Central Health

Annual Report

2015-16

Healthy people, healthy communities

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John George, Chair, Board of Trustees

Message from the Chairperson

On behalf of the Board of Trustees of Central Health, I am very pleased to present Central Health's *Annual Performance Report* for the fiscal year ending March 31, 2016. This *Annual Performance Report* is the second report from the 2014-17 *Central Health Strategic Plan* and was prepared under the Board's direction, in accordance with the *Transparency & Accountability Act and Regional Health Authorities Act.* As a Board, we are accountable for the information, results and variances contained within this annual report.

In this report we will inform you of Central Health's progress on three strategic issues – access, healthy living and client flow. You will also find information in the report about Central Health's partnerships, highlights of the accomplishments of the past year and an overview of some of the challenges and opportunities the health authority will be working on in the next year.

Central Health's leadership, staff, physicians, volunteers and partners are a very dedicated group of individuals who are committed to continuous improvement of the programs and services provided to clients, residents and patients throughout this region. They are focused on building a solid leadership foundation that will continue to move the organization forward for years to come. On behalf of the Board of Trustees, I would like to take this opportunity to extend our sincere gratitude and appreciation to them. We look forward to facing the challenges and celebrating the accomplishments of 2016-17 together.

We expect that 2016-17 will bring challenges in light of Central Health's current fiscal environment, and we have learned that together we can build and implement creative solutions to overcome these challenges. I am certain that as we continue to focus on the provision of safe and high quality program and service delivery in the upcoming year Central Health will continue to make progress towards fulfilling its vision of *healthy people, healthy communities.*

Overview

Key Statistics

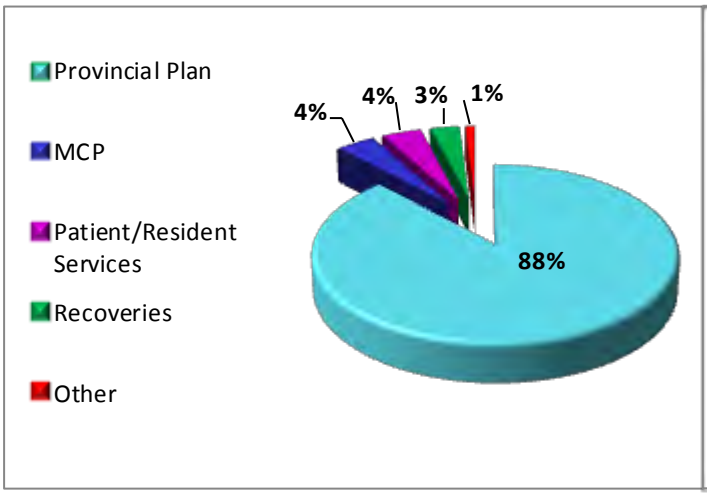
Central Health provides health and community services to approximately 20 per cent of the province's population residing in 177 communities. Central Health is the second largest health region both by the population it serves and the geographic area it encompasses. The 2011 Census data indicates a population of approximately 94,000 people in the region, extending from Charlottetown in the east, Fogo Island in the north, Harbour Breton in the south, to Baie Verte in the west.

Central Health is committed to a Primary Health Care (PHC) model of service delivery where a multidisciplinary team of health professionals, support staff and partners provide the right care to the right person at the right time. Throughout the region, Central Health provides a continuum of community, acute and long term care (LTC) services. Healthcare services in the region are provided through 45 facilities including two regional referral centres, nine health centres, four long term care facilities, 27 community health services, two residential treatment centres and a regional office. A complete list of facilities and contact information can be found in Appendix A. As of March 31, 2016, Central Health is responsible for 811 beds, which includes: 247 acute care, 510 long term care, 13 palliative care, nine respite, five restorative care beds, three residential units and 24 bassinets. In any year, the number and type of beds at any site may fluctuate slightly as a result of major renovations and capital infrastructure.

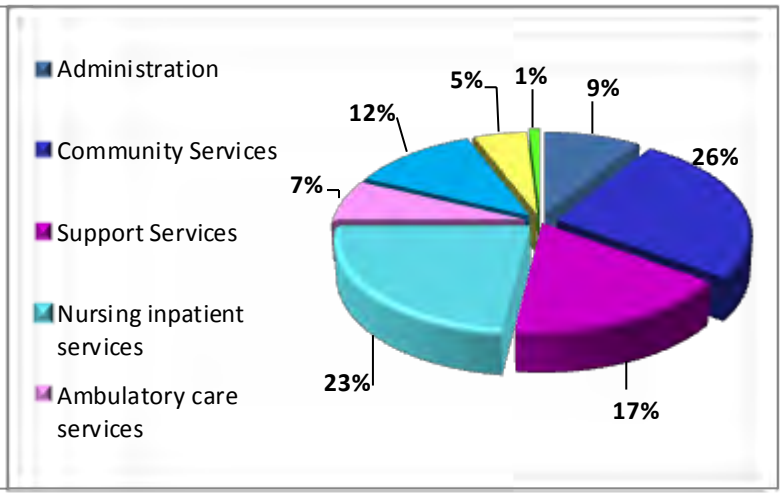
Central Health is responsible for licensing and monitoring standards at 25 privately owned personal care homes (PCH) totaling 1,197 beds. Within its region, Central Health has an oversight role related to the implementation and monitoring of standards for three private ambulance operators and nine community ambulance operators.

With an annual budget of $380M, Central Health invests 73 per cent of the funding in direct care, 17 per cent for support services and 9 per cent for administration. Central Health's audited financial statements are provided in Appendix B. A breakdown of Central Health's revenues and expenditures are depicted in the pie charts at the top of page 6.

Revenue 2015-16



Expenditures 2015-16



Central Health is governed by a Board of Trustees as appointed by the Lieutenant Governor in Council. Central Health employees are made up of approximately 3,100 dedicated individuals who work collaboratively with 111 fee-for-service physicians, over 900 volunteers and two health care foundations to provide quality health care services in the region. A complete list of all trustees can be found in Appendix C and a list of key contacts is provided in Appendix D.

Central Health works collaboratively with the Miawpukek First Nation to support health services delivery in Conne River. This collaboration includes the provision of primary and secondary health care services including health promotion and protection, supportive care, treatment of illness and injury as well as access to emergency services.

Central Health works closely with officials of the Department of Health and Community Services on a variety of initiatives including chronic disease self-management, waitlist management, healthy public policy and provincial strategy development. Central Health administrative and clinical leadership collaborates with the three regional health authorities (RHAs) in Newfoundland and Labrador for mutual benefit and contribution to the health of the province.

Mandate, Lines of Service, Vision, Values and Mission

Central Health has a defined mandate, lines of service, values, vision and mission. These statements are fundamental to the organization and the leadership strives, through words and action, to bring these constructs to life in daily practice.

Mandate

Central Health's mandate is derived from the *Regional Health Authorities Act* and its regulations. Central Health is responsible for the delivery and administration of health services and community services in its health region in accordance with this legislation. A more detailed explanation of Central Health's mandate can be found in Appendix E.

Lines of Service

A multidisciplinary team of health professionals, support staff and partners provide the care and services required to meet the mandate of Central Health.

Central Health accomplishes its mandate through five lines of service:

1. Promoting health and well-being
2. Preventing illness and injury
3. Providing supportive care
4. Treating illness and injury
5. Providing rehabilitative services

Vision

The vision of Central Health is *"healthy people and healthy communities."*

Values

Central Health's core values offer principles and a guiding framework for all employees as they work in their various capacities to support the health and well-being of the people served by Central Health. This is done within available resources except where otherwise directed by legislation. The core values and the related action statements are:

Accountability: Each person is responsible for giving their absolute best effort to achieving the success of the organization's vision of healthy people and healthy communities.

Collaboration: Each person works as part of a team and partners with other providers and organizations to best meet the holistic needs of clients and the organization.

Excellence: Each person contributes to quality improvement and a culture of safety through the life-long development of their knowledge, skills and use of best practices.

Fairness: Each person engages in practices that promote equity and adherence to ethical standards.

Privacy: Each person respects privacy and protects confidential information.

Respect: Each person is committed to fostering an environment that embraces respect, dignity and diversity and encourages honest, effective communication.

Mission

By March 31, 2017 Central Health will have provided quality health and community services and programs which respond to the identified needs of the people of central Newfoundland and Labrador within available resources.

Shared Commitments/Partnerships

Access to Services

Expanding home dialysis services

Central Health received provincial government funding in 2015-16 to introduce a home based dialysis therapy program in the region to include peritoneal dialysis or home hemo dialysis. The regional program is staffed by a full time registered nurse who trains and monitors patients in the program in consultation with nephrologists at Eastern Health. In collaboration with their physician and /or nurse practitioner (NP), patients can choose their mode of therapy. To date there have been three patients trained for home hemo dialysis and one patient trained for peritoneal dialysis. Central Health has also repatriated three patients living in the Central region who were previously supported by Eastern Health. This regional program currently has a total of five patients and is expected to grow to ten patients by fall 2016.

The Fogo Island Dialysis Service officially opened its doors August 27, 2015. The team at Central Health worked diligently to operationalize a new home based therapy service, new equipment and technology and a new self-managed care model that will give dialysis patients another treatment option. The first patient accepted by the Fogo Island Dialysis Service successfully completed three weeks training at the Central Newfoundland Regional Health Centre in Grand Falls-Windsor and is now supported by the Fogo Island Health Centre. This client will now take as much time as necessary, with the support of a registered nurse, to transition to the home setting on Fogo Island.

Ambulance Dispatch and Management System

During the fiscal year of 2015-16, Central Health began work to implement the Ambulance Dispatch and Management System (ADAMS). The Paramedicine and Medical Transport Program at Central Health collaborated with Western Health to develop a plan for the utilization of this computer based system for coordinating ambulance transport. The focus for ADAMS is efficiency, appropriate utilization of ambulance resources, emergency preparedness and staff/client safety. The implementation of ADAMS enhanced the coordination of client transport by road ambulance; ensured continued emergency ambulance response capability within each operator's service area, improved continuity of care at receiving health facilities and helped ensure appropriate utilization of ambulance resources.

The implementation of ADAMS in the region was supported through staff education and a robust communication strategy. The ADAMS go-live date was October 2015 and the system was in use throughout all sites in Central Health by November 2015.

Fogo Island, NL

Healthy Living

Community Residential Board supports clients with complex needs

The Community Support Services Program at Central Health provides residential and supportive services for eligible individuals diagnosed with an intellectual disability. Clients who have complex health care needs require both medical and social services, as well as support from a wide variety of providers and caregivers. Providing person-centred, comprehensive, coordinated and accessible care is of the utmost importance. Diverse stakeholders, including national, provincial and interregional agencies, regional health authorities, government departments, clinicians and respective program managers/directors of Community Support Services, Mental Health and Addictions Services, Emergency Services, Home and Ambulatory Services partnered to provide a collaborative team approach in coordinating person-centred care for Central Health clients who present with multiple and complex care needs.

The Central Residential Services Board (CRSB) historically provided services to clients of Central Health with intellectual disabilities and recently expanded its mandate to include other client populations. The CRSB, a non-profit community based agency, historically managed the Co-operative Apartment Program within Central Newfoundland and Labrador. CRSB's vision is *for individuals with intellectual disabilities to engage society…and for society to embrace them.*

From March 2015 to March 2016, Central Health collaborated with the CRSB and other stakeholders to develop a care plan and residential option for clients who presented with multiple and complex care needs. This collaboration across multiple systems allowed for a more responsive and person-centred approach to meeting the complex needs of clients in a community setting.

Harbour Breton, Connaigre Peninsula, NL

Community Gardens...Bringing generations together

Averee's Garden

Averee's Garden in Harbour Breton is dedicated to the memory of Averee Pierce, a Grade 2 student at St. Joseph's School in Harbour Breton who passed away in March 2012. Her classmates at St. Joseph's school began this project with the support of Averee's Purpose (a foundation started by Averee's parents, Terri and Rod), the Town of Harbour Breton, the Harbour Breton Community Youth Network, St. Joseph's School, Central Health and the Central Regional Wellness Coalition. Through the support of these partners, Averee's Garden bloomed. Central Health's community development nurse provided leadership to this group in supporting grant applications and liaised with the long term care facility to support an intergenerational gardening project.

Averee's Garden group applied to the Central Regional Wellness Coalition for a grant of $2000 to start the garden. The group wanted to ensure that the garden was an organic garden, using as many recycled materials as possible. Everyday an adult volunteer, together with two members of the Grade 2 class, provided care to the seedlings until they were transplanted by the Community Youth Network. The Community Youth Network provided care to the garden during the summer.

In partnership with the Connaigre Peninsula Health Centre (CPHC), Averee's Garden group planted flowers with the long term care residents. For the remainder of the summer the long term care residents maintained the flower beds as part of their recreation program, under the guidance of Central Health's recreation coordinators. Staff at the CPHC reported that the residents in long term care enjoyed the flower garden and the opportunity to be productive and active.

Averee's Garden group finished the growing season and partnered with a local chef to host a harvest party to celebrate *World Food Day* and their accomplishments. All proceeds were donated to Batten's Disease research in Averee's memory. This project would not have been possible without the many dedicated partnerships.

Centreville, Wareham, Trinity (CWT) Community Garden

A Community Development Nurse from New-Wes-Valley provided support to the CWT 50+ Club and the Town of CWT to secure funding from a Provincial Wellness Grant for a community garden. The nurse was on hand to answer questions and provide advice to the group as required.

In June 2015 the CWT Community Garden along with the Central Health's Kittiwake Primary Health Care (PHC) Committee planned and hosted a planting day with children from Centreville Academy. Staff and volunteers from the Indian Bay Ecosystem Corporation were also in attendance. The group planted seedlings that the children had started growing in their classrooms and the children were encouraged to visit the community garden throughout the summer.

In October 2015, Food First NL (Newfoundland Labrador) hosted a harvest day for children and their grandparents. The Kittiwake PHC committee continues to support the community garden by identifying funding opportunities and planning educational and intergenerational events.

Exploits Community Garden

Central Health partnered with the Botwood Boys and Girls Club/Community Youth Network, Legion Action Committee and local businesses to operate a community garden on the Dr. Hugh Twomey Health Centre property, which attracted hobby farmers of all ages.

The program celebrated in the fall of 2015 with a harvest feast where vegetables from the garden were cooked and served at the Botwood Boys and Girls Club to all program participants and their guests and supporters. This project is a wonderful example of a sustainable partnership as the garden has been operational for six years.

Age Friendly Initiatives...Keeping seniors well

Age-Friendly Initiative – Town of Baie Verte

The Town of Baie Verte received an Age Friendly Newfoundland and Labrador (AFNL) community grant from the Government of Newfoundland and Labrador in support of their quest to become an age -friendly community. A committee has been formed and they are currently gathering the information needed to begin planning for age friendly initiatives. Partnerships supporting this age-friendly movement included the Town of Baie Verte, Central Health and community volunteers.

