Excellent Care For All.

2012/13 Quality Improvement Plan

(Short Form)

MUSKOKA ALGONQUIN HEALTHCARE

March 8, 2012

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 HQO in the format described herein.

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.]

OVERVIEW: The vision of Muskoka Algonquin Healthcare (MAHC) provides us clear direction in terms of the importance of quality improvement; **OUTSTANDING CARE – PEOPLE FOCUSED**. In 2012-13 we are renewing our deep commitment to quality improvement and patient safety through a number of enabling factors. The most important factors are alignment and collaboration from the Board to the Bedside in terms of our sharp focus on these important dimensions of care. This alignment and collaboration is strengthened by our committee structure and our committee terms of reference at all levels which have been revisited in the past year to ensure quality and safety is a top priority with clear accountability frameworks at all levels of our organization.

Our 2012-13 Quality Improvement Plan (QIP) development has been strengthened by our lived experience and engagement in striving to achieve our QIP goals and objectives in 2011-12. We are excited about, and committed to, the next phase of our quality improvement journey.

OBJECTIVES: The objectives in our 2012-13 QIP have been structured to encourage improvement in key dimensions of quality care and organizational health. We have focused on objectives in each quality dimension where we believe positive results will garner the most benefit for our patients, our community and our regional partners.

Safety:

@ **Reduction of clostridium difficile associated diseases (CDI)** targeting a CDI rate per 1000 patient days below the provincial average (Priority 1)

@ **Improvement in hand hygiene compliance** through targeting a before patient contact hand hygiene compliance rate that is 5% above the provincial average (Priority 1)

@ **Reduction of patient falls** by decreasing injurious falls by 10% (based on 2011-12 results) (Priority 1)

Effectiveness:

@ **Improvement of organizational financial health** through achievement of a total margin equaling 0% (Priority 3)

Access:

@ **Reduction of wait times in the Emergency Department (ED)** by achieving a 90th percentile ED length of stay for admitted patients of 8 hours (Priority 2)

Patient Centered:

@ **Patient satisfaction** results, based on the NRC Picker survey question *"Would you recommend this hospital to your family and friends?"* by being the top Ontario performer in the teaching and community hospitals categories (Priority 2)

@ **Patient Complaint Resolution** process and timeliness improvement by targeting an 80% compliance with response time expectation through monitoring manager or senior leader time to respond to a verbal or written complaint. (Priority 2)

Integrated:

@ **Reduction of unnecessary time spent in acute care** by reducing Alternate Level of Care (ALC) days by 5% per annum until achievement of the provincial target has been reached |(multi-year objective) (Priority 1)

@ **Reduction of unnecessary hospital readmission** by focusing on a 10% reduction in the number of patients with pneumonia returning to the hospital within 30 days (we believe after an evidence review that these readmissions are also contributing to our hospital acquired clostridium difficile rates) (Priority 1)

We believe that achievement of these objectives will improve the quality, safety and service at MAHC. The change ideas and strategies that we will implement in order to achieve our priority one objectives include:

Priority 1 Objectives	***Target***	***Change Ideas/Improvement Initiatives***
Reduce CDI associated diseases	Less than Provincial Average rate	1- Implementation of an Antibiotic Stewardship Committee at MAHC 2- Support and engagement in the Regional Antibiotic Stewardship Program 3- Audit environmental cleaning practices to ensure best practices are consistently met 4- Implementation of safety checks by the Senior Leadership Team to provide both feedback and engagement of point of care staff to ensure improvement initiatives are undertaken in each clinical and support area
Improve provider hand hygiene compliance before patient contact	5% above the provincial average to a maximum of 100% compliance	1- Roll out an updated campaign regarding hand hygiene at MAHC incorporating the organizational values acronym…we all play A ROLE in patient safety 2- Implementation of safety checks by the Senior Leadership Team to provide both feedback and engagement of point of care staff to ensure improvement initiatives are undertaken in each clinical and

