *100% of 10-point checklist in place for acute telemetry, Palliative Medicine, CCU, ICU in 5 of 9 spread units. *Year two – achieve full implementation of application of admission/discharge process in place for remaining 3 spread units.		
		ER Wait times: 90th percentile ER Length of Stay for Complex non-admitted conditions. Q3 2010/11, NACRS, CIHI	4.5hr Sarnia; 4.0hr CEEH; 4.4hr (comb.)	8hr prov target; 7.5hr prov avg	3					
		ER Wait times: 90th percentile ER Length of Stay for non-admitted, non-complex conditions. Q3 2010/11, NACRS, CIHI	3.4hr Sarnia; 2.7hr CEEH; 3.3hr (comb.)	4hr prov target; 4.3hr prov avg	3					

AIM		MEASURE				CHANGE				
Quality dimension	Objective	Outcome Measure/Indicator	Current performance	Performance goal 2011/12	Priority	Improvement initiative	Methods and results tracking	Target for 2011/12	Target justification	Comments
	Reduce wait times for Cancer Surgery for Breast, Bowel, and Prostate	% Completed within Each Priority Access Target: for breast, bowel, and prostate cancer surgery	78%	90% (ON)	1	Continued implementation of strategies identified by the Cancer Care Program Steering Committee (approved by the Board in June 2010) that were formulated to improve access, decrease wait times, improve quality and patient/family centred care	* Implementation of patient navigator/manager * Implementation of a central booking system for cancer surgery * Implementation of Diagnostic Assessment Pathways (DAP) for breast, lung, and colorectal cancer * Diagnostic assessment clinics established for colorectal and breast	* Maintain wait times for prostate surgery at 90% or greater of cases completed within the provincial target * Improve wait times for breast surgery to 85% or greater of cases completed within the provincial target	Bluewater Health will continue to implement strategies to meet or exceed the Ontario average. In 2011/12 the team will focus on improving wait times for breast surgery specifically. It is anticipated that the improvement initiative will impact all cancer surgeries, however specific focus will be directed at improving colorectal surgery wait times in 2012/13. The Cancer Care Liaison Committee has been established and will oversee monitoring of targets and evaluation of improvement strategies along with the Surgical Program Committee.	Linked to CEO, COS, and Executive compensation.
Patient-centred	Improve patient satisfaction	NRC Picker / HCAPHs: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes")	68.4 (Q2 Inpatient)	75 (Q2 ON Inpatient)	1	Healthy Workplace Team activities to promote the development of an exceptional workplace culture and supportive environment while advancing the strategic priority of Inspired People.	* Top 3 priorities established * Action plan developed with evaluation methods established * Communication plan complete	*Implementation of a strategy for each of the 3 priorities in 11/12	"Attitude of health care providers" is a common reason identified by patients for not definitely recommending and is also a top contributor of patient complaints. It is expected that the Team Renewal, Healthy Workplace, and RTC activities will impact this indicator. Additional indicators related to patient/family centred care have been added to the Quality Performance Council Balanced Score Card.	Linked to CEO, COS, and Executive compensation.
						Initiation of focused Team Renewal activities in Rehab, In-Pt surgery, and Mental Health. The focus of these working groups is to establish mechanisms that will: -improve communication between employees and management - engage the team in collaborative problem solving - enable ongoing identification of issues.	* Action plans with evaluation methods established	* Each team will have recommendations and action plans finalized for the top 2-3 priorities * Implementation of a minimum of 1 strategy by each team in 11/12	Bluewater Health will undertake activities to meet or exceed the ON inpatient score.	
		In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP)					Releasing Time to Care (RTC) - spread to other clinical programs. Patient satisfaction is an integral part of the RTC program and there are established methods contained within the modules.	* Mini-survey findings from areas participating in RTC * Action plans with evaluation methods established	* Survey administration in 100% of participating units * Implementation of a minimum of 1 strategy by each team in 11/12 * Achieve the Ontario Community Hospital Average of 69.4 (from Q2) for "definitely" recommending Bluewater Health.	