Age Friendly Initiative – Twillingate /NWI

Central Health partnered with the Twillingate and New World Island town councils and received funding through an AFNL community grant to begin Phase I of the Age Friendly Community Initiative. A team has been established to engage and identify the needs of the community. Individuals within the community have personal and/or professional interest in establishing age-friendly initiatives and are dedicated to giving back to improve their community. These individuals will be a valuable part of the team working to improve services in this health services area.

Botwood and Area Indoor Walking Program

Central Health's Exploits Health Services Area staff continued to forge partnerships to support the indoor walking program at Botwood Collegiate which was open to all mature adults in the communities of Botwood, Northern Arm and Peterview. This program was run by community volunteers and operated two nights per week during fall and winter at the school gymnasium. Health professionals in Exploits referred clients to the local program for rehabilitation purposes and physical activity.

Annual Healthy Aging Celebration- Kittiwake Coast

June 2015 marked the 8th Annual Healthy Aging Celebration on the Kittiwake Coast. Local Shopper's Drug Mart stores, Healthy Living Celebrations and the Cape Freels Heritage Trust partnered to offer a day of fun and socialization for the 55+ population and also provided them with relevant health information.

The planning committee consisted of Central Health staff who are responsible for organizing the celebration each year. The committee selected topics for the day, invited speakers, advertised the event and registered participants. Committee members attended the celebration and ensured it was a well-coordinated, informative and successful event for the participants.

Sessions on the following topics were provided by Central Health staff, community members and organizations: chronic disease, healthy living, living alone, falls prevention, fraud and the older adult, wills and estate planning, adult protection, dementia, nutrition, healthy heart, golden Zumba, loving life and many more.

The senior population in the area anticipates this event each year. Central Health's contribution has enabled the Healthy Aging Celebration to be a success year after year with 70+ participants in attendance this year.

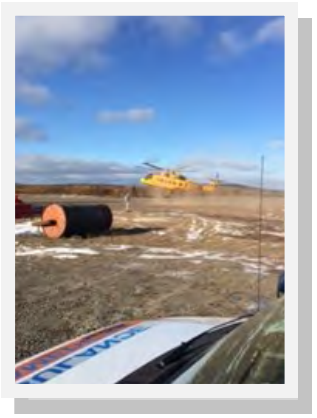
An Accountable, Sustainable, Quality Health and Community Services System

Health Emergency Management (HEM)

Exercising disaster/emergency plans is a vital component of emergency response and recovery preparedness. Exercising brings the skills, knowledge, functions and systems together and applies them against event scenarios. This provides the closest thing to an event to evaluate the state of response efforts.

The Health Emergency Management Program at Central Health takes an active role in internal exercises and in partnering with community stakeholders. On October 1, 2015 paramedics at James Paton Memorial Regional Health Centre (JPMRHC) participated in a mock Code Orange (external disaster/ mass casualty) exercise at the Gander International Airport titled *Smokey 5*. The role of the paramedics during the exercise involved triaging, treating, and transporting casualties from the mock disaster scene at the airport to JPMRHC. The involvement of Para-medicine and Medical Transport allowed the regional lead hand from this program to evaluate the disaster scene response and to participate in the post exercise debriefing.

Casualties from the mock disaster exercises conducted by Central Health.



A second mock exercise, *Vigilant Bear*, was conducted at Buchans on October 28, 2015 and was led by the Department of National Defense (DND) and involved a search and rescue exercise component. Participation in the exercise provided an opportunity for the paramedics and Director of Health Services from A.M. Guy Memorial Health Centre to become familiar with a large scale military exercise and to work side by side with Canadian Forces medics in an emergency response situation. Participation in this exercise provided Central Health employees valuable learning opportunities and an insight into how a community partner responds to an emergency event which requires Central Health's support.

Patient safety...Bringing it to the community

Central Health remains committed to partnering with community members to promote patient safety. In the fall of 2015, Central Health held Patient Safety Public Forums in the communities of Campbellton and Woodstock. Presentations were shared on medication safety, falls prevention, client safety and infection prevention and control to highlight the importance of safety in daily activities at home and in the community. These forums were well received and feedback will be used to improve future events.

Therapy Dog...Bringing hope to the Hope Valley Youth Treatment Centre

The South and Central Health Foundation (SCHF) partnered with the staff of the Hope Valley Youth Treatment Centre (YTC) in Grand Falls-Windsor to provide the first full-time, in-house residential therapy dog in Newfoundland and Labrador. Research for this new program began in 2014 when a staff member of Hope Valley Centre contacted the Citadel Canine Society of BC (British Columbia) to request information on how a therapy dog could be accessed for the facility. The Citadel Canine Society of BC is an organization which provides therapy dogs to veterans, individuals impacted by post-traumatic stress disorder and youth at risk as well as first responders.

In February 2015, the Regional Manager of Mental Health and Addictions approached the South and Central Health Foundation to discuss a potential Therapy Dog Program for Hope Valley YTC. The project was approved by Central Health's Senior Leadership Team and then presented to the Foundation Board for consideration on March 24, 2015. Once the project was approved, employees of Hope Valley YTC were trained to be the primary handlers of the therapy dog.

A portion of the proceeds from the Golfing for Green Charity Tournament in 2015 were reserved for the Therapy Dog Project. A client of Hope Valley YTC, along with a staff member, presented at the tournament's closing reception and spoke about this project and how a client/staff committee had subsequently been formed at Hope Valley YTC for planning such projects.

The puppy, a beautiful, chocolate coloured Labradoodle named Bear, is currently being trained as a service therapy dog at Ruff Sport in Ontario. It is anticipated that Bear will arrive at the Hope Valley Youth Treatment Centre at the end of August 2016, just in time to be loved and cuddled by youth and staff as summer draws to an end.

Bear, Labradoodle for Hope Valley Youth Treatment Centre, Grand Falls-Windsor, NL

Highlights and Accomplishments

Access

Community-based Mental Health and Addictions Services

In April 2014, community-based Mental Health and Addictions Services engaged in a quality improvement initiative to address access and wait times. A triage process was developed and implemented in phases across the region. In 2015-16, with piloting of triage underway, the service began moving towards a more centralized model of delivery to improve program access and efficiency.

Wait times have improved for Mental Health and Addictions Services, while wait lists have been reduced or eliminated. The majority of clients referred are contacted within one business day. Once contact is made the client is triaged and provided an appointment time based on clinical priority. Evidence-based wait time benchmarks were established for each clinical category. From April 2015 to March 2016, the majority of clients throughout the region were provided an appointment time within those benchmarks, ranging from 85.7 percent to 100 percent. Throughout the pilot, the majority of sites maintained no wait list for service. Exceptional circumstances, such as staff transitioning to other positions, have resulted in the creation of periodic and brief wait lists.

It is imperative to reflect on the success of this model in the context of current demand. Referrals for community-based Mental Health and Addictions Services have increased significantly over the past five years. The trend in referrals over the course of the pilot suggests the increase in demand continues. Therefore, not only did the implementation of the model improve access for clients, it did so in a period with an unprecedented number of referrals. Whether it is feasible to maintain this level of access as demand increases is undetermined however, the program continues to identify opportunities for improvement within the new model. The Mental Health and Addictions staff have embraced continuous quality improvement and demonstrated a tremendous commitment to improving access for clients.

Figure 1.1.

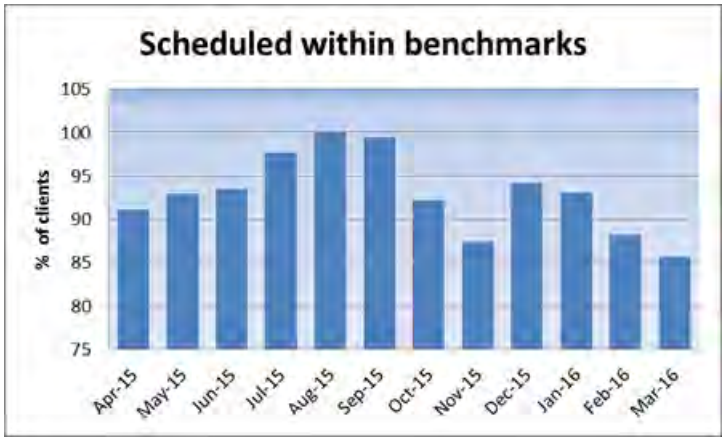
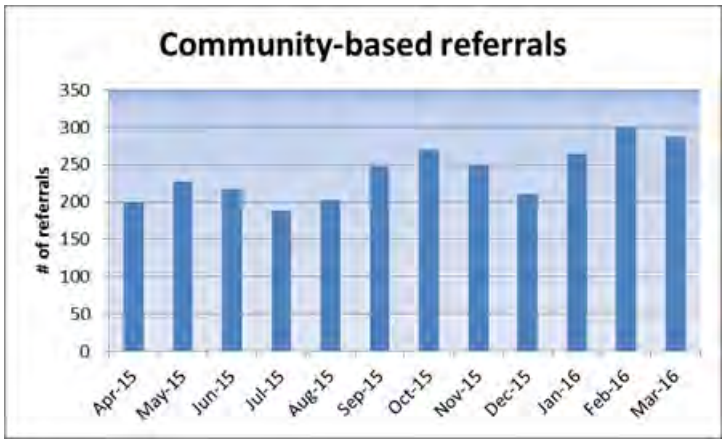


Figure 1.2.



Central Intake Referral Process for Regional Palliative/End of Life Care (PEOLC)

The Palliative/End of Life Care (PEOLC) team recognized the potential for missing and incomplete referral information and inefficient use of resources in their referral process. There were multiple entry points for healthcare providers to refer to this team. The team applied Lean methodology and tools to streamline the referral structure and process. Lean methodology involves a systematic approach to identify and eliminate non value added activities or waste through continuous improvement. To be successful this work required a multidisciplinary team approach including physicians, frontline staff, managers and a Lean leader.

James Paton Memorial Regional Health Centre, Healing Garden, Gander, NL

Lean tools utilized by the teams included:

- value stream mapping which provides a blueprint of a process from the beginning to the end while identifying the value added activities and wastes;
- A3 reporting format to facilitate knowledge sharing amongst teams with respect to the progress of a Lean initiative;
- spaghetti diagrams which trace the path of equipment and people to identify delays or inefficiencies in a process;
- 5S which involves improving workplace organization, visual communication and overall cleanliness aimed at eliminating waste;
- plan, do, study, act (PDSA) cycles which are a problem solving approach to achieving continuous improvements, and visual management boards which display the picture of the current status of processes or procedures for all to assess.

During the exercise significant inefficiencies were discovered in record keeping, assessment structures and utilization of supportive technologies. Waste or non-value added activities were evident in their current state which included waiting, defects, excessive processing, non-utilization of staff creativity and motion. In collaboration with various partners including Information Management and Technology (IM&T) and Clinical Efficiency, the PEOLC team utilized various Lean tools as part of their improvement process.

The PEOLC team defined their goals to include:

- Creation of a central intake process for all referrals
- Realignment of administrative duties to minimize risk for missed referrals and incomplete information
- Alignment of scopes of practice
- Enhancement of effective team systems
- Utilization of Meditech and the Client Referral and Management System (CRMS) for statistical reports while eliminating duplication of information tracking

The team addressed a number of challenges to eliminate waste and improve client flow with the right person fulfilling the right role allowing for the return of recovered time to direct patient care. The many process improvements lead the team to the desired future state and the central intake system that was implemented on March 1, 2016.

Mary Rowsell, Domestic worker at Carmelite House in Grand Falls – Windsor pictured with resident, Ms. Sharpe

Nurse Practitioners...A new role in long term care (LTC)

In September 2015, Central Health's first full time nurse practitioner (NP) in long term care initiated her practice at Lakeside Homes in Gander, Carmelite House in Grand Falls-Winsor and the LTC Transition Unit at the Central Newfoundland Regional Health Centre (CNRHC). Since that time, the NP has been providing comprehensive primary health care to the residents, namely timely access to assessments and treatments for acute, episodic and semi-urgent conditions and injuries.

The NP has assumed a leadership role in influencing LTC clinical best practice and resident outcomes including being actively engaged in de-prescribing antipsychotic medications for residents that do not have a diagnosis of a mental illness. Additionally, she has been overseeing comprehensive medication reviews in collaboration with pharmacists and physicians.

Healthy Living

Reduction in use of antipsychotics

Reducing Inappropriate Use of Antipsychotics in Long Term Care (LTC) is the first collaborative in the Canadian Foundation for Healthcare Improvement's (CFHI) ***Spreading Healthcare Innovations Initiative.*** One in three LTC residents in Canada is on antipsychotic medication without a diagnosis of psychosis by a physician. Research has shown that antipsychotic medications are minimally effective in managing behavioral issues and have risks associated with them, especially for seniors.

Central Health is one of 15 organizations across Canada that was successful in being accepted to participate in this innovative initiative. Central Health received access to funding, coaching and mentoring, educational materials, tools and forums for sharing with other innovators to reduce inappropriate antipsychotic medication use. Four LTC sites were selected to participate in the initiative: Lakeside Homes (Gander); Dr. Hugh Twomey Health Centre (Botwood); Lewisporte Health Centre/North Haven Manor (Lewisporte); and Dr. Y.K. Jeon Kittiwake Health Centre/Bonnews Lodge (New-Wes-Valley). LTC facilities participating in the CFHI led collaborative adopted a number of innovations to lower the use of antipsychotic medications among residents including better use of data for decision making by clinicians and managers, recreation activities tailored to the resident and staff training to support residents with dementia.

A CFHI Central Health Regional Advisory Committee was created at the onset of the pilot project to provide oversight, ensure standardization and support policy development. The goal at Central Health was to reduce inappropriate use of antipsychotic medications by 15 per cent amongst persons living with dementia at each of the four pilot sites by September 2015. The result was an overall reduction of 26 per cent.

There have been a number of other positive outcomes from this project. Central Health plans to monitor antipsychotic use as a quality improvement indicator on its LTC Report Card. Provincial and national networks for collaboration and knowledge transfer have been built and utilized to develop supportive policy. In addition to the four pilot sites, A.M. Guy Memorial Health Centre (Buchans), Copper Crescent (Baie Verte), and Valley Vista Seniors Complex (Springdale) have voluntarily implemented this approach. Future goals include a plan to transfer this program knowledge to the remaining LTC homes in Central Health by September 2016.

