Together we can

Annual Performance Report

2014 ◆ 2015

Eastern Health

Eastern Health

ANNUAL PERFORMANCE REPORT

2014-15

Table of Contents

Message from the Board of Trustees

On behalf of the Board of Trustees of Eastern Health, it is my pleasure to provide this Annual Performance Report for 2014-15. This report outlines the progress on the first year of our Strategic Plan, *Together We Can,* for the planning period of 2014-17.

Throughout the past year, our organization has renewed focus on the four priority areas outlined in our Strategic Plan: **quality and safety, access, sustainability** and **population health**. In this Annual Performance Report, we provide an overview of the progress made on the objectives outlined in the first year of our Strategic Plan. Progress towards these objectives are monitored by a number of key indicators associated with each of our priorities. We also highlight our many accomplishments and note areas where improvement is required as we transition to focus on our objectives for 2015-16.

The ongoing level of commitment and passion demonstrated by the employees, physicians and volunteers within this organization is commendable. Our Annual Performance Report provides us the opportunity to communicate progress and demonstrate commitment and passion to the public, as we work toward our vision of *Healthy People, Healthy Communities*.

As per legislated requirements, Eastern Health's Board of Trustees is accountable for the actual results reported.

Michael J. O'Keefe
Chair, Board of Trustees

Board of Trustees (Top row, l-r): Michael J. O'Keefe (Chair), William Abbott, Robert Andrews, Barbara Cribb, Cindy Goff; (Bottom row, l-r): Bill McCann, Sister Sheila O'Dea, Leslie O'Reilly, Shirley Rose, Frank Ryan

Government Entity Overview

The Eastern Regional Health Authority (Eastern Health) is Newfoundland and Labrador's largest integrated health authority, serving a population of approximately 300,000[1]. The organization provides a full continuum of health and community services, including public health, long-term care, and acute (hospital) care.

In addition to regional programs and services, Eastern Health is responsible for provincial tertiary-level health services[2] through both academic health care facilities and provincial programs, such as Provincial Genetics, Hyperbaric Medicine and the Provincial Public Health Laboratory. Eastern Health also partners with numerous organizations – most notably Memorial University and the College of the North Atlantic – to educate future health professionals, conduct research, advance knowledge, and improve overall patient, client and resident care.

Eastern Health had a budget of approximately $1.39 billion for the 2014-15 fiscal year, with 12,744 employees[3] and 730 physicians (265 of which are salaried). The organization also benefitted from approximately 1,534 volunteers[4] who provided 60,228 hours[5] of volunteer work around the region[6]. Volunteer activities range from one-on-one interactions (e.g. friendly visiting) to large group events with community partner agencies (e.g. dinners and concerts).

Eastern Health continues to benefit from the enormous efforts of its six foundations: Burin Peninsula Health Care Foundation, Discovery Health Care Foundation, Dr. H. Bliss Murphy Cancer Care Foundation, Health Care Foundation, Janeway Children's Hospital Foundation and Trinity Conception Placentia Health Foundation. Each of these foundations is governed by a volunteer board of directors and works to raise funds for numerous types of equipment, facilities, programs and services.

Additionally, auxiliaries are associated with most of Eastern Health's acute care and long-term care facilities. These volunteer groups provide a range of services that include coordinating volunteers and fundraising through gift shops operation.

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[1] 306,259 in Census 2011

[2] Tertiary care is specialized consultative health care, usually for inpatients on referral. It is generally for advanced medical investigation and treatment. Examples include cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions.

[3] The number of employees provides a general "snapshot", as there are fluctuations such as summer hiring. This number is provided as of March 31, 2015.

[4] This is the average number of volunteers who provided service to Eastern Health on a quarterly basis (6,134 volunteers/ four quarters = 1,534 volunteers). This is the best indicator of the number of volunteers as it accounts for re-occurring volunteers.

[5] This number reflects the total number of hours contributed by the 6,134 (re-occurring and new) volunteers.

