

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

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**2/9/2018**

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# Overview

# The objective of Geraldton District Hospital’s (Hospital) Quality Improvement Plan (QIP) is to provide safe, effective, patient-centered care to our community that is easily accessible and is integrated with our community partners. This is achieved through the QIP and through the Hospital's quality improvement process, which has been in place for the past fourteen years and continues to evolve. The process starts at the grass roots level where all staff are encouraged to bring forward quality improvement initiatives to our Quality, Risk & Safety (QRS) Committee to be tested and monitored. The QRS committee meets every two (2) months and is comprised of organizational leadership and front line staff from various departments. The Committee's goals align with that of the Hospital, as they are involved in developing new initiatives that improve the overall quality of care and monitoring indicators with respect to patient safety. The QRS committee reports to the Quality Improvement Committee (QIC). The QIC is comprised of senior leadership, board members and clinical care staff/frontline staff.

# The QIC is responsible for monitoring all indicators and quality initiatives on a monthly basis to determine if our improvement measures for the indicators are obtaining the desired results and to develop solutions for identified challenges to assist our facility in meeting our set targets. The QIC submits minutes and score cards to the Board of Directors on a monthly basis. In the 2016/17 fiscal year, we worked to restructure our quality improvement program, and with the development of the QRS and its relationship with the QIC, it is efficient and collaborative with our community partners. The purpose and scope of the QRS continued to expand in the 2017/2018 fiscal year, as the organization revitalized its Risk Management Program and continues to look for new ways to address quality and patient safety issues.

# For the past 2 years, the Hospital has focused the QIP around quality issues that were brought forward by the community and our partners in the region. This focus aligned with our current Strategic Plan, which highlighted the need for partnerships with stakeholders and communication to ensure seamless transfers of care for our patients. In past QIPs, we focused on indicators and initiatives that developed our referral process for chronic disease management programs through our community partners and we feel that we’ve made great strides in this area. With the upcoming conclusion to our current Strategic Plan, and the development of a new Strategic Plan beginning in the 2018/2019 fiscal year, we’ve decided to shift our focus for the 2018/2019 QIP and re-align our quality program with the new strategic direction of the organization.

# This year, the Hospital is linking the QIP directly with the strategic pillars, goals and objectives of our new Strategic Plan. The Strategic Plan was developed through extensive stakeholder consultation, in which we conducted 12 different community engagement sessions, including sessions for our staff, physicians and volunteers. These engagement sessions informed the strategic direction of our organization, in which we heard the need to focus on Access to Care, Working with Others (Partnerships), and Patient & Family-Centered Care. These are the strategic pillars of our new Strategic Plan. Through the community engagement process, we also developed refreshed Mission, Vision, and Values statements. We believe that our 2018/2019 QIP will align with the strategic direction of the Hospital, as well as our new Mission – “We are committed to delivering Quality, Coordinated, Patient & Family-Centered Care” – and our new Vision – “Partnering for a Healthier Community”.

# QI Achievements from the Past Year

As much as the Hospital is always focused on making strides in improvement, there should always be time taken to celebrate success when it has occurred. Over the course of the last fiscal year, we have made positive changes within the organization and the community and are looking to continue to do so in the future. The greatest improvements took place in our Long-Term Care (LTC) home and our Acute Care (AC) department.

In our LTC home, we focused our efforts on the implementation of a detailed Pain Management Program to ensure that our residents receive care that is based on best-practice, evidence informed guidelines. The degree in which residents have reported experiencing worsened pain has decreased over the last few quarters and we expect it to continue to do so under our new program. This improvement in delivery of care for our residents was made possible through the hard work of all staff, as well as the implementation of the improvement initiatives in the 2017/2018 QIP. These initiatives included: developing an interdisciplinary Pain Management Committee, focusing on our Nursing Restorative Program and activities for residents to keep them active, implement a pain management assessment tool that is better suited for our resident population, auditing and improving our use of pain assessment tools, and continuing the professional development/education of our staff through arranging for the regional palliative care telemedicine coordinator to conduct monthly palliative care rounds and education with our staff. With this success, pain will no longer be a priority indicator on the 2018/2019 QIP; however our new focus will continue to be closely aligned as we look towards palliative care for our patients next. Our LTC home has also applied to become a Best-Practice Spotlight Organization (BPSO) through the Registered Nurses’ Association of Ontario (RNAO), in which the focus will be on pain management, dementia/delirium care, and palliative care – which will match well with past and future QIPs.