		support area 3- Continue with roll out of improved hand hygiene infrastructure including increasing hands free alcohol based sanitizer dispensers in strategic locations and lobby stands that increase the visibility of hand wash stations and key messages for staff, visitors and volunteers
Avoid patient falls	10% reduction in injurious falls. This includes all minor, moderate and major fall injuries.	1- Implement a robust falls prevention strategy including assessment tools and patient identifiers 2- Education for all staff and physicians including education during the orientation process 3- Provide education to patients and family members regarding falls prevention
Reduce unnecessary time in acute care	5% reduction of ALC rates per annum	1- Take a lead role in a Seniors Assessment and Outreach Team that helps surround the geriatric patients in the Muskoka area with the supports necessary to stay in an environment other than an acute care facility 2- Strengthen inter-professional/intra-agency ALC rounds 3- Further develop the terms of reference and role of the MAHC ALC SWAT team that meets in bullet form daily and for a weekly broad review of ALC patients to examine what needs to be implemented to support the patient in an alternate environment
Readmission within 30 days for Pneumonia at MAHC	10% reduction in readmissions for this CMG to MAHC	1- Provide physicians with quarterly data on readmissions to MAHC for this CMG. 2- Utilize a standard order set for pneumonia at MAHC.

ALIGNMENT: The 2012-13 QIP objectives are aligned with all of the plans and strategies that MAHC is committed to achieving. Our recently approved strategic plan focuses on: quality and safety, partnerships and collaboration, sustainable future, people and education and innovation. Each of these dimensions supports and is supported by the objectives in our quality improvement plan. In addition to our overall strategic plan our patient safety plan and the metrics in our balanced scorecard mirror and expand on the QIP objectives.

We recognize the importance of an overarching framework regarding quality improvement in order to ensure organizational synergy. A quality framework, which directs the work of our staff and physician groups, has been created to support this synergy. We have also generated a matrix which clearly outlines how the work of each group and committee is responsible for achieving our quality improvement objectives and how that is aligned with the overall strategic plan.

MAHC Strategic Dimensions

Quality Improvement Dimensions	Quality Care and Safety	Partnerships and collaboration	Sustainable Future	People	Education and Innovation
Safety	**Applying organizational processes and roles to improve each of the dimensions of Quality**				
Effectiveness					
Access					
Pt Centred					
Integrated					
	Board	Quality Council	CEO and Organizational Leaders	Physicians and Clinical Teams	Consumers and Community

Patient Safety Plan → Quality Improvement Plan →

MAHC ROLES

Reference: "A Safety and Quality Improvement Framework for Victorian Health Services" Metropolitan Health and Aged Care Services Division Victorian Government Department of Human Services, July 2005.

INTEGRATION AND CONTINUITY OF CARE: MAHC is an active participant in the integration work that is occurring in the North Simcoe Muskoka (NSM) LHIN. The reduction of ALC patient days has been an ongoing LHIN wide focus and MAHC has worked in collaboration with many other organizations in our LHIN in order to tackle the ALC issue. The participation in a multi agency antibiotic stewardship program is an area where an integrated approach is being utilized to combat the consequences of antibiotic resistant and associated organisms (ARO) and decrease the potential for outbreaks related to these organisms. We believe this integrated stewardship, a first in Ontario, will help achieve positive results in both the CDI reduction objective and in the reduction of unnecessary hospital readmissions.

Continuity of care is affected by many factors. The fiscal health of an organization is paramount in terms of being able to afford best practice initiatives. There is also a direct effect on continuity of care as it relates to safe quality care. Our focus on objectives that improve safety and quality, like hand hygiene compliance, will ensure our ability to provide continuity and avoid disruptions to continuity like outbreaks of hospital acquired infections.

CHALLENGES AND RISKS: The challenges and risks we anticipate can be categorized under some broad categories which include: financial constraint, infrastructure challenges, information technology deficits and the continued battle to combat antibiotic resistant organisms.

We anticipate that our shift in culture, to become as patient centric as possible with a true customer service ethic, throughout our organization will be a goal which requires close attention. In addition, we are concurrently focusing on providing a senior friendly hospital environment. We have also worked diligently to improve our occupational health and safety status through a Work Well Audit and recognize that we must continue to be diligent in ensuring the well being of our staff is an organizational priority.

There are a number of important initiatives occurring simultaneously at MAHC. These multiple projects may diffuse our focus on any individual plan, goal or objective, thus posing a risk to execution.

We have set aggressive targets and plans to address each of these risk categories and challenges as we enter the next fiscal year. We are positioned to build on our successes in 2011-12 that included: achieving a balanced budget, implementing a major infrastructure renewal targeted at improved infection prevention and control and improving our quality framework and reporting.

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.