An Accountable, Sustainable, Quality Health and Community Services System

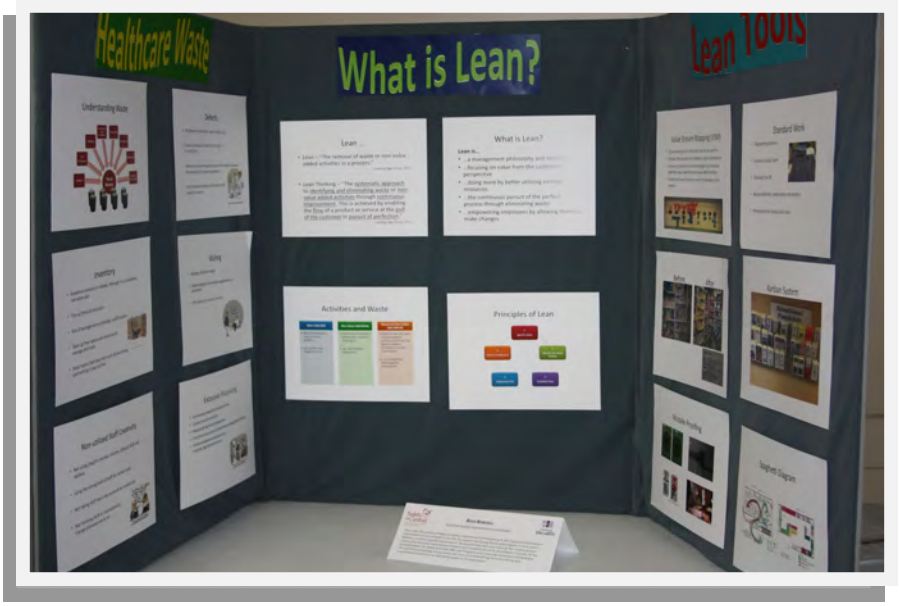
Enhancing leadership capacity at Central Health

In 2014, Central Health adopted the LEADS in a Caring Environment Leadership Framework as its framework for leadership development. Recognizing the demands facing healthcare leaders every day, Central Health embarked on an ambitious journey to introduce its leadership team to the framework in an in-depth and meaningful way in the fall and winter of 2015-16.

The LEADS in a Caring Environment Framework is based on five domains: Lead Self, Engage Others, Achieve Results, Develop Coalitions and Systems Transformation. Partnering with the Canadian College of Health Leaders, Central Health engaged two facilitators to present five one-day workshops to all of its formal leadership team. From the start of the program in September until the last workshop in February, 140 Central Health leaders attended the workshops.

In addition to the workshops, leaders were given the opportunity to participate in a LEADS 360 Assessment to provide a 360 degree view of their leadership capacity through a self-assessment and an assessment by supervisors, direct reports, and other colleagues. Leaders received an individualized report on their leadership strengths and opportunities and developed a learning plan for enhancing their leadership skills. The workshops and 360 Assessments were offered to physician leaders, and five physician leaders participated in the workshops with several more participating in the 360 Assessment. This is an adjunct to the Physician Management & Leadership Program offered by the Faculty of Medicine (Professional Development & Conferencing Services) and the Faculty of Business Administration (Gardiner Centre) of Memorial University.

A LEADS Steering Committee has been established to embed the LEADS framework throughout the organization. This initial project proved to be an opportunity for leadership growth in the system and an avenue for the management team to come together as a community.



LEAN display at Patient Safety Days, October 2015

Lean at Central Health

Central Health has adopted Lean as an approach to facilitating quality improvement along with the Model of Improvement. The organization is committed to assessing and improving the current state through the utilization of Lean methodology and tools. Lean methodology involves a systematic approach to the identification and elimination of non-value added activities or waste through continuous improvement. Lean practitioners progress through levels of training referred to as belts, with Black Belt being the higher level of education. Lean training is certified and Central Health practitioners are trainers to ensure program sustainability.

Senior leadership supported employees to enroll in Lean online education to build internal knowledge, capacity and capability; employees were selected through an expression of interest process. Current Black and Green Belt candidates enrolled in online Lean education programs assisted in developing and implementing Lean initiatives. This contributed to the spread of Lean thinking amongst Central Health employees and multidisciplinary teams.

In an effort to build knowledge and awareness with respect to this methodology, Lean leaders developed and presented nine educational webinar sessions to over 150 employees, managers and physicians. These sessions highlighted the basic Lean principles and tools along with examples of Lean improvement work that was completed or is ongoing within the organization. Newsletters featuring Lean tools and success stories were disseminated to all employees to increase awareness and knowledge.

Program staff have accessed Lean leaders to apply Lean thinking and Lean tools to help achieve process improvements. To date, Lean tools, including value stream mapping, A3 reporting, spaghetti diagrams, 5S and PDSA cycles have been utilized in Ambulatory Care, Community Care, Health Information Management, Rehabilitative Services, Diagnostic Imaging, Inpatient Orthopedics, General Surgery, After Hours Clinic and Medicine programs.

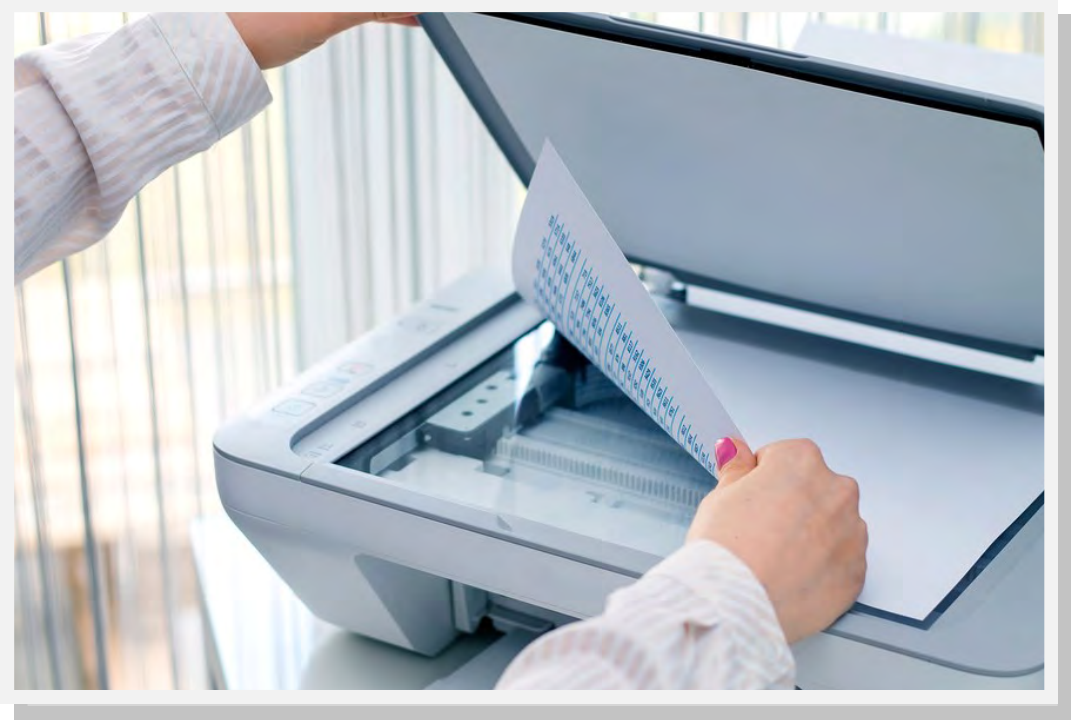
The ultimate goal for all teams was to eliminate waste and add value to the care delivered to the patient while bringing the organization closer to achieving the objective of improved client flow.

Scanning and archiving

During the fiscal year of 2015-16, Health Information Management (HIM) switched from OMTool software to MEDITECH scanning software which provided more functionality with scanned images. The goal of HIM was to record all patient information on the electronic health record and eliminate the need to access a paper chart at JPMRHC. At present, there are only two documents that are filed in a paper format; fetal heart monitor strips and growth charts. There is no longer a requirement for staff to retrieve paper charts from file rooms and to transport them to clinics or the emergency department because all information is readily available electronically. Clinicians have access to the complete JPMRHC chart regardless of the facility in which they are working. Release of information is streamlined at JPMRHC as patients can be provided a compact disc (CD) of their information as opposed to photocopying a paper chart.

HIM plans to operationalize scanning at Central Newfoundland Regional Health Centre on June 1, 2016. This will further enhance Central Health's electronic health record. It will also facilitate centralized release of information, a client centred initiative being undertaken to provide a single point of entry for all client requests for information. Scanning documents will also reduce the footprint necessary to store paper records.

Scanning has and will continue to allow Central Health to share information more effectively, share resources and eliminate waste. As implementation of the scanning solution in regional sites continues, these benefits will be compounded.



Scanning allows for better information sharing, resource sharing and elimination of waste.

Risk Assessment Checklist (RAC) Program

Central Health continues to be committed to providing quality care and services to the citizens of Central Newfoundland and Labrador. The Risk Management Program is one of many mechanisms that support the protection of clients, staff, visitors, the organization and its assets from any loss caused by unplanned and/or uncontrolled events. The Risk Assessment Checklist (RAC) is a tool within the program that helps focus on prevention and reduction of risks. This is a program provided in partnership with Central Health's insurer, Health Insurance Reciprocal of Canada (HIROC).

The RAC Program aims to increase the impact on patient safety and decrease risk by focusing on the highest ranked risks in the HIROC database. The main objectives of the program are to focus on proven mitigation strategies that decrease adverse events and claims. Program modules challenge organizations to examine their policies and practices to reduce preventable risks through organization-wide participation in their identification, assessment and management. Central Health successfully completed Cycle 1 of the RAC in the fiscal year of 2015-16 and is currently working on the next cycle.

Central Health Electronic Patient Order Sets – enhancing evidence-based practice

Patient Order Sets (POS) are groupings of patient orders, for example medication orders or lab tests, that a physician or nurse practitioner uses to standardize the ordering process for many common diagnoses like pneumonia and chronic diseases like diabetes. It is a decision support tool that offers clinicians a menu of best practice and evidence informed ordering options for a specific problem or condition.

The first steps in implementation of POS included developing a library of diagnosis-specific order sets that would not only meet practitioner needs, but also interface properly with Central Health's current resources and workflow. The POS Development Team, in collaboration with regional subject matter expert physicians and other clinicians, developed approximately 30 order sets that clinicians can customize for patient or resident ordering. Since the beginning of the project, 5,816 order sets have been submitted to Pharmacy by nurses and physicians. During the fiscal year of 2015-16 the team spread this initiative to 14 rural health centres and all the long term care facilities within Central Health. Presently, there are 20 additional order sets in development for Acute Care services at CNRHC and JPMRHC.

Kaizen on Medical Unit

A Kaizen is a process used to complement other Lean tools to implement a rapid improvement initiative in a work area. It is a preplanned or facilitated workshop that focuses the team exclusively on the improvement effort.

Several Kaizen events were held on the medical unit at JPMRHC during the fiscal year 2015-16. Numerous departments including Nursing, Information Management and Technology, Plant Maintenance, Materials Management, both health foundations and ancillary services as well as a patient's family member attended the initial meeting to determine the improvement work the medical team would undertake. The Kaizens identified included relocating the wander guard unit, redesigning the nursing station, implementing 5S in

the two utility rooms, designing a Seniors Maintaining Active Recreation Time (SMART) room and adding computer technology on medication carts. The intent was to eliminate waste and add value to the services provided to the patients on the medical unit. The improvement work is returning recovered nursing time to direct patient care. Currently, the 5S is completed in one utility room, the SMART room is under construction and the computer technology on the medication carts has been implemented. Evaluation is ongoing for these three process improvements and the remaining Kaizens will roll out in 2016-17.

Central Health's Model of Nursing Clinical Practice

Central Health's Model of Nursing Clinical Practice (MoNCP) is based on the principles of the Ottawa Hospital's Model of Nursing Clinical Practice. These principles have been adopted in the context of Central Health's healthcare environment. While the MoNCP was initially designed for the acute care setting, its principles can be readily applied to any area of nursing practice. In 2015-16, following implementation of the MoNCP at both JPMRCH and CNRHC, the MoNCP was implemented in all of Central Health's rural sites and long term care homes.

A three year longitudinal study by The Ottawa Hospital (TOH) on the benefits of the MoNCP demonstrated results which include, but are not limited to, increased autonomy and accountability for all nursing staff; improved patient/resident safety and patient/resident satisfaction; enhanced communication between staff and patients/residents and their families. It has improved utilization of the full scope of practice for all categories of nursing staff. TOH evaluation demonstrated that MoNCP has increased support for the orientation and educational needs of novice nursing staff and for nursing staff newly transferred from one area of nursing practice to another. It has also increased support for nursing managers who have a large span of control and heavy volume of patients in their clinical areas.

The MoNCP is a research–based model. Four of Central Health's facilities were chosen to be included in the longitudinal research study being carried out by TOH. Data gathered at the pre-implementation phase and year one and year two post implementation phases will be used to evaluate the impact of the MoNCP on nursing staff as well as on patient/resident outcomes. Internal evaluations following the format of the formal research process are being carried out at all other Central Health sites where the MoNCP has been implemented. Central Health plans to continue to implement the MoNCP by facilitating adaption to community health nursing service areas.

Lean Review of Special Assistance Program

The Special Assistance Program (SAP) provides basic supportive health products to individuals who meet program criteria to assist them with personal care, activities of daily living or other supportive services. Benefits of the program include access to health supplies such as dressings, catheters and incontinence supplies; oxygen and related equipment and supplies; orthotics such as braces and burn garments; over the counter medications for personal care home clients; and equipment such as wheelchairs, commodes or walkers. Individuals must be financially eligible for the program.

The Home and Ambulatory Services Department recognized that clients were not getting their medical equipment and supplies in the timeliest fashion. The number of clients in receipt of the Special Assistance Program has grown by 114 per cent during the past five years. All requests continued to be processed by one special assistance buyer. Requests for service were received in many different formats and often required follow up prior to processing. Much of the process was completed manually despite the possibility of electronic solutions. Furthermore, there were many instances when policy and procedures required unnecessary approvals or paperwork to process client orders. The lack of a streamlined intake and order process caused unnecessary delays and ultimately impacted quality client care.

A multi-disciplinary team, led by a Central Health Lean leader, applied Lean methodology and tools to outline the existing processes and to determine the necessary activities required to process an order. This Lean project took place during the fiscal year 2015-16.

Lean tools utilized included value stream mapping, visual management, current and future state maps and action plans. The team addressed a number of challenges to eliminate wastes and improve flow with the right person fulfilling the right role to return the recovered time to direct patient care. The team is in the early phase of enacting many of the changes that were identified in order to achieve the desired state of improved service delivery to the clients referred to the SAP.

SafetyLine...Enhancing employee safety

Central Health is one of four health authorities in Newfoundland and Labrador that implemented SafetyLine, an electronic monitoring system, for use by community based employees who complete home visits. Working alone is considered to be a high risk occupational hazard, and all health authorities are challenged to improve the ability to ensure the safety of employees who work alone.