In the AC department, we focused on developing referral processes and education opportunities for staff specifically related to chronic diseases that were identified by community partners and our patient population as issues: Diabetes and Chronic Obstructive Pulmonary Disease (COPD). Throughout the 2017/2018 fiscal year, we worked hard to establish new referral processes and to rekindle relationships with our community partners. This allowed us to achieve our goals of increasing our community diabetic patients’ tendency to test their levels, as well as to decrease the number of patients that are admitted to our Hospital diagnosed with COPD. The initiatives we implemented that allowed this success included: providing staff education on the utilization of medication related to Diabetes/COPD and the management of these patients, patient education and their responsibilities in their own care, developing patient awareness of what is offered in the community, and then connecting patients with the services that will best help them manage their condition. Due to the improvements made in these areas, COPD and Diabetes will not be a focus of the 2018/2019 QIP, as we shift our focus to another issue that we heard about in our community: Mental Health.

Apart from these two success stories, the Hospital also continued to focus on providing a safe environment to patients and staff in the 2017/2018 fiscal year, and with our improvement initiatives in place, succeeded. Hand hygiene compliance throughout the hospital was excellent again this year and is well above provincial average, which is a great success for a Hospital with an Acute Care and Long-Term Care facility. This result, especially when compared to the rates among Ontario hospitals for the last year, shows how much work staff is putting in to maintain a safe working environment. Hand hygiene compliance also ties in with Hospital acquired infections. In the 2017/2018 fiscal year, the rates of hospital-acquired CDI, MRSA and VRE were maintained and continued to be at zero (0).

It takes the effort of the entire organization to make positive change and with the commitment of leadership, staff and volunteers to safety and quality improvement, the organization looks to continue to make changes that improve the quality of care given within our facility. With the development of our new Strategic Plan, we look forward to aligning the focus of the QIP with the new strategic pillars of our organization.

# Patient/Resident/Client Engagement

Since the Hospital is located in a small, northern, rural community, we continue to engage with patients and their families to improve quality and care in our facility. Many of our internal committees involve former patients as active members, and not only do our patients and their families sit on our Accessibility Committee, Ethics Committee and Anishnabe Liaison Committee, but they also volunteer at the organization to assist in providing quality care to our patients and residents.

In preparation for the development of our new Strategic Plan, the community engagement sessions that were organized and conducted in various communities/First Nations provided invaluable insight into the thoughts and needs of our patient population. Attendees included past and present patients, their families/caregivers, volunteers at the organization, Hospital staff, past board members, senior citizens, and leaders of their respective communities. We made the effort of going directly to various communities and conducting multiple sessions as we wanted to make the sessions as accessible as we could so that we may receive as much feedback as possible. This included travelling to three of the First Nations in our catchment area, sometimes travelling upwards of 100 km to reach our destination. We also conducted two of the sessions in French with the help of translators, as a large proportion of our patient population is francophone. By putting in the effort to organize and attend these sessions, they were quite well attended and we feel that we received the input necessary to inform the development of our new Strategic Plan, and in turn, our 2018/2019 QIP. As a strategic pillar in the new Strategic Plan, the organization is also looking into incorporating a Patient and Family-Centred Care (PFCC) model as a change in culture, which will look to include patient advisors at our Hospital in the upcoming year.

In recent months, we’ve focused our efforts into developing a Patient & Family-Centered Care Committee at our organization. Led by and attended by senior management, this committee is paving the way towards an approach that will bring the patient’s voice to the forefront of all of our everyday activities, so that we may embed a culture of PFCC in the care that we provide our community. As a part of this process, we are actively recruiting Patient & Family Advisors (PFAs) who will be active members of various organizational committees, including the Board and the QIC. Their voice will be that of the patient, as they advocate for practices and guidelines that fit in with our new culture of care that puts patients and their families at the center. With a few interested individuals already identified, we will continue to make strides in this direction before the end of the 2017/2018 fiscal year and continue forward into 2018/2019 and beyond.