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

PART B: Improvement Targets and Initiatives 2012/13

MUSKOKA ALGONQUIN HEALTHCARE, 100 FRANK MILLER DRIVE, HUNTSVILLE, ON P1H 1H7

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

AIM		MEASURE					CHANGE			
Quality dimension	Objective	Measure/Indicator	Current performance	Target for 2012/13	Target justification	Priority level	Planned improvement initiatives (Change Ideas)	Methods and process measures	Goal for change ideas (2012/13)	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. 2011, consistent with publicly reportable patient safety data	12 month rate MAHC = 0.31	Below Prov Avg.	Be better than the Provincial average	1	1) Antibiotic stewardship – Implement a Antibiotic stewardship committee at MAHC .	1) Standard order set for Community acquired Pneumonia.	80 % compliance with use of standard order set	
							2) Support the Regional Stewardship Program to guide antibiotic use and facilitate access to infectious disease expertise, both for Pharmacy and Physicians.	2) Antibiogram for the region developed and utilized by MAHC prescribers.	80% of physicians are knowledgeable of the antibiogram and utilize to guide prescribing practices for antibiotics	
							3) Perform audits to ensure appropriate environmental cleaning best practices are being met.	3) 50 audits per month per site	90% or greater compliance	
							4) Roll out Safety "Check" for clinical areas that depicts Health Care Associated Infections for the area and drives improvement initiatives in the area by the team	All clinical areas will post a safety check and monitor monthly compliance	100% implementation	
	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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	64% overall compliance for 2011	5% above provincial average (April 2012) to a maximum of 100%	Above provincial average	1	1) Develop a MAHC hand hygiene campaign.....We all play "A ROLE" and implement signage throughout the facility and a communication strategy.	Knowledge and awareness about campaign	Survey staff/physicians/ volunteers and target greater than 75% awareness of campaign	
							2) Implement Safety Checks in clinical areas to showcase performance and to drive improvement.	All clinical areas will post a safety check and monitor monthly compliance	100% implementation	
							3) Environmental changes (hands free dispensers at clinical area entrances) and roll out new lobby stands and clinical area stands.	Roll out change to entrances and lobby areas	100% implementation	
	Avoid patient falls	Falls: Percent of all patients who fell in the last 30 days - Q3 data 2011/12	Q3 number- 29	10% reduction in injurious falls- This includes all falls minor, moderate and major with any degree of injury Decrease by 12 falls/year	Reduce adverse events and align with PSP target	1	1) Implement a falls prevention strategy	Monitor compliance through chart audits of screening tool compliance	80% compliance with screening tool adherence	
							2) Provide ongoing education to all staff and physicians on MAHC's fall risk prevention policy.			
							3) Provide education to patients and family members about how to prevent falls.			
							4) Future replacement bed purchases should focus on High/low beds to reduce injurious falls.			
							5) Implement a falls "Safety Check" for each care area.	All clinical areas will post a safety check and monitor monthly	100% implementation	

AIM		MEASURE					CHANGE			
Effectiveness	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 2011/12, OHRS	1%	(	Balanced budget	3	1) 2)			
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI	12.7		P4R target	2	1) Utilize LEAN methodology and a Process Improvement Partnership to review the entire process of patient admission and discharge developing tools and expectations regarding the pull of patients from the ED and the implementation of tools to streamline the admission and discharge process 2) Continue to implement standard order sets that encourage both efficiency and effectiveness in terms of patient admission and discharge			
Patient-centred	Excel at patient satisfaction	From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?"	Q1 11/12 - ED94.90 and Inpt. 83.37	90%	Higher than best performers in Ontario for teaching and community hospitals	2	1) Develop a customer service program to increase the patient centered approach at MAHC 2) Embed MAHC's values throughout the organization including the "Everyone plays A ROLE in patient safety and satisfaction" campaign			
	Improve patient complaint resolution time.	Complaint Response: Every complainant is contacted by a manager or senior leader within 48 to 72 hours of making a complaint (written or verbal).	** need collation of Q3 11/12 data from complaint tracking log	80% achievement of the target response hours (48 to 72 hours except on statutory weekends/ statutory holidays)	This target in the 80th percentile will help encourage a responsive system that once ingrained can be improved upon as a multi-year	2	1) Design a leadership development strategy/education that will be the platform for complaint handling including the responsiveness that encourages early and satisfactory resolution and strives to drive customer service excellence. 2) Continue to standardize the complaint process so that complaints are handled in the same manner throughout the organization and aligns with our strategic action plan to provide customer service excellence to improve quality care and safety. 3) Design an accountability framework for complaints so it is clear, no matter where they are generated from, who is accountable for commencing the response process and who is responsible to ensure a satisfactory outcome is achieved whenever possible.			

