



Performance-Based Compensation Linked to Quality Improvement Plans

Overview

The *Excellent Care for All Act* (ECFAA, 2010; [S. O. 2010, c. 14, s. 9 \(1\)](#)) requires that hospitals link the compensation of any executive to the achievement of quality improvement targets, as outlined in each hospital's annual Quality Improvement Plan (QIP). An "executive" may be defined as chief executive officer (CEO) or anyone who holds a position equivalent to the chief executive officer, regardless of title, who are under a compensation plan. This requirement is intended to help advance quality and transparency in the health care system.

Performance-based compensation linked to quality improvement ("executive compensation") is explained in this guidance document.

The purpose of executive compensation related to ECFAA is to drive accountability for the delivery of QIPs. By linking the achievement of long- and short-term targets to compensation, organizations can increase staff motivation. This enables organizations to ensure consistency in the application of incentives.

A description of how executive compensation is linked to quality improvement indicators must be included in the hospital's QIP and be made easily available to the public (e.g., through the hospital's website). For example, a hospital's QIP should identify each executive linked to compensation, indicators that are tied to compensation, and the percentage of compensation linked to the achievement of quality improvement targets.

Guidance for ECFAA Compliance

Requirements

Hospital QIPs must include a description of how executive compensation is linked to the hospital's performance on quality improvement indicators [c. 14, s. 8 (3)], for example, by listing each executive role, the percentage of compensation linked to the achievement of quality improvement targets, and the QIP indicator targets that are tied to compensation; this information must also be made easily available to the public (e.g., through the hospital's website):

1. Delineate executive roles.

Executive-level roles in a health care organization may include but are not necessarily limited to:

- The CEO (or anyone who holds a position equivalent to the CEO, regardless of title)
- Members of the administrative and clinical executive staff, such as,
 - chief of staff
 - chief nursing executive
 - senior management reporting directly to the CEO (or person in a position equivalent to CEO)

Organizations should clarify which individuals from their senior management team are defined as "executives," which can be done by establishing formal terms of reference for the senior management team. It needs to be clear which individuals are defined as executives with respect to compensation.

2. Describe the manner in which compensation is linked to quality improvement.

Hospitals should outline the following in the narrative component of the QIP, titled "Executive Compensation," and specify which indicators are tied to performance-based executive compensation in the workplan component of the QIP:

- QIP indicators tied to compensation
- Targets for performance on these indicators
- The percentage of at-risk compensation assigned to these indicators, as well as any weighting of compensation as part of total at-risk pay

Current legislation and regulations do not include specific requirements regarding the percentage of salary that should be performance-based. Compensation structure should be led by the individual organization to drive improvement; it can be based on quality improvement priorities established by the region, Ontario Health or ministry, or the organization. Current practice suggests that organizations should consider linking 5% to 15% of their executives' compensation to quality. The government can mandate a specific percentage at any time.

Examples

The examples below were derived by reviewing best practices in the field. Hospitals are not limited to using the formats provided.

Example 1

This example shows a simple structure for salary at risk for executives, and the set of QIP targets performance-based compensation makes them accountable for achieving.

We've defined (A) the executive-level roles in our organization and the percentage of their salary at risk; (B) the organization's QIP indicator targets linked to these executives' performance-based compensation, (C) terms describing how the at-risk salary is paid out in relation to target achievement. We've summarized in (D).

A. Executive-Level Roles and Corresponding Performance-Based Compensation

- President and CEO: **5%** of annual base salary
- Chief Nursing Executive: **5%** of annual base salary
- Clinical vice-presidents: **5%** of annual base salary
- Chief of staff: **5%** of annual base salary
- Physician-in-chief: **5%** of annual base salary

B. Quality Improvement Targets

Priority area	Indicator target to be achieved for 100% payout
Access and flow	Decrease ambulance offload time to 30 minutes.
Equity	Decrease average time to PIA for sickle cell disease to 15 minutes
Experience	Improve experience at discharge to 95%
Safety	Reduce workplace violence rate to 5%

C. Terms

The indicator targets are equally weighted; therefore, achievement of all targets would result in 100% payout; partial achievement of targets would result in partial payout in a manner determined by the board of directors.

D. Summary

Achievement of the four QIP targets listed above account for a percentage of performance-based compensation. Thus, for our senior management team, 5% of annual compensation is linked to the achievement of the four QIP targets listed above.

Example 2

This example shows the unique weighting of each target in the QIP. It also provides specific values that must be reached to obtain the available incentive.