Another way the Hospital has always, and will continue to engage patients/residents and their families, is through patient and resident feedback surveys and comment cards. The feedback provided through these tools allows the organization to narrow its focus on certain areas of concern. This process provides us with additional information that is necessary to complete the QIP in a manner that reflects the patients' concerns. In the 2018/2019 fiscal year, the Hospital will be updating its comment cards in an attempt to make the process much more patient friendly. This update will include comment card blitzes to certain departments of the Hospital during each month, as well as a revitalization of the scoring system from a simple 1-5 scale to one that is much more intuitive for patients. We are hoping that this will increase the number of comment cards that are completed and better capture the feedback of our patients and their families.

To reflect our continued commitment to improving our patient engagement process, and aligning with our new Strategic Plan, we will be including indicators that will specifically track the satisfaction of patients with the services that they received, as well as the comfort they have with leaving our organization with enough information to care for themselves. In conjunction with these indicators, new initiatives will be developed that will focus on changing processes to make everything we do patient & family-centered.

# Integration, Collaboration & Continuity of Care

The engagement process that informed the development of our new Strategic Plan and 2018/2019 QIP also included an engagement session with our regional stakeholders. From home care to primary care, many active partners in the health care of our community attended this session where we heard from them what the Hospital could do to improve, what the Hospital is doing well, and what the Hospital needs to continue doing in the future. This process allowed us to have a better understanding of where there are gaps in care for our patients and where we could collaborate and partner with our stakeholders to ensure that the continuity of care for everyone is improved. Our 2017/2018 QIP focused on integration and our 2018/2019 QIP will continue that trend as we look to align ourselves with one of our new strategic pillars: Working with Others.

To expand on this strategic direction, the Hospital will continue to lead community discussion through the bi-monthly committee meetings of the Healthier Community Advisory Committee (HCAC). The HCAC is a large community committee whose goal is very simple: a healthier community. This aligns with our new Strategic Plan’s Vision – “Partnering for a Healthier Community”. Our Chief Nursing Executive (CNE) and Chief Executive Officer (CEO) both sit on this committee and will continue to do so as we strive to achieve our Vision and make positive change in the health care delivered to our patients.

One of the Hospital's largest areas of improvement of the last two years, which continues to develop from cooperation with our community partners, is the decrease in Emergency Department visits for CTAS 4 & 5 patients. These patients are those who do not require immediate medical care and are better served by a visit to a nurse practitioner or a family physician’s office. Unfortunately, our community has not had a full complement of physicians for the past few years, making it very difficult to get an appointment with a family physician during their limited office hours. The Greenstone Family Health Team was able to alleviate the stress caused by the limited resources of physicians in the community by hosting a walk-in clinic on the day that was historically the busiest for the Emergency Department. The NorWest Community Health Centres – Longlac Site has continued their evening walk-in clinic as well, which will continue to help provide patients with the care they need in a timely manner.

Integration and partnerships, not only among community stakeholders, but also among regional stakeholders, will be a focus for the upcoming year. The Hospital has become the Lead Organization for the District of Thunder Bay Integrated District Network (DoTB IDN)’s Health Links development. The Hospital, with the cooperation of many local partners, has developed a Greenstone Health Links Committee that meets on a monthly basis to move forward with Health Links activities in our community. We currently have Care Coordinators in both Geraldton and Longlac, where we are recruiting/referring patients to Health Links, which will lead to the most vulnerable patient population having a better continuity of care across the health care system. These Care Coordinators will help their Health Links patients access the community services they need, learn about new services that they may not have heard about, navigate the health care system and ultimately, help them achieve their health care goals. The Hospital is also part of the DoTB Health Links Steering Committee, with our CEO chairing the meetings. This committee directs its efforts toward spreading and sustaining Health Links within the many communities of the District. Health Links will continue to be a focus for the Hospital and we will continue to track our progress through the use of our QIP in the 2018/2019 fiscal year.

# Engagement of Leadership, Clinicians & Staff

In the 2016/2017 fiscal year the Hospital updated its quality improvement team model, which better utilized human resources and the time of our management and staff. The QRS meets every two (2) months and continued to evolve as we went through the 2017/2018; and will continue to evolve going into the 2018/2019 fiscal year. The QRS, which includes Hospital leadership and staff, reports to the QIC which then reports to the board, but replaced the six (6) teams that we had reporting on a monthly basis. This committee brings in members of specific departments to seek their input and in the future, will look to bring in community partners to include them in planning and discussion. These changes will save much time and effort over the course of the year by focusing the Hospital’s resources on more encompassing meetings.