[6] Volunteer services are provided at the following sites: City Hospitals (Health Sciences Centre, St. Clare's Mercy Hospital, Waterford Hospital, Miller Centre/Caribou Memorial Veterans Pavilion, Dr. Walter Templeman Health Care Centre - Bell Island); City Long-term Care (St. Patrick's Mercy Home, Masonic Park, Agnes Pratt, St. Luke's, Hoyles-Escasoni, Glenbrook Lodge); Peninsulas (Golden Heights Manor, U.S. Memorial, Blue Crest Home, Burin Peninsula Health Care Centre, Dr. G.B. Cross Memorial Hospital); Rural Avalon (Harbour Lodge, Interfaith, Pentecostal Senior Citizens' Home, Placentia Health Centre/Lions Manor, Carbonear General Hospital).

The Region

Eastern Health's geographic boundaries include the portion of the province east of (and including) Port Blandford. This 21,000-km^2 region includes the entire Burin, Bonavista and Avalon Peninsulas, as well as Bell Island.

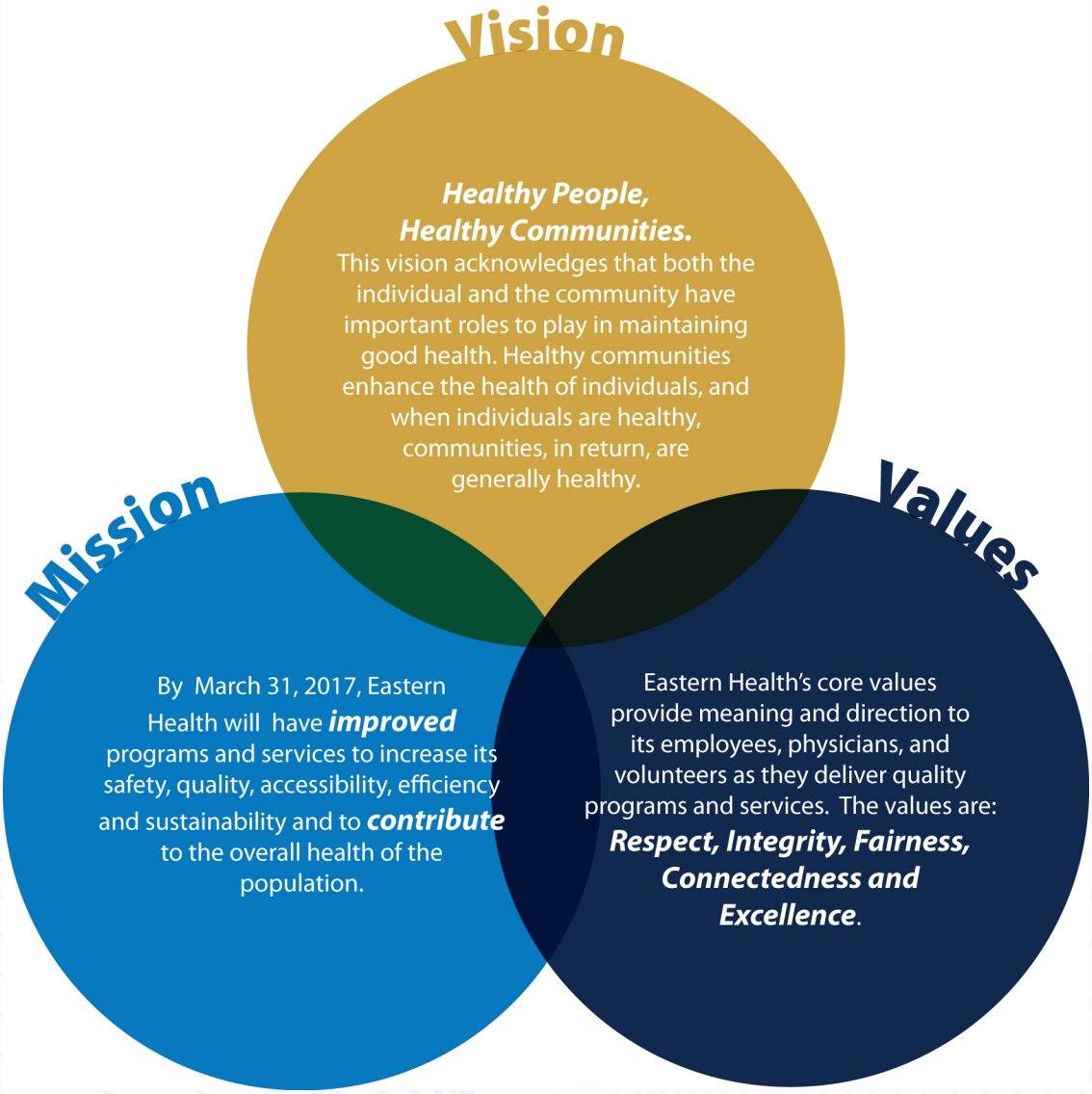
The Eastern Health region includes 111 incorporated municipalities, 69 local service districts and 66 unincorporated municipal units. The organization operates sites in the communities noted on the map below (Figure 1):