Central Health implemented a pilot project in September 2015 with the Addictions Community Team (ACT) to identify any concerns or issues with the system. This pilot successfully identified gaps that needed to be addressed to ensure smooth implementation across the region. Currently, Central Health has 50 per cent of its regional groups using the system and about one third of all its users active, with the goal of having all community based staff using the system by the end of May 2016.

Using SafetyLine, employees enter data regarding their scheduled visits on their desktop computer and if they fail to confirm that they have safely completed a visit, they will be contacted by cell phone via a safety monitor. The monitors are managers or designated administrative/clerical support throughout the region.

After operational hours, the monitor's responsibility is routed to the switchboard at JPMRHC which then alerts the Senior Leader on call if an employee cannot be contacted. Implementation of the SafetyLine has made a significant contribution to the enhancement of a safety culture at Central Health.

Report on Performance

STRATEGIC ISSUE ONE - ACCESS TO SERVICES

Access to healthcare can be broadly defined as the extent to which clients are able to receive services from the health care system. The delivery of services is impacted by numerous factors including capacity, demand and client flow, structure and consistent work practices. Consequently, the end result is often a wait for a needed service. Therefore, access to appropriate and timely health care remains essential to the performance of Central Health and is identified as a strategic priority.

Given this commitment, the Central Health Wait Time Management Framework has been developed and implemented in select areas. The framework aligns with Central Health's mission to provide quality health and community services such that clients can obtain care or service at the right place and right time from the most appropriate healthcare provider, based on respective needs. Figure 1 displays the components of the framework and highlights the three components that have been of focus for the 2015-16 year.

With the endorsement of the framework and use of quality improvement methodologies, Central Health continues to partner with internal and external stakeholders across the care continuum to implement wait time management strategies. The types of strategies vary across departments with a common goal to improve access to health and community services.

Central Health's Wait Time Management Framework 2015-16

Figure 1: Framework

<table>
<tr><td colspan="2">Goal:
By March 31, 2017, Central Health will have improved access to select health and community services.</td></tr>
<tr><td colspan="2">Objective:
By March 31, 2016, Central Health will have implemented components of the wait time management framework aimed at improving access in identified priority areas.</td></tr>
<tr><td colspan="2">Measure: Implemented components of the framework to improve access and wait times.</td></tr>
<tr><td>Planned Indicators for 2015-16</td><td>Actual Progress for 2015-16</td></tr>
<tr><td>Indicator: Implemented recommendations from three of the six components of the Wait Time Management Framework in select priority areas.</td><td>Implementation of recommendations from three of the six components of the Wait Time Management Framework began in 2015-16. The three components of focus were: Structure, Accountability, and Knowledge and Information Management (see Figure 1).The recommendations implemented included:
review/modification of referral forms to increase access to medically appropriate services (Structure)
review/modification of evidence-based urgency categories to increase timely access (Structure)
review/development of clinically appropriate benchmarks and targets (Structure)
development of Wait Time working groups (Accountability)
validation of waitlists (Knowledge and Information Management)
education and increased skillset to develop wait time strategies (e.g. LEADS and LEAN) (Accountability)
use of existing resources (e.g. Meditech, Cognos) to support electronic wait time measurement (Knowledge and Information Management)
The recommendations were implemented with no variance in Orthopedic Surgical Services and Ortho Intake Assessment Clinic (OIAC), Diagnostic Imaging, Cardiopulmonary and Endoscopy Services.</td></tr>
<tr><td>Indicator: Implemented initiatives to improve access in select priority areas.</td><td>Cataract Surgical Services
To improve understanding of the challenges associated with accessing cataract surgery services, Central Health continues to work with local ophthalmologists and staff. Priority initiatives in 2015-16 included a new booking process for cataract procedures within the Surgical Services Program at JPMRHC; utilization of increased</td></tr>
</table>

	operating room time for ophthalmology services, the purchase of ophthalmology equipment to enhance operational efficiencies in the perioperative setting, and implementation of the Operating Room Management (ORM) System. Benchmarks were met for cataract surgical services at CNRHC and strategies are underway to improve access at JPMRHC. ***Diagnostic Imaging (DI)*** Initiatives to improve access to DI services were implemented in 2015-16. To increase the capacity of Computed Tomography (CT) services, a CT technologist worked an additional day/week. Urgent benchmarks for CT waits at CNRHC have improved with the majority of patients now having their procedure within 0-14 days. A new process has been implemented for Cardiolite testing, with a change from an individual procedure list/ per clinician, to a universal-master list – one list for all clinicians. This has resulted in improved efficiency and a 30 per cent reduction in the number of clients waiting. In 2015-16, as a strategy to improve access to ultrasounds (US), the DI Department diverted a portion of patients from JPMRHC to CNRHC to receive their US procedure. This diversion strategy coupled with wait list validation and management processes, resulted in a 50 per cent decrease in the number of patients waiting for US at JPMRHC and urgent benchmarks (0-14 days) are now consistently being achieved. Wait time management efforts have also resulted in a decrease in the number of patients waiting for US at CNRHC with benchmarks being met for both urgent (0-14 days) and non-urgent (30-60 days) US procedures. ***Endoscopy Services*** Efforts to improve access to endoscopy services were ongoing throughout 2015-16. The development of an action plan to guide service delivery has been aligned with the Department of Health and Community Services expected outcomes and the targets for urgent and non-urgent colonoscopies are being monitored.

	A priority initiative for the year included a strategy to remove the longest waiters from the wait list for endoscopy procedures. Additional staff and resources were provided to increase the volume of procedures being completed, with the prioritization of provider workload schedules to accommodate those patients who had been waiting the longest. Other initiatives to improve access included: the relocation of minor procedures to the Ambulatory Services area, the development of a patient satisfaction survey aligned with recommendations from the yearly Global Rating Scale survey and funding for nursing and sterile supply technician positions at one of the regional referral centres. With the implementation of these initiatives, there has been significant improvement in wait times for colonoscopies at JPMRHC, resulting in an improvement in equitable access to care throughout the region. Urgent benchmarks for colonoscopy at JPMRHC are now consistently being achieved with the majority of patients having their procedure within 0-14 days. Non-urgent waits have also dropped notably at JPMRHC with the average wait for a non-urgent colonoscopy being 63 days; this compares to a 537 day wait in March 2015. ***Orthopedic Surgical Services and Orthopedic Intake Assessment Clinic (OIAC)*** Evaluation of OIAC resulted in changes to the referral process and patient criteria. A new triage system with physicians reviewing all referrals for medical appropriateness was initiated in 2015-16. Also, a focus on knees only as the primary referral for the OIAC was implemented. The goal of these changes is to improve access and patient outcomes. Other priority initiatives included development and dissemination of quarterly wait time reports for hip and knee replacement surgeries to employees and physicians, an enhanced communication strategy to primary health care providers regarding the OIAC and validation of hip and knee surgical wait lists.

	Cardiopulmonary Services (CPS) The CPS Department was actively working to meet requirements of the Wait Time Management Framework. This was achieved through the creation of new validation and wait time management processes and restructuring of resources to improve access to care. Referral forms were revised and evidence informed priority ratings assigned. A new referral process was implemented with clients prioritized on the waitlist by a specialist at the time the referral was received. This served to enhance access to medically appropriate tests/procedures. In 2015-16, there was also an increase in the number of holter monitoring tests being completed. At JPMRHC, 240 procedures were completed in 2014-15 with an increase to 628 procedures in 2015-16. At CNRHC, 423 were completed in 2014-15 with an increase to 736 in 2015-16. The additional capacity to increase the volume of holter monitoring tests being conducted and validation of wait lists resulted in a decrease in the number of clients waiting; in March 2015, 826 people were waiting for a holter monitor which dropped to 244 people waiting in March 2016. Capacity to conduct echocardiogram testing was also increased.

Discussion of Results

Improving access to community and health services requires organizational transformation and the use of quality improvement strategies. In recognition of this, the Central Health Wait Time Management Framework (see Figure 1) was developed and is being implemented throughout the region. The framework consists of six components: Capacity, Structure, Accountability, Knowledge and Information Management, Communication, and Evaluation and Monitoring. The framework provides practical tools and resources to facilitate increased knowledge and appreciation for wait time management. With the framework as a guide, the Corporate Improvement Department has partnered with the Orthopedic Surgical Services, OIAC, CPS, Endoscopy and DI Departments to improve access to services.

While implementation of all components of the framework is essential, as it is a continuous process, the primary focus to date has been to implement recommendations related to Structure, Accountability and Knowledge and Information Management. This was a purposeful decision in an attempt to bring awareness to foundational wait time elements and to gain a true understanding of system capacity and demand.

Structure

The structure component of the framework provides recommendations for the collection and use of consistent and accurate wait time data, supported by standard processes. This enables an accurate view of the system, identification of issues and development of sustainable strategies. Efforts have focused on educating staff and physicians on wait time measurement, management and reporting. As a result of this education, CPS, OIAC and Orthopedic Surgical Services created work processes to consistently document patient self-selectors. This is a key structural component of the wait time framework, as voluntary wait times or times when a patient is not socially ready to be treated should be excluded from wait time calculations.

Other structural elements include the review of referral practices and urgency ratings. Urgency ratings are a means by which clients waiting for the service are seen in order of need. CPS has developed referral forms and urgency classifications that are indicative of medically appropriate tests and clinically appropriate wait times. The OIAC has revised their referral form and triage process for appropriate triaging to achieve optimal patient health outcomes and timely access to care.

Accountability

All those involved in wait time management must be accountable to their agreed roles in decision making and leadership. These elements fall under the component of Accountability in the Wait Time Management Framework.

Central Health has provided educational opportunities from the Institute of Healthcare Improvement (IHI) and provided regional Lean education sessions that will be of benefit to groups when assessing system capacity, client flow and referral processes. This has increased staff's skillset in change management, development of indicators/targets, monitoring and evaluation, and communicating effectively – all of which are instrumental to developing strategies to improve access.

Increased accountability in waitlist management also requires continuous collaborative communication between service providers, office staff, and waitlist management staff. Defined wait time management groups are therefore an essential requirement of the Wait Time Management Framework. While many departments had pre-existing wait time management groups, the Orthopedic Surgical Services, OIAC and the CPS departments established new working groups in 2015-16. All groups meet regularly resulting in employee and physician engagement with targeted work to improve access to care.

Knowledge and Information Management

Recommendations from the Knowledge and Information Management component of the framework focus on understanding and utilizing information management systems. Waitlist management provides information about the service demand and how well Central Health is doing in providing care and/or services. The Corporate Improvement Department has developed quarterly wait time reports for units that are visually effective in identifying trends and problems, and used to drive improvement efforts.

Wait time management working groups are exploring options from existing booking and registration systems to improve the management of wait times resulting in enhanced productivity and reduced waste. Through collaboration with Information Management and Technology, Corporate Improvement Department and front line staff, the DI department conducted PDSA cycles and simulations to create a robust master list schedule for booking ultrasounds. With this concept of one master list, the DI Department also made changes to how cardiolite tests are being registered and conducted. These changes are improving access to these services.

Waitlist validation is an essential requirement of Knowledge and Information Management. This has been a common priority for many departments in an attempt to confirm that everyone on the list still requires the service. For instance, CPS has created a process to validate waitlists resulting in a significant reduction in the number of people waiting. In preparation for a centralized booking process trial for Bone Mineral Densitometry Services, the DI Department has been working with IM&T to validate their pending list. The OIAC Department has also worked with the Corporate Improvement Department and begun validation processes of their wait list.

The electronic ORM documentation system has been implemented for surgical services at CNRHC and JPMRHC. ORM allows for the creation of standardized documentation and operational efficiencies within patient flow, all of which support accurate and transparent wait time data reporting and management.

Enhancing patient experience -"The closest thing to being cared for is to care for someone else." ~ Carson McCullers

Objective: By March 31, 2017, Central Health will have implemented the wait time management framework in the priority areas identified as requiring improvement.
Measure: Implemented the framework and improved access to select health and community services.
Indicator: • Implemented recommendations from all of the components of the Wait Time Management Framework in select service areas.

One of the many walking trails in central region showing the natural beauty of the area. Springdale, NL

STRATEGIC ISSUE TWO - HEALTHY LIVING

Central Health's Chronic Disease Prevention and Management (CDPM) Program has been established to impact efforts across the continuum of care to ensure patients/clients receive the most appropriate care, in the most appropriate place, at the most appropriate time. Formal processes and connections are in place, and continue to be developed, with internal departments and external stakeholders to effectively shift to a comprehensive chronic disease model of care.

Current work in the CDPM Program is focused on improving access, flow, care processes and outcomes for people living with identified high priority chronic diseases: heart failure, chronic obstructive pulmonary disease (COPD), diabetes and stroke. Current research, national best practice guidelines, Central Health's CDPM Strategy, Accreditation Canada Standards and adopted models of care such as the Self-Management Service Delivery Model, Expanded Chronic Care Model and Primary Health Care Service Delivery Model provide the framework and foundation to guide work plan development and implementation.

Goal By March 31, 2017, Central Health will have improved capacity to address population health related issues within the region.
Objective By March 31, 2016, Central Health will have implemented initiatives to address priority health related issues in the region.
Measure Initiatives implemented to address priority health issues in the region.

Planned indicators for 2015-16	***Actual progress for 2015-16***
Identified at least two priority health issues	Through environmental scans and a review of healthcare utilization, COPD and Heart Failure were determined to rank highest in hospital admissions and readmissions, length of stay, and emergency room visits. Building on opportunities that were in place through a pan - Canadian collaborative and private partnerships, these chronic diseases were determined to be the two priority areas by the Chronic Disease Prevention and Management Advisory Committee in consultation with senior leadership. Data from the *Report on Residents of Central Health Hospitalized with Specific Chronic Conditions (released January 2014)* show that of acute care hospitalizations due to select chronic diseases, the majority were due to COPD (37%), followed by congestive heart failure (CHF) (26%); COPD and CHF were the second and fourth case mix groups across all hospital admissions; length of stay was higher than expected for both COPD (actual average for all cases: expected average for all cases was 9.5 : 6.1) and CHF (actual average for all cases: expected average for all cases was 10.7 : 6.7); and the number of patients hospitalized more than 2 times was 29 per cent and 25 per cent for COPD and CHF respectively.
Documented action plan to address at least two priority health issues.	The CDPM advisory committee finalized and approved the CDPM Work Plan which provided direction for the following priority areas: Self-Management Program; Regional Stroke Program; Regional Diabetes Care Program; Cardiac Rehabilitation; Heart Failure Outreach Program; Telehealth; and COPD Program.