In the 2017/2018 fiscal year, as part of our Accreditation cycle, we performed both a Patient Safety Culture tool to assess staff’s perspective on patient safety in our organization as well as a Staff Satisfaction Survey to understand areas that the staff feel we are doing well in, would like to see improved or areas they are concerned with. We had a significantly higher participation rate for both surveys than we’ve had in the past and the feedback was invaluable for Hospital leadership to create action plans to address issues raised by staff and make positive change. Action has already been taken on many of the issues raised by staff including organizational communication and work-life balance, and we will continue to focus on addressing staff needs in the next fiscal year.

The Hospital continues to include staff members and leadership in the planning processes for the strategic direction of the organization through the development of the new Strategic Plan. Multiple engagement sessions were held with managers to gather their feedback on what should be the focus of the organization going forward. There was also a staff engagement session and a survey that was distributed to all staff that was conducted to gather their input as well. This feedback was crucial in informing us on what steps needed to be taken to address issues within the Hospital and community that should be the focus of our new Strategic Plan and QIP. With their knowledge of the inner working of the Hospital, many individual steps were addressed and ideas put forward to improve upon specific aspects of our service. In 2018/2019, staff, clinicians and management will be heavily involved in the implementation of the strategies focusing on PFCC, palliative care, mental health and workplace violence.

Throughout the 2018/2019 fiscal year, staff will continue to be provided with education and training on a host of subjects. The focus of this education will centre on the change ideas implemented in this year’s QIP. Through providing staff with education and training involved with mental health, PFCC, palliative care and workplace violence, the Hospital will increase the quality of care given to its patients. This education will involve what community services are available in the area for mental health and palliative care, as well as how best to help these patients while they are staying with us. We will also focus education on the culture change necessary to decrease workplace violence, as well as create an organization that is truly patient & family-centered.

# Population Health & Equity

In general, the North West LHIN (NW LHIN) has a more distinct population than the rest of the province and faces many unique challenges pertaining to the health of the population. However, with the geographic area of the NW LHIN being so large and the communities being so rural/remote, different regions within the NW LHIN have even more unique health populations. In the Greenstone region, we have a much higher rate of mental health related issues than the provincial average. We also have issues with lack of services/coordination in our area, including but not limited to supportive housing. These have been identified as areas of concern for our region, and as such, they have become focal points in the creation of this year's QIP.

Our goal as an organization was to develop a QIP that focused on these issues, as well as our strategic pillars, so that we could identify ways that different organizations in the region could work together to achieve better results. With the continued development of Heath Links in our region, we feel that we are making great improvements in improving the health of our most complex patients, through partnerships with stakeholders and coordinating the patients’ care.

Due to the large geographic catchment area that we serve, as well as the unique demographics, the Hospital always strives to provide services that are accessible and culturally competent to the entire population. Our catchment area includes Greenstone, which is a municipality that spans hundreds of kilometers and includes six (6) communities, and four (4) First Nations. Therefore, transportation and accessibility have always been a concern. We are looking to address this issue for complex patients through Health Links. We believe that a more connected and collaborative approach to complex patients' care will help make their health care journey more accessible.

The Greenstone area also has a high population of Francophone and Indigenous people. To reflect this, we took great care in gearing our community engagement sessions towards making it as accessible as possible for them. Through the use of French language translators, and visiting the First Nations in person, we had a high turnout and very high quality discussions that helped to inform the creation of our new Strategic Plan and QIP. We also have many French speaking staff and we have French translation services available, upon request. We make great efforts in respecting the patients preferred language throughout their visit to the Hospital. In addition to this, we have a spiritual room, with capabilities to perform smudging ceremonies, that is accessible to any patients that would like to make use of it during their hospital stay. In the past, all of our staff underwent Cultural Awareness Training to ensure that they recognize and respect the different cultures of the people who may visit our Hospital. These are ways that the Hospital is using and will continue to develop in order to create a culture or care that is equitable for all.

