Let's Make Healthy Change Happen.

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

MUSKOKA ALGONQUIN HEALTHCARE

3/29/2019

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

Overview

Muskoka Algonquin Healthcare (MAHC) proudly serves the community of Muskoka by providing safe, quality, patient and family centered care at two sites located in Bracebridge and Huntsville. MAHC is a rural teaching hospital and is affiliated with several academic institutions, including the Northern Ontario School of Medicine (NOSM), York University, and Georgian College.

We are committed to best practices and delivering the highest quality of care ensuring optimal patient outcomes through an integrated approach to safe, quality patient care with all of our partners. To assist us in fulfilling this commitment, MAHC adopted an iteration of the Health Quality Ontario (HQO) definition of a high quality health system as the definition for Quality at MAHC. The iteration that has been approved by our Quality Committee and the Board of Directors is directly aligned with the definition that the NSM LHIN has adopted.

Our 2019-2020 Quality Improvement Plan (QIP) reflects the fourth year that MAHC, the North Simcoe Muskoka Home and Community Care, Muskoka Health Links, the Cottage Country Family Health Team, the Algonquin Family Health Team, and Community Mental Health have worked collaboratively to improve the quality of care for the people of Muskoka and have some shared QIP initiatives. As a collaborative, we are working to improve safe, integrated, effective, patient centered access to care throughout the entire continuum of health care.

Our 2019-2020 Quality Improvement Plan (QIP) is designed to leverage the forward momentum of our overarching quality and safety culture by ensuring that our environment becomes even safer for our patients, by elevating best patient outcomes through cost effective strategies, by being proactive in anticipating and responding to patient needs, and by improving care transitions from our hospital to the community in collaboration with our partners. Our ongoing quality improvement journey has been informed by our patients and their families, our staff, physicians, Board of Directors, and health care partners. Our collaborative work in the development of our QIP helps to ensure that our patients receive the right care, in the right place, at the right time. This year's iteration of the QIP includes a reduced number of quality initiatives to ensure that full implementation, development and sustainability of the identified indicators are the focus. Each of our clinical care committees have also identified at least one quality initiative and will be focusing on those at the committee level for possible inclusion in future QIPs.

Each selected QIP objective, and its associated improvement indicator, is supported by several underlying initiatives to improve quality of care for the Muskoka community. By working together with our partners, we continue to strive toward significantly enhancing care through the following focused strategies:

(i) Timely Access will be measured by the time interval between the disposition of the patient from the Emergency Department (ED) for admission to an inpatient bed or Operating Room. Patients admitted to the ED, who are unable to be transferred to an inpatient bed in a timely manner, are generally older and in need of complex medical care. This puts this patient population at greater risk of falls and confusion. This in turn, leads to increased wait time for all ED patients. This indicator is closely aligned with patient wait time for discharge/transfer to alternate level of care. The development and implementation of MAHCs Gridlock Policy has improved these metrics over the previous year, however, we will continue to work with both internal and external stakeholders to achieve a further decrease in time.

(ii) Medication reconciliation at discharge: When discharging patients from hospital, it is extremely important to ensure that accurate medication reconciliation is captured to ensure safe medication compliance once the patient is home or transferred to an alternate level of care. This ensures that treatment quality and efficacy is maximized and is an important way to enable safe, seamless care. We have identified this indicator as our Collaborative initiative, and have identified members of our regional partners to assist in moving this forward.

(iii) Workplace Violence: MAHC is committed to ensuring a safe workplace for all physicians, staff, patients and volunteers. Last year, Data collection on workplace violence incidents was gathered (as defined by the Occupational Health and Safety Act), and this data was further analyzed to determine current baseline rates and to identify measures to be implemented to reduce the risks associated with identified trends. This year's QIP will focus on ensuring that we are indeed capturing all workplace violence incidents and further analysis of the data, through the Workplace Violence Working Group will be used to identify two significant improvement initiatives, and an improvement plan implemented in April 2020.