	The work plan was developed based on components of the Expanded Chronic Care Model and aligns with Central Health's Chronic Disease Prevention and Management Strategy. The CDPM Advisory Committee finalized and approved the action plan/ work plans for both the Heart Failure and COPD programs. Central Health's COPD Outreach Program is an 18 week program based in patients homes, for people with advanced COPD. Bringing together an interdisciplinary team, the primary objectives of the program are to provide self-management support; system navigation; coordination of care; individualized COPD action plans; psychosocial support; and access to advanced care planning. Central Health's Heart Failure Outreach Program is a telephone-based service offering an active partnership between patients, primary care providers, registered nurses and other health care professionals. The primary objective is to provide a disease management program with the goal of enhancing the client's ability to understand and self-manage their condition, symptom control, improve quality of life, and decrease inappropriate health care use. To provide appropriate, accessible, patient centered, coordinated and effective care, examples of action plan initiatives include primary care provider engagement; development and implementation of program flow/system navigation; formal engagement and partnerships with internal stakeholders; development of standard education tools; and development of best practice disease management.
Implemented actions to address at least two priority health issues.	Cardiopulmonary Services implemented the third prong of the approach for COPD care in Central Health. A COPD outreach pilot project was initiated and 20 patients were enrolled. The program was offered within the health services area served by JPMRHC. The aim of the pilot was to reduce health care utilization by program participants by 15 per cent and to improve the patient's self-efficacy and self-management skills through

	education and personal action plan development. The 18 week COPD Outreach program consists of 5 home visits by either a social worker or respiratory educator, interspersed with follow up phone calls and interprofessional case rounds. The work plan for CHF was implemented for the pilot phase in 2015-16 and the program was piloted throughout Central Health in this fiscal year. Through significant engagement with primary care providers (PCP) at all health service areas throughout the region, referral intake for the program exceeded 85 resulting in 45 active patients. Utilizing a self-management service delivery model, this disease management program includes comprehensive health risks and heart failure assessments which generate complex, individualized care plans. Patient education, system navigation and primary care provider engagement are integral components of this program. Utilization of central intake and booking processes, and telephone based service allows broad access throughout the region. Participation in the program requires primary care provider participation, allowing the heart failure nurse to communicate effectively regarding urgent and routine patient care, improving symptom management and control outside the emergency department and acute system when appropriate.

Discussion of Results

During the fiscal year 2015-16 the CDPM Advisory Committee completed foundational work which led to the development of a CDPM Department Work Plan. The highlights included comparing the CDPM Self - Assessment against the Accreditation Canada standards; facilitating a planning day to develop a vision and mission for the CDPM Department; finalizing priority areas for the work plan based on opportunities for improvement identified through self-assessment; and hosting an internal CDPM Conference in October 2015. At the conference, the committee was able to enhance knowledge of the CDPM strategy, models of care and engagement, gather information used in priority planning, facilitate a focus group and further define specific program area work plans. Approximately 100 Central Health staff attended and the feedback regarding the event was positive.

Central Health identified that COPD was the fourth leading cause of all hospital admissions in the region and the leading cause for admission of all chronic diseases. COPD is a common, progressive, incurable and manageable lung condition with uncomfortable breathing as the predominant symptom. COPD is soon to be the third leading cause of death worldwide and already a primary cause of emergency department (ED) and hospital visits in Canada. In an effort to address this chronic disease, Central Health has a three pronged approach to COPD Care which includes standard patient order sets, a Respiratory Care Centre and a COPD Outreach Program.

Standard Patient Order Sets (POS) guide inpatient treatment and make the link to post admission care through automated referrals. The Respiratory Care Centre is a 9-month ambulatory care program for those with mild to moderate COPD and includes an initial visit with a physician and registered respiratory therapist followed by four (4) follow-up visits at one month, three months, six months and nine months. The COPD Outreach Program is an 18 week program delivered in the home to patients with advanced COPD. The program consists of five visits interspersed with follow-up phone calls. Once the program is completed, follow-up calls are completed at 3, 6 and 12 months. The COPD Outreach Program brings together a team of professionals including a Respiratory Therapist, a Social Worker and an Internist to partner with patients in:

- Self-management education and support
- Navigating the local healthcare system and gaining access to services which support them at home
- Improving communication between all the professionals who are assisting in their care
- Facilitating access to a helpline that should improve the early care of an acute exacerbation of COPD
- Developing action plans
- Psychosocial support
- Considering advance care planning

The implementation of the COPD Outreach Program has shown significant improvements in the processes of care for patients with advanced COPD. Pre and post Care Transition Measures (CTM-3) demonstrated a 26.3 per cent improvement in patients awareness of their responsibilities for managing their COPD and a 27.6 per cent improvement in patients knowledge surrounding their medications. The CTM-3 is used to demonstrate how well patients transition from hospital to home and has been adapted to show impact of the COPD Outreach Program. Efficiency of the health care system data demonstrated significant improvements in healthcare utilization with a 63 per cent reduction in ED visits, 57 per cent reduction in admission rates and a 31 per cent reduction in length of stay.

Central Health's Heart Failure Outreach Program was developed as a pilot project in partnership with FONEMED North America and the NL Healthline and initiated in the fall of 2014. This regional, telephone based service offers an active partnership between patients, primary care providers, registered nurses and other health care professionals with the goal of heart failure symptom control and improved quality of life. Built utilizing a self-management service delivery model, components of the program include registered nurse-led assessments and care plan development; support to help guide patient decision making for optimal health; education and knowledge translation; and health coaching.

The remote, telephone based service delivery model ensures equitable, regional access to service. A total of 86 referrals have been received from primary care providers throughout the region, and there are 45 active participants in the program. With access to appropriate technology, three active participants were selected to trial utilization of biometric equipment to allow daily measuring and monitoring of weight, pulse and blood pressure. Daily measures are logged into their ihealth account, which is accessible by their heart failure nurse for regular review.

Formal evaluation of the program is in progress through a partnership with the Newfoundland and Labrador Centre for Health Information (NLCHI). The current focus is on the development and implementation of a regional long term program sustainability plan.

Objective: By March 31, 2017, Central Health will have continued to implement strategy goals to address priority health areas.
Measure: Implemented strategy goals to address priority health related issues in the region
Indicator: • Continued implementation of Heart Failure sustainability work plan and COPD work plan. Finalized and implemented work plans for the Regional Stroke Program and Regional Diabetes Care Program • Implemented the approved Self-Management Work Plan

Creating and maintaining a homelike environment to assist in motivating, stimulating and encouraging residents in long term care. Long Term Care Unit, Norte Dame Bay Memorial Health Centre, Twillingate, NL

Registration desk, Dr. Hugh Twomey Health Centre, Botwood, NL

STRATEGIC ISSUE THREE - CLIENT FLOW

Determining how current processes, such as bed availability, transfers/repatriation, length of stay and discharge planning support the flow of clients through the system requires a comprehensive team approach including client and/or family involvement.

The organization recognizes that clients are waiting too long to see emergency room healthcare providers as a result of various contributing root causes that are complex and unique to the two secondary care facilities, JPMRHC and CNRHC. To improve client flow, teams have been striving to understand the current state with respect to the demands on the healthcare system and the capacity available, the waits and delays and the unevenness in work processes. Multidisciplinary teams, along with physician leaders, are discovering opportunities to make improvements to processes and services for more seamless client flow in the organization. Lean thinking and methodology has been applied to implement action plans to reach the desired future state of enhanced client flow in the ED and inpatient areas.

The Clinical Efficiency Consultant continues to collaborate with different teams to implement client flow improvement initiatives to eliminate waste and add value to service delivered to the clients in the program areas. The improvement efforts are intended to facilitate improved transfers of boarded patients from the ED to the inpatient units to reduce and mitigate overcrowding in the ED. This is accomplished through developing coalitions amongst nursing, physicians, managers, physiotherapy, nutrition services, support departments including Information Management and Technology, other stakeholders and most importantly, the client. The purpose is to achieve results in improved client flow thereby creating a safe, quality service.

Goal
By March 31, 2017, Central Health will have reduced and mitigated overcrowding in the Emergency Department by improving client flow.
2015-16 Objective
By March 31, 2016 Central Health will have identified challenges related to client flow data analysis and supported areas for improvement.
Measure
Challenges related to client flow data analysis identified and areas of improvement supported.

Planned indicators for 2015-16	***Actual progress for 2015-16***
Client flow data was analyzed and utilized to implement interventions to improve client flow in four selected inpatient areas.	Client flow data was pulled from multiple sources and analyzed by team members from the General Surgery Unit, Medicine Unit and Inpatient Orthopedics at JPMRHC and the General Surgery unit at CNRHC. The multidisciplinary team in each area utilized this data to enhance understanding of the current state and devise action plans to improve patient flow. Common interventions implemented for all inpatient areas included improved communication strategies and timely documentation. In addition, each unit implemented team specific improvement processes such as the General Surgery Unit at CNRHC improved timely referral generation from approximately 40 - 80 per cent of the time to both clinical nutrition and physiotherapy to ensure a multidisciplinary approach to discharge planning for surgical patients. Targeted huddles between physiotherapy and nursing were implemented each weekday morning to improved timely discharge in Inpatient Orthopedic Unit at JPMRHC. Conditional discharge orders written by physicians were promoted to improve time of discharge on the General Surgery unit at JPMRHC and CNRHC while at CNRHC, the General Surgery unit utilized communication boards to promote information sharing regarding discharge readiness amongst team members. The goal for all inpatient units was to improve discharge planning and decrease length of stay.

Implemented strategies in the emergency department to improve transfers of admitted clients to inpatient units.	Improving the transfer of admitted patients from the emergency department (ED) to inpatient units required a multidisciplinary team approach. The team members included ED nursing, ED ward clerk, nursing from the inpatient unit, managers, Director of Site Operations, and representatives from Health Information Management and IM&T. Each multidisciplinary team was presented with the transfer time data from the ED to the targeted inpatient unit. The current state was mapped to identify the challenges that hampered the transfers of admitted patients. A number of strategies were implemented including improved communication through the utilization of the Bed Manager tool to share the bed census for all facilities with physicians, managers and senior leaders. This increased awareness to utilize regional acute care beds to optimize client flow. Process maps were devised to outline the communication process that team members should follow upon a patient admission in the ED. These process maps and defined care provider roles promoted timely bed assignment and timely handover. Consistent morning huddles held by the Director of Site Operations with managers and care facilitators to discuss patient admissions also improved the transfers of admitted clients to the inpatient units at JPMRHC.
Implemented policies and procedures to provide a standardized client flow approach to improve bed utilization regionally and reduce emergency room overcrowding.	Three new policies, Acute Care Bed Management, Overcapacity and Client Repatriation, were developed and implemented to provide a standardized approach to improve bed utilization and mitigate overcrowding in the ED at CNRHC and JPMRHC. The Acute Care Bed Management Policy outlined a procedural approach to efficiently manage and appropriately use acute care beds in all inpatient program areas to optimize patient flow from all admission points of entry including ED, operating rooms, repatriation and transfer. This policy improved communication between managers

	of all acute care facilities to optimally utilize acute care beds. The Overcapacity Policy outlined a standardized procedure to follow when capacity in a facility is beyond the optimal bed utilization of 85%. Overcapacity impedes patient flow through the admission points of entry when there is 90 per cent utilization of acute care beds. The response to this policy from most inpatient units was the forward thinking to identify and create a safe area where an overflow bed could be placed on the unit to admit a patient when the policy is put in action. The third policy approved and deployed, Client Repatriation Policy, outlined a standardized approach and time frame for repatriating/transferring clients to an acute care facility near their residence or transferring to another acute care facility in Central Health. This ensured Central Health is able to best provide client specific services through optimizing client flow between secondary and primary health centres or between primary sites. In response to stakeholder feedback on the implementation of this policy, a brochure, *Transfer to Another Facility for Continued Care*, was developed to provide to patients upon admission. The purpose of the brochure was to communicate and explain that a transfer to another facility in Central Health is necessary to ensure every patient receives the right care, in the right place, at the right time by the right healthcare provider. These policies were distributed to stakeholders to promote the appropriate and optimal utilization of all regional acute care beds.
Client flow data communicated to select stakeholders to monitor targets to improve client flow in the emergency department	The multidisciplinary teams working on client flow improvement initiatives were presented with client flow data which the teams monitored quarterly through shared written reports. Each team set goals and the data kept the teams informed of the impact interventions or actions had on achieving the desired future state. Decreasing length of stay, improving transfer times, meeting discharge times were some of the targeted indicators that were

	tracked and monitored while striving to enhance and sustain improved client flow. Client flow data was posted on visual management boards on units. As well, the ED indicators were shared and monitored by the Board Performance Improvement Committee every quarter. Additionally, bed occupancy in all facilities, along with ED admissions and scheduled surgeries for the two secondary sites, was retrieved from Bed Manager every weekday and provided to the team and physicians to facilitate conversations to improve client flow.

Springdale, NL

Discussion of results

Client flow has been recognized as having the potential to impact safety, accessibility, efficiency, effectiveness and client satisfaction. It requires a collaborative effort between the frontline employees, managers and physicians in the many program areas throughout Central Health. To improve client flow, it is important to understand the demands on the system and the capacity available, the waits and delays and the unevenness in work processes. Teams worked together to understand the current state and used client flow principles and Lean methodology to discover opportunities and implement initiatives to improve processes and services to achieve a desired future state of enhanced client flow.

The goal of the Inpatient Orthopedic Team was to improve discharge planning and decrease the 5.3 day length of stay (LOS) for patients who had total knee replacement (TKR) and total hip joint replacements (THR). Through the application of a Lean lens, the team looked for opportunities to enhance the value of the patient services while eliminating the waste that challenges everyday work. The team devised an action plan and worked with healthcare partners to implement huddles to ensure clear communication regarding discharge planning, and timely arrival of medications for appropriate administration and discharge. Specified standing discharge orders were written by physicians and education and pre-operative screening was completed by the OIAC to improve patient discharge readiness. The delivery of trays was transferred from nursing to dietary staff so the right people were providing the right care to the patients.

The collaborative efforts of the team resulted in improvements in the LOS for both surgeries in the first six months of the fiscal year. Patients having a TKR were discharged in 4.1 days and those receiving a THR were discharged in 4.8 days, on average. The team continues to strive to find opportunities for improvement and further decrease the LOS while improving the patient experience.

The General Surgery team at both CNRHC and JPMRHC mapped their current state for patients admitted after having colon surgery. The team's goal was to implement strategies to reduce the average LOS below seven days and enhance the quality of service delivery for this patient cohort.

The teams agreed to promote written conditional discharges for all patients who had colon surgery to facilitate discharge by eleven o'clock the next morning. The team at JPMRHC used PDSA (Plan-Do-Study-Act) to implement this improvement through tests of change. PDSA is a problem solving tool that is utilized to continuously improve a process or procedure through identifying what to change and how to do it, followed by executing the improvement and checking to ensure it works. Finally, the team determines whether to implement the change and/or future improvements. In this instance the team's tests of change included face to face meetings and data presentation, utilization of signage in the charting area, and one on one conversation.