**Access to the Right Level of Care – Addressing ALC Issues**

Alternate Level of Care (ALC) occupancy of Acute Care beds continues to be a regional and organizational issue. The Hospital has, and will continue to, make strides in improving the transition of ALC patients from Acute Care beds to their destination. Unfortunately, few usable solutions are available to us since our small rural context is vastly different than that of larger, more urban facilities. For example, with the absence of services such as Meals-on-Wheels, 24-hour assisted living services, homemaking services or other privatized services, it is very difficult for our ALC patients to live safely in the community.

To address these concerns our Acute Care unit works closely with the LTC home, the CCAC, as well the patients’ families. During meetings with the patient's family, strategies are put into place on how to fill service gaps in the community. Our LTC is attached to the Hospital and allows us to have vacancies in LTC quickly filled to promote better options for ALC patients within constraints of their list of options.

In 2016 our organization was chosen to be one of eighteen (18) Hospitals from around the world to participate in the Acute Care for the Elderly (ACE) collaborative, which aimed to create an elderly friendly environment in the Hospital's Acute Care unit. With our aging population and growing ALC issues, this was identified as a major improvement initiative to be undertaken over the course of the year. To help with the ALC issues in our Hospital, we developed an Identification of Seniors At Risk (ISAR) Emergency Department screening tool. This tool is used on any patient sixty-five (65) years of age and over that present in the Emergency Department and allows them to receive the appropriate level of care based on the screening results. One of the interventions of the screening for high-risk results is for the patient to be referred to CCAC services to ensure that they are receiving any services that they may need in the community to reduce their risk of being admitted to the Hospital or becoming an ALC patient. The ACE collaborative ended in mid-2017; however we will continue to leverage what we learned as part of the collaborative to improve the care that seniors receive at our organization.

However, ALC continues to be an issue in our community and with the lack of available resources, we have needed to be creative and collaborative in creating solutions. At a local level, the Municipality has done work to hire a consultant who examined the efficacy and feasibility of constructing Supportive Housing for the region. The Municipality heard this as an issue within the community, and with what the Hospital learned as part of its community engagement process of the Strategic Plan, we have partnered with the Municipality to focus on the Supportive Housing Project. With the large numbers of ALC currently in our AC unit, a full LTC home, a long wait list for LTC, a growing aging population, no alternatives to LTC, and a lack of services available to our elderly population for living at home, this will continue to be a focal point for our organization and community in the coming years.

**Opioid Prescribing for the Treatment of Pain & Opioid Use Disorder**

In 2017 the Ministry of Health & Long Term Care (MOHLTC) expanded their scope and response to the rising use of opioids, as it is rapidly growing into a crisis. All Hospitals in Ontario are mandated to report any instance of opioid overdose that comes through their Emergency Department (ED). As an organization, we’ve done what we can at a local level to try and address the crisis through how we prescribe and treat our patient’s pain.

The Hospital and our physician group support the prescription of non-addictive medications as alternatives to opioids. In addition to this, the physicians will not renew a prescription for narcotics without arranging for an appointment beforehand, and will not renew a prescription through the ED. As a strategy to try and decrease the prescriptions of narcotics in treating pain, and to help those who have addiction issues, the Hospital relies on our regional partners to help support our patients. At a local level, we have counsellors and substance abuse/addictions nurses that can be leveraged to support patients through the First Nation and Inuit Health Branch operated clinics and North of Superior Counselling Programs. We also have a methadone clinic that is operated out of Longlac, which is run by the Ontario Addiction Treatment Centers. At a larger regional level we rely on services provided by the St. Joseph’s Care Group such as counselling and chronic pain management.

As an organization we will continue to monitor the opioid crisis and its development in our region. We will look to the MOHLTC for guidance and implement any mitigation strategies that they roll out at a provincial level.

**Workplace Violence Prevention**

The Hospital is committed to providing a safe environment for all staff, volunteers, visitors, patients and their families. As such, the organization provides a wide range of training and education that allows staff and our volunteers to be prepared for any potential workplace violence events. This training includes training from the Crisis Prevention Institute (CPI Training) of non-violent crisis intervention for the entire Hospital staff. For nurses and volunteers, the Hospital provides education on Zero Tolerance and Gentle Persuasive Approach (GPA), and for all nursing staff, P.I.E.C.E.S (Physical, Intellectual, Emotional, Capabilities, Environment, Social & Cultural).