Associated with all of the QIP objectives above are targeted change ideas that will drive and achieve improvements within the quality dimensions of effective, efficient, patient centered, safe, and timely. These change ideas range from unit level engagement of staff, to process mapping, to sub-region collaboration with our community partners. The MAHC culture supports and encourages high quality integrated care in each and every patient-family/provider interaction. We believe that together we can build healthy communities that are aligned with regional and provincial priorities.

Additional indicators, identified as priorities, but not included on this Quality Improvement Plan include the following which are being developed by our clinical care teams as internal quality initiatives:

- Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital
- This quality improvement initiative will be investigated by our Family Practice Committee and as necessary, improvement plan developed. This indicator lends itself well with a collaborative focus and will also be brought forward to our Collaborative QIP Working Group.
- Average number of inpatients receiving care in unconventional spaces or ER stretchers per day
- In the fall of 2018 a small working group was created and tasked with identifying clinical spaces which could be converted into patient care areas should additional beds be required for in-patient care. A total of 48 additional bed spaces were identified between both MAHC sites and a plan developed to ensure that the spaces were appropriately furnished. This has allowed us to increase capacity and reclaiming clinical spaces which may have been used as non-clinical work areas
- Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter
- This indicator is being monitored daily by our clinical teams who continue to work with our partners to efficiently discharge patients to the most appropriate care setting. This metric will continue to be reviewed on a monthly basis by our Quality Council and Senior Leadership. It will also be included on our Patient Quality and Safety Dashboard which is shared with the Quality Committee of the Board.

- Percentage of complaints acknowledged to the individual who made a complaint within five business days
- MAHC has a completely developed process in place to ensure timely response to all submitted patient/family complaints. These are also reviewed at the appropriate clinical care committee to further identify trends and identify quality improvements
- Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment
- This indicator will be brought forward with our clinical care committees for further discussion and with our community partners as a potential collaborative initiative.
- Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission
- MAHC is not a Form 1 facility and transfers all mental health admissions from our Emergency Department to an appropriate care facility in our region.

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

Last year the NSM Home and Community Care, Cottage Country Family Health Team, Algonquin Family Health Team, Muskoka Health Links, Community Mental Health, and MAHC partnered on a few improvement opportunities with the goal of enhancing the quality, safety, and access to care through shared accountability. Together, we achieved success in key areas and are proud of our second year of accomplishments with a collaborative approach to quality improvement in Muskoka.

By working together with our partners, we met with success by:

- Enhancing the support to our complex patients through hospital-community based initiatives such as Health Links and Tele homecare (connecting patients with care through technology).
- Educating staff and physicians on strategies that support care transitions of the elderly with complex behaviors.
- Integrating Behavioural Success Agents to assist with developing care plans for patient with dementia related behaviours.
- Maintaining the successful integration of Home and Community Care employees on site at MAHC in the role of Care Coordinators who assist in a timely and seamless discharge plan for patients requiring additional support in the community.
- Identification of immunization status (pneumovax, influenza) for all admitted patients who met eligibility requirements for immunization in collaboration with the family health teams. This ensured that patients who may require immunization were identified and appropriately immunized.
- Our Patient and Family Advisory Council has identified several areas for improvement and have submitted their recommendations to the Senior Team for further discussion
- Hand Hygiene compliance rates have been maintained at, or above our identified target of 91.2% in the Before Indication
- Workplace Violence has remained an important focus at MAHC. In addition to improved reporting and tracking, MAHC has implemented numerous process and policy changes, enhanced security, and construction of safe rooms in the ED. An overarching framework for violence prevention and mitigation is in the final stages of development. Much of the work has been accomplished through the ongoing collaboration with interdisciplinary staff, physicians, community partners and patients and families.
- In December 2018, Muskoka Algonquin Healthcare was proud to receive a three year Accreditation with Exemplary Status from Accreditation Canada