Part C: The Link to Performance-based Compensation of Our Executives

Purpose of Performance-based compensation:

1. To drive performance and improve quality care
2. To establish clear performance expectations
3. To create clarity about expected outcomes
4. To ensure consistency in application of the performance incentive
5. To drive transparency in the performance incentive process
6. To drive accountability of the team to deliver on the Quality Improvement Plan
7. To enable team work and a shared purpose

Please refer to Appendix E in the [QIP Guidance Document](#) for more information on completing this section of the QIP Short Form.

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

Our executives' compensation is linked to performance in the following way:

Purpose of Performance-based compensation:

The purpose of performance-based compensation related to ECFAA is to drive accountability for the delivery of quality improvement plans. Performance-based compensation can help organizations to achieve both short and long-term goals. Performance-based compensation will enable organizations to:

1. To drive performance and improve quality care
2. To establish clear performance expectations
3. To create clarity about expected outcomes
4. To ensure consistency in application of the performance incentive
5. To drive transparency in the performance incentive process
6. To drive accountability of the team to deliver on the Quality Improvement Plan
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Organizational positions to which performance-based compensation applies:

Compensation for the *following executive positions at Bluewater Health* will be linked to our organization's achievement of quality improvement targets set out in our annual Quality Improvement Plan:

- Chief Executive Officer
- Chief of Professional Staff
- Vice President, Medical Affairs/Chief Quality, Patient Safety, Risk Management
- Vice President, Operations/Chief Operating Officer
- Vice President, Operations
- Chief Nursing Executive, Interprofessional Practice, Organizational Development
- Chief, Communications and Public Affairs

Linking compensation to the Quality Improvement Plan

Our 2011-12 Pay for Performance Plan is in compliance with ECFAA and the Public Sector Compensation Restraint to Protect Public Services Act, 2010.

For all of our executives, **2%** of their current base salary will be withheld and will now be “at risk” and linked to Bluewater Health achieving the targets set out in its 2011-12 Quality Improvement Plan on the indicators outlined below. Specifically, the linkages are with the following:

Quality Dimension	Objective
Safety	Improve provider hand hygiene compliance
Safety	Improve reliability with medication reconciliation process
Effectiveness	Improve organizational financial health
Access	Reduce wait times in Emergency Department
Access	Reduce wait times for Cancer Surgery for Breast, Bowel and Prostate Cancers
Patient centred	Improve patient satisfaction

It is intended that the hospital must achieve 100% of the targeted improvement set out in the QIP for an objective in order for the performance-based compensation for that objective to be earned. Each objective is weighted at 0.5% of current salary, so that the full 2% of base salary can be earned back if the hospital achieves or exceeds its QIP targets in 4 of the 6 objectives. In no circumstances will the payout of performance-based compensation exceed 2% for the 2011-12 fiscal year.

The Board of Directors has the residual discretion to modify the amount of performance-based compensation (subject to the 2% maximum) following assessment of the Hospital's performance related to the QIP, in the event that there has been significant achievement of the objectives specified above but the targets set out in the QIP have not been achieved.

Part D: Accountability Sign-off

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/provider surveys, aggregated critical incident data, and patient safety indicators;
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.

Bruce Davies
Board Chair

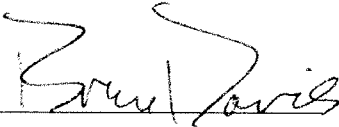
David Campbell
Quality Committee Chair

Sue Denomy
President and CEO


Part D: Accountability Sign-off

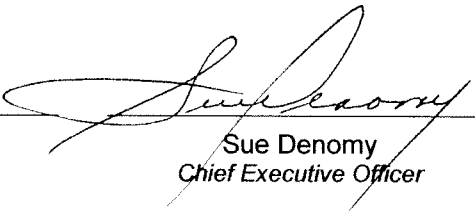
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Bruce Davies
Board Chair

(attached)


David Campbell
Quality Committee Chair


Sue Denomy
Chief Executive Officer

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Bruce Davies
Board Chair



David Campbell
Quality Committee Chair

Sue Denomy
President and CEO