AIM		MEASURE					CHANGE			
Integrated	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 2011/12, DAD, CIHI	29.6 acute and 15.4 CCC	5% reduction per year till alignment with provincial best performers rate of 5.5%	Time required to implement dramatic improvement initiatives	1	1) Senior's Assessment and Outreach Team- focused on SMMH site at present	Measure to see if there is an improvement in ALC days at the SMMH site	To see a consisten decrease in the ALC days for the site.	
							2) Maintain active participation in the ALC SWAT group, which is an interprofessional, interfacility group targeting ALC improvements, as well as continue with weekly MAHC ALC rounds and continue to support the model of transitional care coordinators (discharge planning and CCAC liaison.			
	Reduce unnecessary hospital readmission	Readmission within 30 days for Pneumonia to MAHC: The number of patients with Pneumonia CMG readmitted to MAHC for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions -	13.8% for 2010/11	10% reduction in readmission for the CMG to MAHC	Reduce Pneumonia readmissions to MAHC, to provide overall decrease in readmission rates to any facility	1	1)Provide quarterly data to physicians regarding Pneumonia readmissions.	Number of Medical Committee meetings that data is shared.	All Medical Meetings will receive and review readmission data for CA Pneumonia.	
							2)Use of Standard order set for CA Pneumonia	% of patients admitted with CA Pneumonia who are managed using standard order set.	80% compliance with order set utilization.	

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

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

Muskoka Algonquin Healthcare (MAHC) has a performance based accountability framework that ensures the performance of executive level leaders is clearly linked to the achievement of performance improvement targets as set out in the Quality Improvement Plan and is supportive of the organization's Strategic Plan and corporate metrics.

Annually, the Board of Directors approves the Personal Business Commitments of the Chief Executive Officer and the Chief of Staff. While at the same time, the remaining members of the Senior Leadership Team, as outlined below, develop individual personal business commitments in a collaborative effort with the Chief Executive Officer.

Senior Leadership Team Members include:

- Chief of Staff
- Senior Director, Corporate Services & Chief Financial Officer
- Senior Director, Clinical Services, Quality, Safety & Chief Nursing Executive
- Senior Director, Clinical Support & Planning
- Senior Director, Clinical Services & System Transformation

In order to ensure that expected levels of performance of all senior executives are clearly articulated and understood, measures have been aligned with three performance assessment categories (PAC) – Quality, Financial and Strategic / Significant Initiatives as per MAHC's approved Executive Compensation Philosophy, Strategy and Policy as well as being aligned with the Quality Improvement Plan Dimensions. These goals are based on strategic initiatives that are highly relevant to the long-term success of the hospital. Achievement of the three Performance Assessment Categories is rated on a scale and calibrated to varying levels that provide meaningful feedback and opportunity for improvement.

Chief Executive Officer: 15% of base salary is linked to achieving approved targets as per the following scale:

Performance Assessment Category	Does Not Meet	Almost Fully Achieved	Fully Achieved	Exceeded
Payment as a % of Base	0	10%	12%	15%
Quality (50% weighting)	0	4%	4.8%	6%
Financial (30% weighting)	0	4%	4.8%	6%
Strategic/Significant Initiative (20% weighting)	0	2%	2.4%	3%

Senior Leadership Team: 3% of base salary is linked to achieving approved targets as per the following scale:

Performance Assessment Category	Does Not Meet	Almost Fully Achieved	Fully Achieved	Exceeded
Payment as a % of Base	0	1.4%	2.8%	3%
Quality (50% weighting)	0	0.35%	0.70%	0.75%
Financial (30% weighting)	0	0.21%	0.42%	0.45%
Strategic/Significant Initiative (20% weighting)	0	0.28%	0.56%	0.60%

The following table outlines the 2012-2013 personal business commitments and performance goals for the Chief Executive Officer.