Patient/Client/Resident Partnering and Relations

MAHC has been very purposeful in elevating the patient voice in 2018-2019. MAHC launched its Patient and Family Advisory Council (PFAC) in January 2017, and this has enabled transcendence of the patient voice with MAHC initiatives. MAHC recruited 10 patient and family advisors who represent all regions of Muskoka. The Advisory Council reviews the QIP for input and support. Since this time, patient and family representatives have sat on the safe room work group, d the Endovascular Access workgroup, Capital Planning Task Force and have become regular members on the ethics, family practice, obstetrical services and emergency department committees. It is anticipated that advisors will be added to all clinical care committees by April 2020.

The PFAC has identified several areas for improvement and would like increased involvement with Patient Satisfaction initiatives in the coming year. They have submitted their recommendations to the Senior Management Team for additional input and support. They were also instrumental in beginning work within the LHIN for networking and collaboration among the various PFAC committees within the LHIN. The committee has also presented directly to the Board of Directors for MAHC.

Workplace Violence Prevention

Muskoka Algonquin Healthcare has Policies and Procedures with respect to reducing the risk of violence, reporting of workplace violence, and for summoning immediate assistance in the event there is violence occurring in the workplace. In order to test our policies we conduct Mock Code Whites (Workplace Violence Code). To support our staff when there are incidents of violence in the workplace formal debriefs are conducted as needed. From a training perspective we currently provide a training program to deescalate confrontational and violent situations. We have recently switched our training program from Non-violent Crisis Intervention (NVCI) to the MANDT training program and it is mandatory for all staff at MAHC to attend.

To support the policies & procedures, training and support within MAHC, there is infrastructure in place to help keep people safe. This includes:

- The ability to summon support and assistance with the use of panic buttons in the Emergency Department and switchboard
- Safe rooms with cameras for monitoring patients
- Signage that outlines our expectations of respectful behavior towards staff and appropriate conduct while in our hospital.
- Practices to ensure safety when working with potentially aggressive patients.
- Enhanced security coverage, particular during high volumes seasons.
- Ongoing education
- Formal debriefs to ensure practice changes occur from trends.
- Development of safe rooms within the ED for potentially aggressive patients
- Patient flow processes to assist in getting patients to the right bed in the most efficient manner.
- Development of Behavioural Support Agents to create care plans for inpatients exhibiting aggressive behavior related to dementia.

Overall, the security guard presence at MAHC has been increased to include additional hours of coverage across the organization at our two sites to support peak times of aggression and violent behavior that may sometimes occur.

To support the care of our patients and ensure the safety of our staff a Mental Health Working Group was established and recommendations for change were made. The working group became an implementation committee that worked toward the implementation of the recommendations, which have included:

- Purchase of pineal restraints and safety pajamas
- Implementing order sets for mental health patients in the emergency department
- Creating a locked, secure emergency department
- Developing a Code Silver with plans for a mock event with our OPP partners.
- Focus on shortening time to see physician in ED for mental health patients
- Collaborate with Canadian Mental Health Association (CMHA) to provide onsite support.
- Working closely with neighbouring schedule one facilities to ensure standardized approaches to care to support transitions
- Funding has been secured for, and renovations have begun, for two monitored safe rooms at each of our sites, Huntsville District Memorial Hospital and South Muskoka Memorial Hospital. Completion of this project is May 2019.
- Working with our partners to effect timely transfers of patients to a Schedule 1 facility

The Joint Occupational Health and Safety Committee and the Emergency Services Committee continue to monitor the implementation of the recommendations provided by the Workplace Violence Working Group, and develop strategies to further enhance workplace safety. The overall safety and security of our people at MAHC is of great importance and is on a path of consistent quality improvement as we learn from both violent incidents and near misses.