Figure 1: Communities with Eastern Health Sites

Vision, Mission and Values

The vision of Eastern Health is ***Healthy People, Healthy Communities***. By aligning its core values and mission throughout its lines of business, Eastern Health is working towards accomplishing this vision. Figure 2 below outlines the organization's vision, mission, and values.

Figure 2: Eastern Health's Vision, Mission and Values



Lines of Business

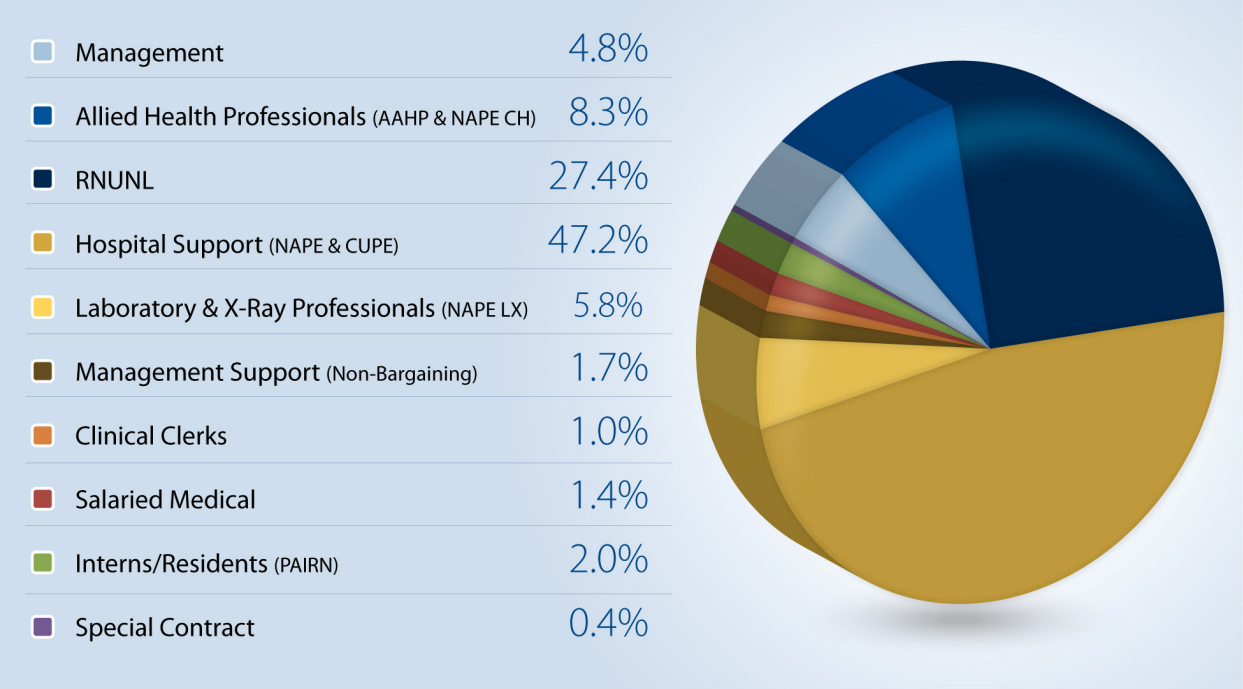
Eastern Health's lines of business are the programs and services delivered to patients, clients, residents and their families. These programs and services improve the health and well-being of individuals and communities across the continuum of health and at all stages of life. Eastern Health has four main lines of business: **1) Promote Health and Well-Being; 2) Provide Supportive Care; 3) Treat Illness and Injury; and 4) Advance Knowledge.**

Eastern Health offers a wide variety of health and community services throughout the region and, in many cases, throughout the province. Each program and service has its own access criteria and local health professionals work with individuals and families to determine the most appropriate services based on identified needs. A detailed listing of Eastern Health's lines of business is available in *Strategic Plan 2014-17: Together We Can* and can be found at **www.easternhealth.ca**.