The initiative was supplemented by nursing staff at JPMRHC who started the required documentation for discharge on the night shift thereby reducing the requirement for morning documentation when other care demands are higher. To promote an eleven o'clock discharge various communication strategies including posters on the unit, promotion of early rounding and conversations with stakeholders and patients were utilized. Discharge planning was improved on the General Surgery Unit at CNRHC through use of a communication board which identified the patients who were ready for discharge. The team also actioned improvement initiatives including promotion of timely documentation, increased generation of referrals to team members and improved assessment time by social work.

The team on the medical unit at JPMRHC recognized the process variation in admission practices along with communication failures which resulted in wait and delays and impedance to discharge planning. Physician with nurse accompaniment during rounds was discussed and the team identified the need for improvement as physician and nurse team rounding was found to be occurring only 30 per cent of the time. As well, timely documentation, human resources on night shifts and physician handover were added to the action plan as areas for improvement. The improvement work on this unit is continuing into 2016-17 along with additional projects to eliminate waste and add value to the service delivered to improve LOS.

Multidisciplinary teams met to address the transfer times from the ED to General Surgery at CNRHC and JPMRHC; and ED to Medicine/Intensive Care Unit at CNRHC. Both EDs had transfer times significantly higher than the targeted indicator of four hours. Each team mapped the current state and discussed strategies to reach the desired state of decreasing the transfer times when beds were available. Improvement initiatives included adding an overflow bed to the units, enhancing communication protocols, sharing bed occupancy data and implementing morning huddles. Quarterly reports highlighting transfer times for each inpatient unit were shared with the intent to monitor and understand any trends. Continued partnerships and collaboration with the whole multidisciplinary team is essential to address the challenges with client flow issues and to make and sustain improvements. The client flow work will continue as we strive for future improvements in length of stay and transfer times in pursuit of continuous improvement.

The client flow work highlighted the need for a standardized approach to manage acute care beds. Three bed management policies were developed in response; Acute Care Bed Management, Overcapacity and Client Repatriation. The objective of these policies was to outline a standardized approach to efficiently manage and appropriately use acute care beds in all inpatient program areas to optimize patient flow from all admission points of entry (ED, operating rooms, repatriation/transfer) to inpatient units and other facilities within Central Health.

The Overcapacity Policy provided a protocol to address the impedance of patient flow when there is 90 per cent utilization of acute care beds. The Client Repatriation Policy outlined a standardized approach and time frame for repatriating/transferring clients to an acute care facility near their residence or transferring to another acute care facility in Central Health.

The dissemination of client flow data to stakeholders involved in improvement initiatives is critical to determining what interventions are required to improve the flow of clients as well as monitoring and tracking the data after a new process is implemented. Client flow data has been distributed to teams in written reports with accompanying graphs and displayed on visual management boards on inpatient units. In addition, the ED and hospital flow indicators are communicated in the Board Performance Improvement Scorecard.

The Bed Manager is a technological solution used to provide real time bed occupancy data in all Central Health facilities to targeted stakeholders. The purpose is to present the information to facilitate the necessary conversations to promote the utilization of all regional acute care beds to effectively mitigate overcrowding in the ED at the secondary sites.

2016-17 Objective By March 31, 2017 Central Health will have targeted specific barriers and implemented strategies to improve client flow throughout the organization.
Measure Specific barriers related to client flow will have been targeted and improvement strategies implemented.
Indicator • Implemented improvement strategies to reduce transfer times from the emergency department to inpatient units to improve client flow and reduce overcrowding in the emergency department • Implemented continuous improvement strategies to enhance client flow and discharge planning on the inpatient units to mitigate overcapacity

Opportunities and Challenges

Organizational learning and development

Central Health is in the process of implementing an electronic Learning Management System (LMS) which will facilitate organizational learning and development through alternate delivery methods including e-learning. The LMS will create opportunities to increase compliance with required courses as one of the strengths of the LMS is its ability to track and document required training.

Educators in Professional Development and Continuing Education Services (PD&CES) have developed training modules (Essential, Advanced and Basic Skills) for managers and staff to facilitate utilization of the system. They will be embarking on an ambitious plan to train over 140 individuals in the Essentials or Advanced Module and over 3000 employees in Basic Skills in 2016-17.

It is the intention of PD&CES that all managers and staff will transition to the LMS in January 2017, eliminating the need for all previous training databases and ensuring higher compliance with legislative and organizational training requirements.

Medication reconciliation implementation

Medication reconciliation (Med Rec) is a process whereby healthcare providers systematically gather a best possible medication history (BPMH) in partnership with the client/family upon admission. Admission orders are then generated to ensure that the client is ordered the appropriate medications and any changes in the client's medication regime are intentional. Central Health is committed to the development of a robust medication reconciliation process as a primary patient safety goal.

A Med Rec process on admission, transfer and discharge is a Required Organizational Practice set out by Accreditation Canada for several client care service areas. Med Rec processes help to ensure that accurate and complete medication information is communicated upon care transitions in order to prevent adverse drug events. In Central Health, medication occurrences remain one of the top three occurrences reported. Currently, Mental Health and Long Term Care service areas have Med Rec completely implemented on all three care transitions.

By 2018, health authorities will be required by Accreditation Canada standards to have Med Rec implementation completed in all applicable service areas. Although Med Rec is a critical component of providing safe care, it is complex and challenging to successfully implement organization wide. In order to support the most effective and efficient process, Central Health has been working with the other regional health authorities to secure a technical solution to enable providers to perform Med Rec electronically, an improvement which is anticipated to be implemented in the 2016-17 fiscal year. Central Health remains committed to aligning resources within the organization to meet the requirements set out by Accreditation Canada and more importantly, is committed to improving patient safety for the residents of

the region. Central Health has provided education sessions on the Intranet which are available to all nursing staff, recognizing that education provides an opportunity to prevent future occurrences and has trained nursing staff at JPMRHC and CNRHC in BPMH.

Licensing requirements for pharmacy technicians

By January 2018, all pharmacy technicians in the province will be required to enhance their skills in order to become licensed pharmacy technicians. Currently, there is no licensing for this occupation in Newfoundland and Labrador.

In order to assist current pharmacy technicians to attain this new level of competency, the provincial Department of Health and Community Services and the regional health authorities will provide financial assistance to cover the cost of courses, exams, education leave and travel to write the qualifying exams. The requirements for certification as a pharmacy technician include four online courses, an evaluating competency exam, a two-part qualifying exam (theory and practical), a jurisprudence exam for Newfoundland and Labrador, and an eight to 12 week practicum under the supervision of a registered pharmacist.

Central Health is supporting its current pharmacy technicians to transition to this new scope of practice but anticipates there may be a gap in the number of individuals successfully attaining the new designation and the number required within the health authority. This may be due to personal choice to pursue certification, being unsuccessful in the certification process, retirements and other departures. In order to meet the demand, Central Health is recruiting pharmacy technicians from colleges in the area in advance of the certification requirement.

The challenge to obtain the required number of pharmacy technicians is exacerbated as there is only one fully accredited Pharmacy Technician program being offered in the province at Keyin College in Grand Falls -Windsor. This three year program will only have seven graduates by January 1, 2018, which is the licensure deadline. It is anticipated that a significant number of students may not complete the three year program due the difficulty of the course as evidenced by the 25 per cent failure rate reported by the Pharmacy Examining Board of Canada (PEBC).

The opportunity for RHAs to work together on this challenge has been recognized and the professional practice department of Eastern Health is assisting all RHAs in the development of new learning programs.

Shared Services

Budget 2015 announced the establishment of a new provincial Health Shared Services strategy for regional health authorities. Sharing services means combining administrative support functions or back office functions to find efficiencies, economies of scale, better value for money and to enhance service quality. This presents an opportunity for Central Health to share in the costs of its administrative functions including purchasing, human resources, information technology and telecommunications, and finance and payroll with the other RHAs and the Newfoundland and Labrador Centre for Health Information (NLCHI). Work is ongoing in fiscal 2016-17 to support the implementation of this shared services model of business for the Newfoundland and Labrador health authorities.

Workplace Safety

Central Health continues to work toward a healthy and safe workplace with a focus on mental health in the workplace, supporting staff affected by adverse events and completion of a workplace security assessment. This work is led through collaboration between programs which include Employee Wellness/ Health and Safety, Mental Health and Addictions, Corporate Improvement Department and representation from many other departments and programs.

Central Health enrolled in a national Mental Health @ Work pilot project through Excellence Canada in 2011 and since then has been working towards increasing levels of certification. In 2015-16, Central Health, led by a Mental Health @ Work Steering Committee, worked towards Level III certification. In order to achieve an award at this level, Central Health developed an action plan for each program area based on the identified top three risk areas; Organizational Culture, Civility and Respect and Psychological Protection. Central Health will be required to re-evaluate progress through the administration of the Guarding Minds @ Work survey in April 2016 and receive a site visit from Excellence Canada to validate the submission for certification.

Health care providers who are involved in an unanticipated patient incident, a medical error and/or a patient related injury can be emotionally traumatized by the event. These health care providers often feel personally responsible for the patient outcome; experience a sense of failure and question their professional competence. Central Health began the initiation of formal response to second victims in 2015 -16. The planned approach includes: development of a Second Victim Support Framework, development of management competencies in responding to second victims; utilization of a peer support model; and development of policies and procedures.

As part of the commitment to the provision of a physically safe environment, Central Health issued a request for proposal (RFP) for a security assessment of all of its facilities. The RFP was awarded to Paladin Security in January 2016 and the assessment was initiated soon afterward through focus groups, site visits and document review. The review examined the physical security of Central Health facilities, as well as the training and preparation for events and the security measures currently in place.

Central Health is currently awaiting a final report from Paladin Security. The challenge in the coming year will be to implement any recommended changes in process and infrastructure within available resources, and to continue to embed a culture of safety throughout the organization.

Work done to improve these elements of the work environment will go a long way to create a safer and healthier workplace, both physically and psychologically. Central Health recognizes that it is important to have employees who are psychologically healthy and safe as positive employee mental health has a direct impact on the overall success of our organization and the health and safety of our staff and clients, patients and residents.

Appendices

Harbour Breton, Connaigre Peninsula

Appendix A – List of Sites and Contact Information

A.M. Guy Memorial Health Centre
P.O. Box 10
Buchans, NL A0H 1G0
P: (709) 672-3304/3305 F: (709) 672-3390

Baie Verte Peninsula Health Centre
7 Hospital Road P.O. Box 190
Baie Verte, NL A0K 1B0
P: (709) 532-4281 F: (709) 532-4939

Bay d'Espoir Community Health Centre
P.O. Box 369
St. Alban's, NL A0H 2E0
P: (709) 538-3244 F: (709) 538-3228

Belleoram Community Health Centre
P.O. Box 206
Belleoram, NL A0H 1B0
P: (709) 881-6101 F: (709) 881-6104

Bell Place Community Health Centre
3 Bell Place
Gander, NL A1V 2T4
P: (709) 651-3306 F: (709) 651-3341

Bonnews Lodge
Badger's Quay, NL A0G 1B0
P: (709) 536-2160 F: (709) 536-3334

Carmelite House
50 Union Street
Grand Falls-Windsor, NL A2A 2E1
P: (709) 489-2274 F: (709) 292-2593

Central Health Regional Office
21 Carmelite Road
Grand Falls-Windsor, NL A2A 1Y4
P: (709) 292-2138 F: (709) 292-2249

Central Newfoundland Regional Health Centre
50 Union Street
Grand Falls-Windsor, NL A2A 2E1
P: (709) 292-2500 F: (709) 292-2645

Centreville Community Health Centre
P.O. Box 181
Centreville, NL A0G 4P0
P: (709) 678-2342 F: (709) 678-2110

Change Islands Community Health Centre
c/o Medical Clinic
Change Islands, NL A0G 1R0
P: (709) 621-6161 F: (709) 621-3126

Connaigre Peninsula Health Centre
P.O. Box 70
Harbour Breton, NL A0H 1P0
P: (709) 885-2043 F: (709) 885-2358

Dr. Brian Adams Memorial Community Health Centre
P.O. Box 239
Gambo, NL A0G 1T0
P: (709) 674-4403 F: (709) 674-2000

Dr. C.V. Smith Memorial Community
Health Centre
P.O. Box 9
Glovertown, NL A0G 2L0
P: (709) 533-2372 or 2374 F: (709) 533-1021

Dr. Hugh Twomey Health Centre
P.O. Box 250
Botwood, NL A0E 1E0
P: (709) 257-2874 F: (709) 257-4613

Dr. Y. K. Jeon Kittiwake Health Centre
Brookfield, NL A0G 1J0
P: (709) 536-2405 F: (709) 536-2433

Eastport Community Health Centre
P.O. Box 111
Eastport, NL A0G 1Z0
P: (709) 677-2530 F: (709) 677-2430

Exploits Community Health Centre
P.O. Box 945, 2 Airbase Road
Botwood, NL A0H 1E0
P: (709) 257-4900 F: (709) 257-3640

Fogo Island Health Centre
P.O. Box 9
Fogo, NL A0G 2B0
P: (709) 266-2221 F: (709) 266-1070

Gaultois Community Health Centre
Gaultois, NL A0H 1N0
P: (709) 841-7331 F: (709) 841-4461

Grand Falls-Windsor Community Health Centre
36 Queensway
Grand Falls-Windsor, NL A2B 1J3
P: (709) 489-4861 F: (709) 489-8844

Green Bay Community Health Centre
Little Bay Road, P.O. Box 597
Springdale, NL A0J 1T0
P: (709) 673-4974 F: (709) 673- 4970

Green Bay Health Centre
P.O. Box 280, 275 Main Street
Springdale, NL A0J 1T0
P: (709) 673-3911 F: (709) 673-2114

Hare Bay Community Health Centre
P.O. Box 219
Hare Bay, NL A0G 2P0
P: (709) 537-2209 F: (709) 537-2905

Hope Valley Youth Treatment Centre
Mental Health and Addictions Services
15 Lincoln Road c/o 50 Union Street
Grand Falls-Windsor, NL A2A 2E1
P: (709) 292-8360

James Paton Memorial Regional Health Centre
125 Trans Canada Highway
Gander, NL A1V 1P7
P: (709) 256-2500 F: (709) 256-7800

Lakeside Homes
95 Airport Boulevard
Gander, NL A1V 2L7
P: (709) 256-8850 F: (709) 256-4259

La Scie Community Health Centre
P.O. Box 492
La Scie, NL A0K 3M0
P: (709) 675-2429 F: (709) 675-2478

Lewisporte Community Health Centre
394-412 Main Street P.O. Box 1209
Lewisporte, NL A0G 3A0
P: (709) 535-0905/0906 F: (709) 535-0360