Executive Compensation

The Ontario government passed the Excellent Care for All Act (ECFAA) and Bill 16 in 2010 which required Hospital Boards to establish an “at risk” component of executive compensation and achieve targets tied to the QIP. At MAHC, each senior leader develops goals that create synergy with the Strategic Plan and the QIP and that align with responsibilities within their portfolio and in accordance with our Executive Compensation Policy. Executive compensation is linked to performance in three performance assessment categories: Quality, Financial, and Strategic. Performance assessment categories are rated on the following scale:

- Quality = 50%
- Financial = 30%
- Strategic = 20%

Each year, all executives at MAHC have 3% of their compensation “at risk”. This portion of the compensation is held and measured against achievement of goals and objectives.

Contact Information

Esther Millar
Chief Nursing Executive and Clinical Services
Email: esther.millar@mahc.ca
Phone: 705-645-4404, x3259

Natalie Bubela
Chief Executive Officer
Email: Natalie.bubela@mahc.ca
Phone: 705-789-2311, x6002

Phil Matthews
Board Chair

Don Eastwood
Chair, Quality & Patient Safety Committee

Other

MAHC actively seeks strategic partnerships to fully realize the potential of integrated care as demonstrated throughout this document. By working closely and collaboratively with our partners, we are creating new opportunities through a shared understanding to improve quality, safety, and access to care in the Muskoka region. We also work extensively with partners within the broader North Simcoe Muskoka Local Health Integrate Network (NSM LHIN) to successfully implement an integrated health system plan through the Second Curve forum.

These strategic partnerships have created an interconnected system that promotes shared care models optimizing patient transitions through better information management and information sharing. These interconnected partnerships enhance quality and improve safety for our patients and their families by simplifying the system and designing services that maximize efficiencies. For instance, we are achieving smoother transitions between points of care through integrations such as:

- Muskoka Health Links: This is a Ministry of Health and Long-Term Care initiative in partnership with the NSM LHIN and the District of Muskoka. Muskoka Health Links brings our partner organizations together to coordinate care for patients with complex needs through the creation of joint personalized care plans.
- Care Coordinators: This is an integrated Home and Community Care role within MAHC that streamlines the discharge process and transition arrangements for patients who require support following discharge.
- Tele homecare: This is a great initiative using technology to enhance health care access and support for patients living with congestive heart failure and chronic obstructive pulmonary disease.
- Creation of collaborative care plans with our rehabilitation, Home and community care partners and family health teams.
- Regional Planning: MAHC collaborated with the sub region initiative entitled “MAHST” that was initiated to redesign the Muskoka local health care system. Recommendations were provided to the North Simcoe Muskoka Local Health Integration Network (NSM LHIN). The group continues to meet to explore opportunities to support effective, equitable, and seamless care in the region.
- Seniors Assessment and Support Outreach Team (SASOT): SASOT works collaboratively with other community partners such as family health teams, nurse practitioner clinics and Home and Community Care Services to ensure patients receive a seamless, integrated service. SASOT assesses and provides outreach support to people aged 65 and older who live in South Muskoka by assessing senior’s health and day-to-day function and by linking and referring seniors to appropriate services where available. Through their outreach work, SASOT is reducing emergency department visits and helping seniors to avoid an unnecessary admission to the hospital. They also work to support the discharge of complex alternate level of care (ALC) patients in hospital.

Engagement of clinical staff and leadership in the development of the MAHC QIP has been broad. Board members, the Senior Leadership Team, front-line managers, front-line clinicians and physician representatives have all collaborated in the development of our QIP. MAHC employees in all departments are involved in quality improvement initiative methodologies such as LEAN, KAIZAN that continuously enhance the quality of care to our patients. As well, all employees are strongly encouraged to identify and implement quality improvement strategies throughout the year. MAHC also led the development of a collaborative QIP with external partners as identified previously.

Leadership and front-line staff participate in daily huddles around quality boards to identify current safety issues and to discuss urgent and/or emerging issues. Our Senior Leadership Team and clinical leaders, round on both patients and staff creating a visible presence to patients and staff, providing an opportunity to compliment and recognize staff on excellent work and address concerns.