CEO Personal Business Commitment Metrics for 2012-2013

Performance Assessment Category	Quality Improvement Plan Dimension	Metric	Metric Detail	Current Performance	2012-2013 Target (based on current performance)
QUALITY	Safety: Lead MAHC to a substantially improved quality and safety environment through an organization wide quality and safety focus for patients and staff.	1. As per health system funding reform – quality based funding, ensure minimization of practice variation through the introduction of five new order sets from the top MAHC 20 case mix groups (CMGs) by March 31, 2013.		32 (as at January 2012)	37
		2. Ensure a Falls Prevention Program for all hospital in-patients is implemented with a target of at least a 10% reduction in the number of injurious falls over 2011-12 actuals.		29 (Q3, 11-12)	26.1
	Patient Centred (Be nice to me): The focus is on delivering high quality care and service to our community from a clinical, technical and customer service perspective.	3. Oversee that an analysis is undertaken to understand who the 1% of patients at MAHC utilizing significant hospital resources are that will lead to the development and implementation of a plan, by fiscal year end, to address their needs with the goal of reducing their reliance on hospital resources.		Not applicable	Plan implementation by March 31, 2013
	Access: The focus is on improving the access our community has to the care they require. Process improvements that increase productivity are an important component of improving access.	4. Support the implementation of processes targeted at reducing the Emergency Room Length of Stay for admitted patients to 8 hours or less.	Admitted patients with length of stay =< 8 hours	25 (December 2011)	8 hours or less
	Integrated: The focus is on ensuring system-wide attention to indicators related to continuity of care and care transitions.	5. Reduce the number of Alternate Level of Care (ALC) days, not designated ALC for long-term care (LTC) by 5% over 2011-12 actuals.	Number of non LTC ALC days to total patient days	3960 (Year to date as at January 12, 2012)	3564
FINANCE	Effectiveness (Heal me): The focus is on delivering the right services to our community and ensuring that we sustain our operational capability into the future	6. Lead MAHC to financial stability by meeting or exceeding the approved budget targets by March 31, 2013 and work with the Senior Leadership Team to understand MAHC's HBAM funding allocation for 2012-13 and how to leverage hospital operations to best promote efficiency and optimization of resources within this allocation.		Balanced Budget	Balanced Budget
		7. Ensure the patient accounts receivables balance is reduced by a minimum of 10% over 2011-12 actuals		$927,000 (as at Q3 11-12)	$834,000
		8. Support the implementation of an Attendance Management program with the target of reducing non culpable absenteeism to or better than the Ontario Hospital Association reported Ontario experience.	Group	MAHC 10-11	OHA 10-11
			Service	15.97	14.24
			Nurse	20.63	13.69
			Paramedical	6.92	7.06
			Clerical	8.35	9.04
			Administration	8.06	4.54
		9. Support the analysis and understanding of why the turnover rate for staff is 10% (2011 year) and ensure strategies are implemented to reduce this rate to the OHA reported average of 9% (2009).		10%	9%
STRATEGIC	Effectiveness (Heal me): The focus is on delivering the right services to our community and ensuring that we sustain our operational capability into the future	10. Ensure completion of the provincial pre-capital submission process requirements by March 31, 2013.		Not applicable	Pre-Capital Submission By March 31, 2013
	Patient Centred (Be nice to me): The focus is on delivering high quality care and service to our community from a clinical, technical and customer service perspective.	11. Work with the Senior Leadership Team, Physician Leadership and other stakeholders to support the development of a high level plan that will inform the Master Program by March 31, 2013		Not applicable	High Level Plan Completed by March 31, 2013
		12. Ensure the selection of an IT partner to initiate planning for clinical standardization by March 31, 2013.		Not applicable	Clinical standardization initiated by March 31, 2013
	Other – People Development (Life-Long Learning): The focus is on accessing learning opportunities that advance the hospital's focus on providing cost-effective, safe, people focused, quality care.	13. Ensure that the number of front line and management staff with yellow belt training in LEAN (Process Improvement Partnership) increases to a total of 20 in 2012-13.		Not applicable	20 Staff Yellow Belt Trained by March 31, 2013
		14. Support the creation and implementation of a Leadership Development Program by March 31, 2013.		Not applicable	Leadership Development Program Implemented

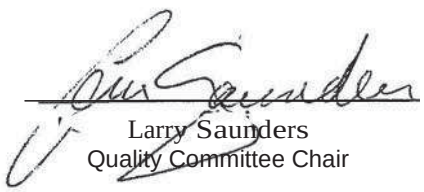
Part D:
Accountability Sign-off

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

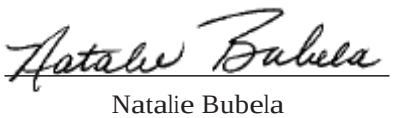
I have reviewed and approved our hospital's Quality Improvement Plan and attest that our organization fulfills the requirements of the Excellent Care for All Act. In particular, our hospital's Quality Improvement Plan:

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).

Sven Miglin
Board Chair



Larry Saunders
Quality Committee Chair



Natalie Bubela
Chief Executive Officer