Lewisporte Health Centre (including North Haven Manor)
21 Centennial Drive P.O, Box 880
Lewisporte, NL A0G 3A0
P: (709) 535-6767 F: (709) 535-8383

McCallum Community Health Centre
McCallum, NL A0H 2J0
P: (709) 846-4104 F: (709) 864-4104

Mose Ambrose Community Health Centre
P.O. Box 2 site 3A
Mose Ambrose, NL A0H 1M0
P: (709) 888-3541 F: (709) 888-6281

Musgrave Harbour Community Health Centre
P.O. Box 69
Musgrave Harbour, NL A0G 3J0
P: (709) 655-2518 F: (709) 655-2116

New World Island Community Health Centre
c/o NWI Medical Clinic
Summerford, NL A0G 4E0
P: (709) 629-3682 F: (709) 629-7114

Notre Dame Bay Memorial Health Centre
Twillingate, NL A0G 4M0
P: (709) 884-2131 F: (709) 884-2586

Rencontre East Community Health Centre
Rencontre East, NL A0H 2C0
P: (709) 848-3410 F: (709) 848-3410

Robert's Arm Community Health Centre
P.O. Box 219
Robert's Arm, NL A0J 1R0
P: (709) 652-3410 F: (709) 652-3671

St. Alban's Community Health Centre
P.O. Box 490, Cormier Avenue
St. Alban's, NL A0H 1E0
P: (709) 538-3738 F: (709) 538-3563/3899

St. Brendan's Community Health Centre
c/o Medical Clinic
St. Brendan's, NL A0G 3V0
P: (709) 669-5381/4401 F: 669-3105

Therapeutic Residence
Grand Falls—Windsor, NL
P: (709) 489-6651
Valley Vista Senior Citizens' Home
P.O. Box 130
Springdale, NL A0J 1T0
P: (709) 673-3936 F: (709) 673-2832

Victoria Cove Community Health Centre
c/o Medical Clinic
Victoria Cove, NL A0G 4N0
P: (709) 676-2155 F: 676-2352

Appendix B - Financial Statements

Grant Thornton

Consolidated Financial Statements

Central Regional Health Authority

March 31, 2016

Contents

Grant Thornton

Independent Auditors' Report

Grant Thornton LLP
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Gander, NL
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To the Board of Trustees of
Central Regional Health Authority

We have audited the accompanying consolidated financial statements of Central Regional Health Authority which comprise the consolidated statement of financial position as at March 31, 2016, and the consolidated statements of operations, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's responsibility for the financial statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the organization's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the organization's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements present fairly, in all material respects, the consolidated financial position of Central Regional Health Authority as at March 31, 2016 and the results of its consolidated operations and changes in net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Grant Thornton LLP

Gander, Canada

June 21, 2016

Chartered Professional Accountants

Central Regional Health Authority
Consolidated Statement of Financial Position

March 31	2016	2015
Financial assets		
Cash	$ **10,431,922**	$ 25,531,798
Receivables (Note 3)	**15,957,582**	17,943,520
Residents' trust funds held on deposit	**663,030**	806,475
Cash restricted for security deposits	**40,022**	37,532
Investments restricted for general endowment purposes (Note 4)	**913,364**	879,504
Replacement reserves (Note 9)	**175,516**	165,156
	28,181,436	45,363,985
Liabilities		
Payables and accruals (Note 5)	**25,830,184**	33,675,620
Employee future benefits		
Accrued vacation	**16,265,510**	15,204,206
Accrued severance (Note 6)	**31,030,200**	29,683,330
Accrued sick (Note 6)	**16,929,710**	16,291,236
Deferred grants (Note 7)	**20,534,777**	25,023,293
Long-term debt (Note 8)	**10,605,429**	11,962,051
Trust funds payable	**663,030**	806,475
Security deposits liability	**40,022**	37,531
Replacement reserves (Note 9)	**175,516**	165,155
J.M. Olds scholarship and library funds	**82,980**	83,731
	122,157,358	132,932,628
Net financial debt	**(93,975,922)**	(87,568,643)
Non-financial assets		
Capital assets (Note 10)	**54,392,100**	56,949,347
Deposits on capital assets	**609,328**	245,810
Inventories (Note 11)	**2,386,331**	2,444,850
Prepaids (Note 12)	**4,705,068**	3,378,348
	62,092,827	63,018,355
Accumulated deficit	$ **(31,883,095)**	$ (24,550,288)

Commitments (Note 14)
Contingencies (Note 15)

On behalf of the Board

Trustee

Trustee

See accompanying notes to the consolidated financial statements

Central Regional Health Authority
Consolidated Statement of Operations

March 31	Budget 2016	Actual 2016	Actual 2015
Revenue			
Provincial plan operating	$ 333,817,303	$ 333,818,528	$ 312,446,952
Provincial capital grants	-	3,591,557	7,097,594
Other capital contributions	-	300,302	457,190
MCP	13,777,431	13,012,427	13,314,663
Patient-resident services	14,315,000	14,758,010	13,768,329
CMHC mortgage interest subsidy	56,982	52,766	55,920
Capital project funding	2,534,785	12,921,284	13,554,791
Recoveries	9,745,500	10,697,425	10,168,053
Cottage operations	1,566,686	1,548,484	1,516,953
Foundations	844,100	1,054,928	919,020
Other revenue	4,494,425	4,723,741	4,039,129
	381,152,212	396,479,452	377,338,594
Expenditure			
Administration	35,724,910	33,774,833	30,990,653
Community and social services	99,449,916	99,162,760	88,081,121
Support services	65,376,360	65,002,319	61,620,657
Nursing inpatient services	85,963,023	90,779,911	87,203,528
Ambulatory care services	25,104,046	25,139,329	21,941,067
Diagnostic and therapeutic services	46,720,089	47,069,948	43,017,097
Medical services	17,816,541	18,182,819	17,754,541
Educational services	1,661,341	1,546,216	1,119,020
Undistributed	925,200	11,821,785	13,637,308
Cottage, operations, including amortization of $512,262 (2015 - $502,817)	1,585,71	1,536,694	1,517,204
Foundations, including amortization of $4,096 (2015 - $4,312)	849,000	798,415	853,750
	381,176,137	394,815,029	367,735,946
Surplus – shareable	(23,925)	1,664,423	9,602,648

See accompanying notes to the consolidated financial statements

Central Regional Health Authority
Consolidated Statement of Operations

March 31	Budget 2016	Actual 2016	Actual 2015
			(continued)
Non-shareable items			
Gain on disposal of capital assets	-	**(28,971)**	25,150
Amortization of capital assets	-	**(5,921,298)**	(6,113,365)
Accrued vacation pay – increase	-	**(1,061,617)**	(1,089,664)
Accrued severance pay – increase	-	**(1,346,870)**	(1,220,831)
Accrued sick pay – increase	-	**(638,474)**	(83,397)
	-	**(8,997,230)**	(8,482,107)
(Deficit) surplus - shareable and non-shareable	**(23,925)**	**(7,332,807)**	1,120,541
Accumulated (deficit)			
Beginning of year	-	**(24,550,288)**	(25,670,829)
End of year	$ -	$ **(31,883,095)**	$ (24,550,288)

See accompanying notes to the consolidated financial statements

Central Regional Health Authority

Consolidated Statement of Changes in Net Financial Assets (Debt)

March 31

	2016	2015
Net debt - beginning of year	**$ (87,568,643)**	$ (91,037,355)
Surplus (Deficit)	**(7,332,807)**	1,120,541
Changes in capital assets		
Acquisition of capital assets	**(4,016,429)**	(7,722,060)
Amortization of capital assets	**6,437,656**	6,620,494
Other adjustments	**-**	167,152
Gain on disposal of capital assets	**28,971**	(25,150)
Proceeds on disposal of capital assets	**107,049**	95,622
Deposits on capital assets	**(363,518)**	(141,418)
Increase (decrease) in net book value of capital assets	**2,193,729**	(1,005,360)
Changes in non-financial assets		
Decrease (increase) in inventories	**58,520**	(204,861)
(Increase) decrease in prepaids	**(1,326,721)**	3,558,392
(Increase) decrease in non-financial assets	**(1,268,201)**	3,353,531
(Increase) decrease in net debt	**(6,407,279)**	3,468,712
Net debt, end of year	**$ (93,975,922)**	$ (87,568,643)

See accompanying notes to the consolidated financial statements

Central Regional Health Authority

Consolidated Statement of Cash Flows

Year ended March 31

	2016	2015
Operating		
Surplus (deficit)	$ (7,332,807)	$ 1,120,541
Amortization	6,437,656	6,620,494
Gain on disposal of capital assets	28,971	(25,150)
Investment losses	(10,191)	(35,787)
	(876,371)	7,680,098
Changes in		
Receivables	1,985,938	470,410
Payables and accruals	(7,845,436)	6,583,505
Accrued vacation pay	1,061,304	1,090,612
Accrued severance pay	1,346,870	1,220,831
Accrued sick pay	638,474	83,397
Deferred grants	(4,488,516)	(2,508,430)
Inventories	58,519	(204,861)
Prepaids	(1,326,720)	3,558,392
Net cash (applied to) provided from operations	(9,445,938)	17,973,954
Financing		
Repayment of long-term debt	(1,356,622)	(1,387,167)
Repayment of capital leases	-	(117,902)
Net changes in J.M. Olds funds	(750)	880
Net cash applied to financing	(1,357,372)	(1,504,189)
Investing		
Additions to capital assets	(4,016,429)	(7,722,060)
Deposits on capital assets	(363,518)	(141,418)
Increase in general endowment fund investments	(23,668)	(39,907)
Proceeds on disposal of capital assets	107,049	95,622
Other adjustments	-	167,152
Net cash applied to investing	(4,296,566)	(7,640,611)
Net (decrease) increase in cash	(15,099,876)	8,829,154
Cash, net of bank indebtedness:		
Beginning	25,531,798	16,702,644
Ending	$ 10,431,922	$ 25,531,798

See accompanying notes to the consolidated financial statements

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

1. Nature of operations

The Central Regional Health Authority ("Central Health") or ("The Authority") is charged with the responsibility for the provision of health care services in the Central region of Newfoundland and Labrador.

The mandate of Central Health is to provide the best possible health and community services and programs which respond to the identified needs of the people of Central Newfoundland and Labrador within available resources.

Central Health is a not-for-profit corporation and is exempt from income taxes and is constituted under the Regional Health Authority's Act.

2. Summary of significant accounting policies

These consolidated financial statements have been prepared in accordance with Canadian public sector accounting standards. Outlined below are those policies considered particularly significant by the Authority.

Basis of consolidation
These consolidated statements represent the consolidated assets, liabilities, revenues and expenses of the following entities which comprise the reporting entity. The reporting entity is comprised of all organizations which are controlled by Central Health including the following:

North Haven Manor Cottages
Valley Vista Cottages
Bonnews Lodge Apartment Complex
Central Northeast Health Foundation
South and Central Health Foundation

Use of estimates
The preparation of consolidated financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and disclosure of contingent assets and liabilities, at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Items requiring the use of significant estimates include accrued severance, accrued sick leave, useful life of tangible capital assets and allowance for doubtful receivables.

Estimates are based on the best information available at the time of preparation of the consolidated financial statements and are reviewed annually to reflect new information as it becomes available. Measurement uncertainty exists in these financial statements. Actual results could differ from these estimates.

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

2. **Summary of significant accounting policies** (cont'd.)

Cash and cash equivalents
Cash and cash equivalents include cash on hand and balances with banks, net of any overdrafts. Bank overdrafts are considered a component of cash and cash equivalents and are secured by approved authority to borrow authorized by the Province's Minister of Health and Community Services.

Revenues
Revenues are recognized in the period in which the transactions or events occurred that gave rise to the revenues. All revenues are recorded on an accrual basis, except when the accruals cannot be determined with a reasonable degree of certainty or when their estimation is impracticable.

Transfers are recognized as revenues when the transfer is authorized, any eligibility criteria are met, and reasonable estimates of the amounts can be made. Transfers are recognized as deferred revenue when amounts have been received but not all eligibility criteria have been met.

Expenses
Expenses are reported on an accrual basis. Expenses are recognized as they are incurred and measurable based upon the receipt of goods and services or the creation of an obligation to pay.

Deferred revenue
Certain amounts are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the delivery of specific services in transactions. These amounts are recognized as revenue in the fiscal year the related expenses are incurred, services are performed or when stipulations are met.

Non-financial assets
Non-financial assets are not available to discharge existing liabilities and are held for use in the provision of services. They have useful lives generally extending beyond the current year and are not intended for sale in the ordinary course of operations. The change in non-financial assets during the year, together with the excess of revenues over expenses, provides the change in net financial assets for the year.

Severance and sick pay liability
An accrued liability for severance is recorded in the accounts for all employees who have a vested right to receive such payments. Severance pay vests after nine years of continuous service. An estimate for the provision of employees with less than nine years of service has been determined by actuarial analysis.

An actuarially determined accrued liability has been recorded on the statements for non-vesting sick leave benefits. The cost of non-vesting sick leave benefits are actuarially determined using management's best estimate of salary escalation, accumulated sick days at retirement, long-term inflation rates and discount rates. Actuarial gains or losses are being amortized to the liability and the related expense straight-line over the expected average remaining service life of the employee group.

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

2. Summary of significant accounting policies (cont'd.)

Inventories
Inventories have been determined using the following methods for the various areas. Cost includes purchase price plus the non-refundable portion of applicable taxes.

General stores	At average cost
Drugs	First-in, first-out

Capital assets
The Authority has control over certain lands, buildings and equipment with the title resting with the Government and consequently these assets are not recorded under capital assets. In accordance with an operating agreement with Newfoundland and Labrador Housing Corporation, certain assets of the North Haven Manor Cottage Units Phase I, II, III, North Haven Manor Cottage Units Phase IV, Valley Vista Cottages, and Bonnews Lodge Apartment Complex are being amortized at a rate equal to the annual principal reduction of the mortgages related to the properties.

Purchased capital assets are recorded at cost. Contributed capital assets are recorded at fair value at the date of contribution. Other capital assets are being amortized on a declining balance basis over their useful lives, at the following rates:

Land improvements	5.0%
Buildings and service equipment	5.0%
Equipment	12.5%
Motor vehicles	20.0%

Capital and operating leases
A lease that transfers substantially all of the risks and rewards incidental to the ownership of property is accounted for as a capital lease. Assets acquired under capital lease result in a capital asset and an obligation being recorded equal to the lesser of the present value of the minimum lease payments and the property's fair value at the time of inception. All other leases are accounted for as operating leases and the related payments are expensed as incurred.