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 _____ (signature)

Board Quality Committee Chair _____ (signature)

Chief Executive Officer _____ (signature)

Other leadership as appropriate _____ (signature)

MUSKOKA ALGONQUIN HEALTHCARE

2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Timely**	**The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.**	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**968***	**5.25**	**5.25**	**Our target is to maintain current performance as MAHC is performing well within the LHIN and when compared to provincial average.**		**1)Continue to monitor time to inpatient bed once decision to admit has been made.**	**1. Continue to utilize Patient Flow Navigators for admission avoidance.**	**1.1 Document number of admissions avoided by utilization of PFN for admission avoidance.**	**Maintain current target for time to inpatient bed once decision to admit has been made.**	
												2. Continue to review bed utilization at daily bed meetings and ensure timely discharge where appropriate.	**2.1 Daily bed utilization report will be circulated twice daily to ensure all stakeholders are aware of bed status at each site and plan for gridlock/surge. 2.2 Review, revise and implement additional PDSA cycles for discharge at 1100 hrs. and monitor results.**		
												3. Continue to monitor ALC days and work with community partners to identify solutions and continue to report rates on a monthly basis to Senior Management Team, Quality Council, clinical Care Committees, Board Quality & Safety Committee and Board of Directors.	**3.1 continue to monitor ALC days with monthly reporting to Senior Leadership Team, Quality Council, clinical Care Teams, Board Quality & Safety Committee and the Board of Directors.**		
												4. Ensure adequate support services (ENVS) are available to avoid delay to inpatient bed due to room not being ready.	**4.1 Continue to work with Support Services to identify time of discharge to room availability, as well as document date/time when unable to transfer due to room readiness.**		
												5. Ensure the Gridlock and Patient Distribution Policy is being consistently adhered to and that when appropriate, patients are transferred to the alternate site.	**5.1 Ongoing education for all staff, team leads and managers regarding the Gridlock and Patient Distribution Policy. 5.2 Complete a process mapping exercise to identify bottlenecks or issues. 5.3 Source out additional information or education on patient flow practices.**		
												6. Continue to educate physicians regarding the importance of timely orders once decision to admit has been made.	**6.1 Continue to educate physicians regarding the importance of timely orders once decision to admit has been made using just in time sessions, attending ED rounds and through the ED Committee.**		
												7. Monitor and adjust inpatient capacity to respond to demand for inpatient beds.	**7.1 Monitor seasonal variations and develop staffing strategies to address anticipated volumes. 7.2 Review discharge times to ensure timely availability to beds and efficient patient flow. 7.3 review of conservable days by the utilization committee and development of strategies as needed by the family practice committee.**		
Theme II: Service Excellence	**Patient-centred**	Percentage of respondents who responded positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	968*	56	56.00	Ensuring that the patient has sufficient information at discharge, including medication reconciliation decreases the risk of readmission within 30 days and supports patient focused care.		1)Develop and trial a new Patient Oriented Discharge Summary (PODS) by March 31, 2020.	1. Review current PODS via Open Lab and create draft template for use at MAHC.	1.1 Review of existing tools and completion of draft by June 30, 2019.	By March 31, 2020 a new PODS tool will be trialed on select clinical units and percentage of respondents who responded positively to the following question "did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?" will be monitored beginning April 1, 2020.	
												2. Engage Clinical Managers, Team Leaders and front line staff in review and creation process.	2.1 Draft will be finalized with review by clinical managers, team leads and front line staff.		
												3. Once a draft has been developed review with input from Patient and Family Advisory Committee.	3.1 Draft of PODS tool and recommendations will be presented to the Patient and Family Advisory Committee in September 2019.		
												4. Identify clinical areas for trial beginning January 1, 2020.	4.1 Clinical managers, Team leads and front line staff to identify areas for trial and to create education for staff by December 1, 2019.		