In addition to the education/training provided, the Hospital’s management is also involved in ensuring that their staff works in a safe environment. Managers are involved in annual risk assessments for their departments, where staff communicate to their managers any area where they feel that safety could be improved. Regular monthly inspections are performed through the Joint Health & Safety Committee on various parts of the facility. The Hospital also has a Workplace Violence & Harassment Prevention Program that oversees the prevention of violence and harassment in the organization. Staff are encouraged to report any and all instances of violence in the workplace, as there is zero tolerance for it within our organization.

The Hospital also works with outside agencies to support a safe workplace. The Ontario Provincial Police (OPP) visit our Hospital and LTC home once a year to do inspections of the facility to identify any areas of concern related to staff/patient safety. Based on their feedback we will make changes to the physical structure of our facility and the procedures that we follow to prevent violence. We also employ security guards on a 7 day/week basis, with coverage every night for 8 hours. Their presence ensures that our staff and patients are protected as they work/stay in our Hospital.

With the inclusion of the mandatory Workplace Violence indicator and the change ideas that we’ve developed for the 2018/2019 QIP, we will continue to put a focus on violence in the workplace to ensure that our organization is safe for our staff, volunteers, patients, and their families.

# Performance-Based Compensation – Accountability Management

The purpose of Performance-Based Compensation is to drive accountability for the delivery of quality improvement. By linking compensation to the achievement of quality dimension core indicator targets, the Hospital is able to: drive performance, improve quality, establish clear performance expectations and create clarity about expected outcomes. The Hospital is also able to ensure consistency and transparency in the application of performance incentives and drive accountability with respect to the delivery of the QIP.

Performance-based compensation applies to the following positions:

1. Chief Executive Officer (CEO) – Board decided and approved

2. Chief Financial Officer (CFO) – CEO decided and approved\*

3. Chief of Staff (COS) – Board decided and approved

4. Chief Nursing Executive (CNE) – CEO decided and approved\*

5. Chief of Clinical Services (CCS) – CEO decided and approved\*

\*(Numbers 2, 4 and 5 are decided upon collaboratively by CEO, CNE, CCS & CFO)

Executive Positions – Percent Compensation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Year  April 1st | CEO | CFO | COS | CNE \* | CCS \* |
| 2017/18 | 10% - as per current contract | - | 1% | 1% | 1% |
| 2018/19 | 2% - Board decision | Internal decision | 1% - Board decision | Internal decision | Internal decision |
| 2019/20 | TBD | Internal decision | TBD | Internal decision | Internal decision |

\*Both the CNE and CCS, despite being executive staff, do not reach the current salary expectations of six figures; hence, we will continue to set performance indicators to maintain the highest quality levels. However, once they do reach six figures they will be subject to salary performance based implications.

Manner in Which Compensation is Linked to Performance

The legislation and regulations do not include specific requirements regarding the percentage of salary that should be subject to performance-based compensation, the number of targets that should be tied to executive compensation, weighting of these targets, or what the targets should be. A clear link between QIP indicators and performance-based compensation fulfills the requirements of the ECFAA (Excellent Care for All Act). Performance-based compensation should be something that is led by the individual organization to drive performance and improvement on organization‐designated priorities.

Executive Compensation – Selected Indicators

|  |  |  |  |
| --- | --- | --- | --- |
| Executive Position | Quality Dimension | Indicator | Target |
| CEO | Effectiveness | Total Margin | >0.0 |
| CFO | TBD | TBD | TBD |
| COS | Timely | Reduce Wait Times in ED – Complex Patients | <12 Hours |
| CNE | Patient Safety | Reduce Hospital Acquired *C. difficile* | <1.0 |
| CCS | Access/Patient Centred | Ultrasound Appointments/Bookings | <8 days |

The percentage of salary and indicators may be amended from year to year at the discretion of the Board of Directors. Should one or more of the targets not be met because of extenuating circumstances beyond the control of the Executive, then the Board of Directors may amend the percentage of the salary at risk for the respective Executive.

## 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 : James McPherson

Quality Committee Chair: Ralph Humphreys

Chief Executive Officer : Lucy Bonanno