Impairment of long-lived assets
Long-lived assets are reviewed for impairment upon the occurrence of events or changes in circumstances indicating that the value of the assets may not be recoverable, as measured by comparing their net book value to the estimated undiscounted cash flows generated by their use. Impaired assets are recorded at fair value, determined principally using discounted future cash flows expected from their use and eventual disposition.

Replacement reserves
Under certain operating agreements with Newfoundland and Labrador Housing Corporation (NLHC) the Authority is required to maintain a Replacement Reserve Fund which is to be used to fund major maintenance and the purchase of capital assets. These funds may only be used as approved by NLHC. Transactions in the reserves are shown in Note 9.

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

2. Summary of significant accounting policies (cont'd.)

Pension costs
Employees of Central Health are covered by the Public Service Pension Plan and the Government Money Pension Plan administered by the Province of Newfoundland and Labrador. Contributions to the plans are required from both the employees and Central Health. The annual contributions for pensions are recognized in the accounts on a current basis.

Financial instruments
The Authority recognizes a financial asset or a financial liability on its statement of financial position when the Authority becomes a party to the contractual provision of the financial instrument. The Authority initially measures its financial assets and liabilities at fair value, except for certain non-arms length transactions. The Authority subsequently measures all its financial assets and liabilities at amortized cost except for investments restricted for endowment purposes which are subsequently measured at fair value.

Financial assets measured at amortized cost include cash and cash equivalents, receivables, trust funds and replacement reserve funding. Financial assets measured at fair value are investments restricted for endowment purposes.

Financial liabilities measured at amortized cost include bank indebtedness, payables and accruals, employee future benefits, deferred grants, long-term debt, obligations under capital lease, trust funds, security deposits, replacement reserves and scholarship and library funds payable.

Unless otherwise noted, it is management's opinion that the Authority is not exposed to significant interest, currency or credit risks.

3. Receivables

	2016	2015
Operating		
Provincial plan grants - operating	**$ 6,338,500**	$ 8,598,449
Capital grants	**80,000**	287,076
Patient, rents and other	**6,871,890**	5,909,743
MCP	**1,862,650**	2,150,049
Cancer Foundation	**733,022**	678,844
HST	**557,194**	688,051
Due from NLHC	**10,527**	10,527
	16,453,783	18,287,739
Allowance for doubtful	**(496,201)**	(344,219)
	$ 15,957,582	$ 17,943,520

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

4. Investments restricted for general endowment purposes

The Central Northeast Health Foundation Inc. and the South and Central Health Foundation maintain investments restricted for general endowment purposes, with their market value as follows:

	2016	2015
Central Northeast Health Foundation Inc.	$ 262,311	$ 242,936
South and Central Health Foundation	651,053	636,568
	$ 913,364	$ 879,504

5. Payables and accruals

	2016	2015
Operating		
Trade	$ 18,149,335	$ 16,525,421
Due to NLHC subsidy	15,174	12,380
Residents comfort fund	80,073	75,766
Accrued - wages	7,551,459	17,023,608
- interest	34,143	38,445
	$ 25,830,184	$ 33,675,620

6. Employee future benefits

Future employee benefits related to accrued severance and accrued sick obligations have been calculated based on an actuarial valuation as at March 31, 2012 and extrapolated to March 31, 2016. The assumptions are based on future events. The economic assumptions used in the valuation are Central Health's best estimates of expected rates as follows:

	2016	2015
Wages and salary escalation	3.75%	3.75%
Interest	3.70%	2.90%

Based on actuarial valuation of the liability, at March 31, 2016 the results for sick leave are:

Accrued sick pay obligation, beginning	$ 17,999,872	$ 16,535,793
Current period benefit cost	1,862,700	1,704,464
Benefit payments	(2,522,211)	(2,298,789)
Interest on the accrued benefit obligations	685,331	633,307
Actuarial losses	4,412,980	1,425,096
Accrued sick pay obligations, at end	$ 22,438,672	$ 17,999,871

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

6. Employee future benefits (continued)

	2016	2015
Based on actuarial valuation of the liability, at March 31, 2016 the results for severance are:		
Accrued benefit obligation, beginning	**$ 33,140,527**	$ 29,468,470
Current period benefit cost	**2,378,599**	1,957,955
Benefit payments	**(2,246,598)**	(2,009,693)
Interest on the accrued benefit obligation	**943,949**	1,148,262
Actuarial losses	**(3,823,739)**	2,575,533
Accrued severance obligation, at end	**$ 30,392,738**	$ 33,140,527

A reconciliation of the accrued benefit obligation and the accrued benefit liability is as follows:

Sick benefits

Accrued benefit obligation	**$ 22,438,672**	$ 17,999,871
Unamortized actuarial gains (losses)	**(5,508,962)**	(1,708,635)
Accrued benefit liability	**$ 16,929,710**	$ 16,291,236

Severance benefits

Accrued benefit obligation	**$ 30,392,738**	$ 33,140,527
Unamortized actuarial losses	**637,462**	(3,457,197)
Accrued benefit liability	**$ 31,030,200**	$ 29,683,330

7. Deferred grants

	2016	2015
Deferred operating grants	**$ 1,347,325**	$ 2,579,863
Deferred capital grants	**19,187,452**	22,443,430
	$ 20,534,777	$ 25,023,293

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

8. Long-term debt

	2016	2015
Operating		
0.99% CMHC mortgage on Lakeside Homes; repayable in equal monthly instalments of $11,734, interest included; maturing April, 2020, renewable April, 2020.	**$ 563,281**	$ 695,009
7.5% CMHC mortgage on Lakeside Homes; repayable in equal monthly instalments of $4,574, interest included; maturing July, 2023.	**310,852**	341,484
1.59% Canadian Imperial Bank of Commerce deferred demand loan; repayable in equal monthly instalments of $3,056, plus interest; maturing December, 2018.	**100,769**	137,441
3.53% Canadian Imperial Bank of Commerce loan for Carmelite House, unsecured; repayable in equal monthly instalments of $58,386, interest included; maturing January, 2027.	**6,299,814**	6,769,037
2.97% Canadian Imperial Bank of Commerce mortgage on 3 Twomey Dr, Botwood housing; repayable in equal monthly instalments of $384, interest included; maturing June, 2027, renewable July, 2018.	**44,092**	47,349
2.89% Canadian Imperial Bank of Commerce mortgage on 145 Commonwealth Ave, Botwood housing; repayable in equal monthly instalments of $347, interest included; maturing July, 2027, renewable August, 2018.	**39,939**	42,904
8.0% Newfoundland and Labrador Housing Corporation mortgage on Valley Vista Senior Citizens Home; repayable in equal monthly instalments of $10,124, interest included; maturing August, 2027.	**915,431**	962,662

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

8. **Long-term debt** (cont'd.)	**2016**	2015
7.88% Newfoundland and Labrador Housing Corporation mortgage on Authority offices; repayable in equal monthly instalments of $8,165, interest included; maturing October, 2024.	**611,018**	659,292
1.82% Newfoundland and Labrador Housing Corporation mortgage on Valley Vista Senior Citizens Home; repayable in equal monthly instalments of $7,752, interest included; maturing July, 2019.	**300,592**	387,293
2.99% Bank of Nova Scotia 1st mortgage on land and building at 1 Newman's Hill, Twillingate; repayable in equal monthly instalments of $406, interest included; maturing July, 2024, renewable May, 2017.	**35,912**	39,655
2.99% Bank of Nova Scotia 1st mortgage on land and building at 42 Howlett's Road, Twillingate; repayable in equal monthly instalments of $352, interest included; maturing April, 2020, renewable May, 2017.	**16,210**	19,891
2.89% Bank of Nova Scotia 1st mortgage on land and building at 30 Smith's Lane, Twillingate; repayable in equal monthly instalments of $350, interest included; maturing July, 2020, renewable December, 2016.	**17,085**	20,736
	9,254,995	10,122,753
North Haven Manor Cottages Phase I, II, III		
4.25% Industrial Alliance Insurance and Financial Services Inc. mortgage on North Haven Manor Cottages; repayable in equal monthly instalments of $8,668, interest included; maturing December, 2016.	**$ 76,660**	$ 175,185
1.64% Newfoundland and Labrador Housing Corporation mortgage on North Haven Manor Cottages; repayable in equal monthly instalments of $8,541, interest included; maturing November, 2018.	**267,234**	364,477
	343,894	539,662

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

8. **Long-term debt** (cont'd.)

	2016	2015
North Haven Manor Cottages Phase IV		
1.67% Newfoundland and Labrador Housing Corporation mortgage on North Haven Manor Cottages; repayable in equal monthly instalments of $3,029, interest included maturing July, 2025, renewable April, 2017.	**313,927**	344,752
Valley Vista Cottages		
2.26% Newfoundland and Labrador Housing Corporation mortgage on Valley Vista Cottages; repayable in equal monthly instalments of $4,865, interest included; maturing June, 2016.	**14,515**	71,863
1.53% Newfoundland and Labrador Housing Corporation mortgage on Valley Vista Cottages; repayable in equal monthly instalments of $9,738, interest included; maturing December, 2017.	**201,534**	314,366
1.67% Newfoundland and Labrador Housing Corporation mortgage on Valley Vista Cottages; repayable in equal monthly instalments of $4,807, interest included; maturing May, 2018, renewable June, 2016.	**122,650**	177,789
	338,699	564,018
Bonnews Lodge Apartment Complex		
2.04% Newfoundland and Labrador Housing Corporation 1st mortgage on Bonnews Apartment Complex; repayable in equal monthly instalments of $3,714, interest included; maturing November, 2024, renewable April, 2019.	**353,914**	390,866
	$ 10,605,429	$ 11,962,051

The aggregate amount of principal payments estimated to be required in each of the next five years and thereafter is as follows:

2017	$ 1,331,020
2018	1,247,923
2019	1,106,386
2020	975,477
2021	844,759
Thereafter	5,099,863

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

9. Replacement reserves

	2016	2015
Balance, beginning	**$ 165,155**	$ 159,399
Add:		
Allocation for year	**60,220**	60,220
Contributions from Authority	**12,900**	12,900
	238,275	232,519
Less:		
Approved expenditures	**62,759**	67,364
Balance, ending	**$ 175,516**	$ 165,155
Funding		
Replacement reserve funds	**$ 30,473**	$ 20,112
Due from Newfoundland and Labrador Housing Corporation	**145,043**	145,043
	$ 175,516	$ 165,155

10. Capital assets

	Cost	Accumulated Amortization	2016 Net Book Value	2015 Net Book Value
Operating				
Land	$ 551,225	$ -	**$ 551,225**	$ 553,384
Land improvements	1,212,046	901,045	**311,001**	336,675
Buildings and service equipment	74,007,758	54,228,563	**19,779,195**	21,222,347
Equipment	126,820,882	94,059,557	**32,761,325**	33,748,509
Equipment under capital lease	2,781,898	2,604,185	**177,713**	225,106
Motor vehicles	2,959,681	2,159,684	**799,997**	849,663
Motor vehicles under capital lease	196,503	184,859	**11,644**	13,663
	$ 208,529,993	$ 154,137,893	**$ 54,392,100**	$ 56,949,347

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

11. Inventories

	2016	2015
General stores	$ 1,067,817	$ 1,100,408
Drugs	1,318,514	1,344,442
	$ 2,386,331	$ 2,444,850

12. Prepaids

	2016	2015
Operating		
Equipment maintenance	$ 2,206,328	$ 1,083,986
Malpractice and membership fees	66,177	108,094
General insurance	263,531	208,305
Municipal taxes	786,596	810,650
Other	1,382,436	1,167,313
	$ 4,705,068	$ 3,378,348

13. Line of credit

The Authority has access to a $15 million line of credit in the form of revolving demand loans at its bankers. These loans have been approved by the Minister of Health and Community Services. This line of credit was unused at March 31, 2016 and March 31, 2015.

14. Commitments

Operating leases

The Authority has a number of agreements whereby it leases property and equipment. These agreements range in terms from one to five years. These leases are accounted for as operating leases. Future minimum lease payments under operating leases are as follows:

2017	$ 432,696
2018	352,898
2019	279,838
2020	227,540
2021	93,039

Central Regional Health Authority
Notes to the Consolidated Financial Statements
March 31, 2016

15. Contingencies

As of March 31, 2016 there were a number of legal claims against the Authority in varying amounts for which no provision has been made. It is not possible to determine the amounts, if any, that may ultimately be assessed against the Authority with respect to these claims, but management and the insurers believe any claims, if successful, will be covered by liability insurance.

Appendix C - Board of Trustees

John George, Chair

David Dove, Vice Chair

David Brown, Trustee

Rhonda Byrne, Trustee

Dermot Flynn, Trustee

Marjorie Gaulton, Trustee

Valerie Hoskins, Trustee

Rick LeDrew, Trustee

Gerard O'Brien, Trustee

Bill O'Reilly, Trustee

Donald Sturge, Trustee

Sunflower from garden at Dr. Hugh Twomey Health Centre, Botwood, NL

Appendix D - Key Contact Information

Ms. Rosemarie Goodyear – President & CEO
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Mr. Terry Ings – Vice President, Human Resources & Support Services
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Mr. Sean Tulk – Vice President, Information Management & Chief Operating Officer for Central Newfoundland Regional Health Centre
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South and Central Health Foundation
Main Lobby
Central Newfoundland Regional Health Centre
P.O. Box 739, Grand Falls-Windsor, NL A2A 2K2
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Appendix E - Mandate

Central Health's mandate is derived from the *Regional Health Authorities Act* and its regulations. Central Health is responsible for the delivery and administration of health services and community services in its health region in accordance with the above referenced legislation.

In carrying out its responsibilities, Central Health will:

- promote and protect the health and well-being of its region and develop and implement measures for the prevention of disease and injury and the advancement of health and well-being;
- assess health services and community services needs in its region on an ongoing basis;
- develop objectives and priorities for the provision of health services and community services which meet the needs of its region and which are consistent with provincial objectives and priorities;
- manage and allocate resources, including funds provided by government for health services and community services, in accordance with legislation;
- ensure that services are provided in a manner that coordinates and integrates health and community services;
- collaborate with other persons and organizations including federal, provincial and municipal governments and agencies and other regional health authorities to coordinate health services and community services in the province and to achieve provincial objectives and priorities;
- collect and analyze health and community services information for use in the development and implementation of health and community services policies and programs for its region;
- provide information to the residents of the region respecting:
    - the services provided by the Authority,
    - how they may gain access to these services,
    - how they may communicate with the Authority respecting the provision of those services;
- monitor and evaluate the delivery of health services and community services in compliance with prescribed standards and provincial objectives and in accordance with guidelines that the Minister may establish for the Authority;
- comply with directions the Minister may give.

Central Health will ensure accountability for its strategic and operational plans by monitoring and reporting in accordance with legislative, regulatory and policy requirements.

Central
Health