												5. Continue quarterly monitoring of NRC patient satisfaction survey results to the question "did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital" with Quality Council, clinical care committees and the Board Quality & Safety Committee on a quarterly basis.			
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	968*	CB	80.00	The 80% target was set 2 years ago and remains a stretch target we wish to achieve. Med Rec on Discharge values are a manual audit of randomly selected charts. The electronic format is not yet available. In the period of October to December 2018 a total of 90 charts were audited and 65/90 (72%) had a BPMH created. Given our current performance the 80% target should be achievable.	Algonquin FHT, Cottage Country FHT	1)All patients being discharged will have a complete medication reconciliation done and communicated at that time.	1. Ensure every discharged patient will have their medication reconciled upon discharge. To be monitored through chart audits and CERNER reports. 2. PharmNet module or revised Med Rec discharge form implemented and MAHC pilot by April 1, 2019. 3. Monthly Med Rec Committee meetings to monitor implementation of project plan, data and recommend process change. 4. Physician, nurse and pharmacy education as per project plan by April 2019.	1.1 PharmNet module implemented and utilization monitored by April 2021. 2.1 Education of 100% of physicians, nurses and pharmacy staff on medication reconciliation at discharge process and respective roles. 3.1 Collaboration with Family health Teams to monitor compliance. 4.1 Education Plan to be developed and implemented prior to launch of PharmNet module. 4.2 Ongoing education on developed Medication Reconciliation form through physician rounds, just in time education sessions and at all clinical care committees. 4.3 Monitor individual compliance and provide feedback to physicians. 4.4 Review process and adjust process based on learnings.	The PharmNet module will be implemented by April 2021.	
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**968***	**9**	**9.70**	**It is anticipated that there will be an increased number of reports, which will meet the definition of violence as the Violence working Group is established and begins the education process.**		**1)Education and Training for all staff, including mandatory MANDT Training and recertification.**	**1.1 Formation of a Violence in the Workplace working group by April 30, 2019, which will report to the JOH&S Committee with a mandate to define the problem, understanding the root causes for each reported incident and provide recommendations. This report will also be provided quarterly to Quality Council, Board Quality & Safety Committee as well as clinical care teams.**	**1.1.1 The Violence in the Workplace Working Group will further develop the framework for reporting and addressing workplace violence based on the PHSA and OHA toolkits and frameworks**	**By April 30, 2019 the working group will be formed and will develop their Terms of Reference and creation of a work plan.**	**FTE=558**
											2)Continue to work with staff to promote reporting of all incidents.	**2.1 the working group will review all incident reports, which contain data regarding "the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker to identify rates per 100 workers, trends and to identify areas for improvement.**	**2.1.1 The working group will review all incident reports which contain data regarding workplace violence and conduct a root cause for identified themes.**	**By April 30, 2019 the working group will be formed and will develop their Terms of Reference and creation of a Work plan.**	
												2.2 The working group will share results with the Joint Health & Safety Committee, Senior Leadership team and all clinical care committees to assist in the identification of strategies to reduce violent incidents at MAHC.	**2.2.1 The Violence in the Workplace Working Group will provide quarterly data (rate /100 employees) to the Joint Occupational Health & Safety Committee, Senior Leadership Team and all care committees to assist in the identification of strategies to reduce violent incidents at MAHC and to monitor reporting trends.**		
											3)Formation of a violence in the Workplace Working Group to monitor rates and provide recommendations from trends.	**3.1 Identification of two strategies to reduce violent incidents at MAHC utilizing OHA Toolkit "Preventing Workplace Violence in the Healthcare Sector" in consultation with the Violence in the Workplace Working Group to ensure best practices.**	**3.1.1 Violence in the Workplace Working Group will present recommendations for two priority strategies to reduce violent incidents at MAHC by March 31, 2020.**	**The Violence in the Workplace Working Group will present recommendations by March 31, 2020.**	
												3.2 Development of a Violence Prevention Framework to guide a comprehensive approach to prevention, mitigation and response.			