Employees

As of March 31, 2015, Eastern Health had 12,744 employees, approximately 82 per cent of whom were female. Figure 3 shows Eastern Health employees by classification.[7]

Figure 3: Eastern Health Employees by Classification



[7] Acronyms included in the graph are as follows: AAHP: Association of Allied Health Professionals; CUPE: Canadian Union of Public Employees; NAPE: Newfoundland Association of Public Employees: NAPE LX: Lab and X-ray; NAPE CH: Community Health; NAPE HP: Health Professionals; RNUNL: Registered Nurses' Union Newfoundland & Labrador; PAIRN: Professional Association of Interns and Residents of Newfoundland.

Provincial Mandate

Eastern Health has a regional mandate, as outlined in Appendix I, as well as unique provincial responsibilities for tertiary level institutional services, including:

- Cancer Care
- Cardiac and Critical Care
- Children and Women's Health
- Diagnostic Imaging
- Laboratory Services
- Mental Health and Addictions
- Rehabilitation
- Surgery

In efforts to bring services closer to where people live, the organization administers the following provincial outreach programs outside of Eastern Health's geographic boundaries:

- Child Rehabilitative Clinics
- Regional Cancer Centres
- Satellite Systemic Therapy (Chemotherapy) Clinics

In addition, Eastern Health also administers distinct provincial services as follows:

- Cardiac Genetics
- Hyperbaric Medicine
- Medical Control and Registration of Pre-Hospital Care Providers
- Neonatal Transport Team
- Provincial Air Ambulance
- Provincial Equipment Program - Community Living and Supportive Services
- Provincial Fertility Services
- Provincial Genetics
- Provincial Health Ethics Network Newfoundland and Labrador (PHENNL)
- Provincial Insulin Pump Program (up to age 25 years)
- Provincial Kidney Program
- Provincial Organ Procurement Program
- Provincial Pediatric Advice and Poison Control Lines
- Provincial Pediatric Enteral Feeding Program
- Provincial Perinatal Program
- Provincial Public Health Laboratory
- Provincial Synagis® Program – Respiratory Syncytial Virus (RSV)
- Stem Cell Transplantation

Eastern Health has ongoing education and research roles within the academic health sciences community and has particularly strong affiliations with Memorial University to further this aspect of the provincial mandate.

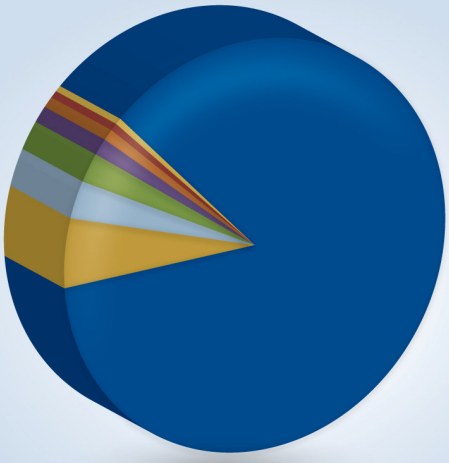
Revenues and Expenditures

Figure 4 shows Eastern Health's operating revenue and expenditures for 2014-15. See Appendix III for Audited Financial Statements in full detail.