Executive Roles

Executive	Percentage of annual salary linked to achieving QIP targets
CEO	15%
Physician-in-chief, Chief of Nursing, EVPs of Corporate Services and Redevelopment, VPs of Research, Communications and Community Engagement and Education	10%

Allocation

Objective	Weighting	Allocation based on performance	
		100%	50%
Reduce ED wait time (90th percentile emergency department wait time to physician initial assessment) Current: 35 minutes Target: 30 minutes	30	≤30 minutes	31 to 35 minutes
Increase percentage of staff who have completed relevant equity, diversity, inclusion, and antiracism education Current: 50% Target: 80%	15	≥80%	51% to 79%
Increase percentage of patients who feel they received adequate information about their health and their care at discharge. Current: 70% Target: 77%	15	≥77%	70% to 76%
Improve rate of medication reconciliation at discharge Current: 85% Target: 90%	40	≥90%	85 to 89%

Terms

Complete attainment of the target improvement will result in full payment. Greater than 50% attainment but less than complete will result in 50% of the payment. Less than 50% attainment will result in zero payment. The level of attainment will be determined by the Board.

Summary

The four QIP objectives listed above account for 50% of performance-based compensation for our CEO, and 30% of performance-based compensation for other senior management. Thus, annual compensation linked to achievement of the four above QIP targets is 15% for our CEO and 10% for our senior management team.

Recommendations

1. ***Provide a clearer link between compensation and QIP indicators.***

As hospitals vary in size and organizational structure, flexibility is encouraged in the development or re-evaluation of a QIP based compensation strategy. However, as flexibility is supported, QIPs must provide a clear link to quality improvement targets and compensation, with appropriate delineations for CEOs and other executives. Hospitals should generate a summary or concluding statement that adequately summarizes the compensation strategy. An example of this is provided in Example #1.

2. ***Provide compensation as a percentage of annual salary or a percentage of at-risk based compensation.***

To ensure that this section of the QIP is completed adequately and clearly, hospitals should not be providing compensation as a dollar amount. Assigning static monetary values to non-static quality indicators produces an unclear determination of compensation linked to QIPs. This is emphasized further by the difficulty in determining executives' salary for the reporting year. Hospitals utilizing a dollar amount for executive compensation should move towards allocating a percentage of annual compensation linked to QIP indicators and clearly state this for each member of the executive team.

3. ***Set aggressive and aspirational executive compensation targets to drive quality.***

The percentage range of executive compensation tied to QIP indicators shows wide variance. This variance is enhanced by the lack of a mandated minimum for the portion of annual compensation to be variable and linked to QIP. Although there is not currently a mandated minimum, it is recommended that aggressive targets are set for QIP indicators tied to executive compensation to drive quality, and hospital allocations for executive compensation tied to QIPs should reflect this.

4. ***Expand performance-based compensation to senior management***

Members of the senior management team not reporting directly to the CEO, may also be included in compensation tied to QIPs targets, at the discretion of the organization. Although this is not a requirement of ECFAA, the expansion of compensation to other members of senior management may enhance performance of QIP indicators while increasing accountability, transparency and driving sustainable improvement in future years of ECFAA.

5. ***Develop a system for monitoring.***

Organizations should monitor target-setting versus actual payouts, to help determine whether the incentive plan design was in fact effective. If over a few years, executives are reaching maximum performance on all their quality improvement targets, this may signal that targets need to be re-calibrated going forward.

6. Seek consultation with the appropriate organizations if experiencing difficulty.

There are several organizations that have been involved in QIP support development however, it is important to contact the appropriate stakeholder should you have questions or concerns. This may alleviate any potential issues that organizations may have regarding legislative compliance and best practice.

Table: Roles of Organizations in Executive Compensation linked to QIPs

Organization	Role in Quality Improvement-based Compensation
Ontario Health	Receives QIP submission through the Navigator tool including compensation percentage tied to QIPs indicators. Primary point of contact re: questions about QIPs indicators, Navigator tool, Narrative component.
Ministry of Health	Responsible for oversight and accountability of Ontario Health. The ministry partners with OH on the QIP annual cycle and sets provincial priority areas for health quality improvements.
Ontario Health regions	Regions work with Ontario Health to identify regional priorities to improve health quality and encourage regional uptake of related indicators

QIP Matrix and QIP Guidance Materials

- Support identification of potential QIP indicators that could be tied to compensation.
- As noted in the QIP guidance document, every year, Ontario Health releases a list of priority and optional indicators that organizations can consider including in their QIP. Collectively, these indicators support a shared focus on key system priority issues in Ontario.
- Organizations may also choose to include custom indicators (i.e., indicators that are not included in the suite of indicators provided by Ontario Health) that are aimed at improving issues that are important to communities they serve or that align with any of the priority issues.

QIP Navigator

- The QIP Navigator tool supports organizations in providing information that is required for executive compensation in the narrative and workplan sections (mandatory sections for hospitals).

Other Information Required in the Workplan section of QIP

- Starting in 2024/2025, the QIP workplan included a “yes/no” radio button “Is this indicator related to executive compensation?” to support organizations in the connection of QIP indicators to executive compensation