Figure 4: Eastern Health's Operating Revenue and Expenditures by Sector for 2014-15

Operating Revenue

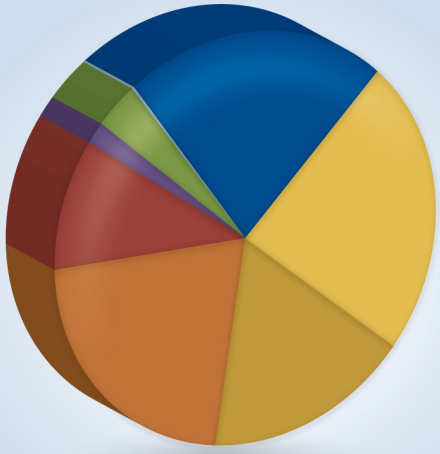
$1,429,033,000



Provincial Plan	$1,232,070,000
Medical Care Plan	$77,434,000
Other [8]	$41,500,000
Provincial Plan Capital Grant	$31,878,000
Resident	$18,479,000
Inpatient	$12,422,000
Outpatient	$8,225,000
Other Capital Contributions	$7,025,000

Expenses

$1,423,494,000



Acute Care	$668,943,000
Community	$228,683,000
Long-Term Care	$161,961,000
Support	$214,319,000
Administration	$97,680,000
Research and Education	$16,124,000
Amortization of Tangible Capital Assets	$33,975,000
Employee Future Benefits	$1,809,000

[8] Examples of other revenue consists of recoveries for shared compensation, Workers' Compensation, and dispensing fee recoveries.

Shared Commitments

Partnerships are integral to Eastern Health's ability to fulfill its mandate and to address the strategic directions of the Provincial Government. Throughout 2014-15, Eastern Health continued to foster partnerships with many groups including:

- federal/provincial/municipal governments;
- crown corporations such as the Newfoundland and Labrador Centre for Health Information;
- educational institutes including Memorial University and the College of the North Atlantic;
- volunteer groups and auxiliaries;
- faith and fraternity based owner boards for long-term care services;
- a diverse range of community-based organizations;
- physicians and private services providers;
- professional associations and unions; and
- the general public.

Eastern Health also maintains a unique relationship with the hospital/health centres in Saint-Pierre et Miquelon based on a 1994 agreement between Canada and France. Tripartite agreements with Caisse de Prévoyance Sociale (CPS) and Centre Hospitalier F. Dunan (CHFD) enables Eastern Health to provide services to its French neighbours when required.

Some of the many examples of Eastern Health`s partnerships towards enhancing health service delivery over the past year include:

Healthy Aging

Eastern Health opened the Jim Shields Garden (the "wandering garden") at the Caribou Memorial Veterans Pavilion in July 2014, in partnership with the Health Care Foundation and the Royal Canadian Legion – and with the support of Veterans Affairs Canada, the provincial government and various other military and veterans associations. This garden will allow veterans to enjoy the outdoors, in a secure and safe environment, reflecting Eastern Health's priority of safe, quality care.

Community Development

Eastern Health also recognizes the importance of collaborating with a broad-range of external groups, such as community-based organizations, to work towards common goals and objectives for the mutual benefit of Eastern Health and the population it serves. One of many examples of such partnerships during 2014-15 includes Eastern Health's $50,000 Community Development Fund, which provides grants to community organizations and groups that identify and take action on priority needs contributing to healthier communities. The Community Development Fund aligns with the Government of Newfoundland and Labrador's Strategic Direction Population Health.

For example, the Sir William Ford Coaker Heritage Foundation received a $10,000 Community Development Grant during 2014-15 to develop a project to strengthen the social support networks in Port Union by providing opportunities for youth and seniors to come together to exchange skills and knowledge through storytelling, crafts, and digital media technology.

Mental Health and Addictions

Throughout the year, Eastern Health availed of many opportunities to discuss addictions and substance abuse issues with various groups across the region to increase awareness of problematic substance abuse and the available supports. One example includes the great work completed during National Addictions Awareness Week. In November 2014, Eastern Health held an open forum in Marystown and St. John's in partnership with the Newfoundland and Labrador English School District; Memorial University; and community groups and representatives. Close to 100 people participated in the forums, which focused on a range of awareness topics including understanding addictions; alcohol and culture; drug impaired driving and harm reduction.

Quality Health Care

Eastern Health, in collaboration with the Dr. H. Bliss Murphy Cancer Care Foundation and the Government of Newfoundland and Labrador, offered the third competition for research funding on areas of concern identified by the Cameron Inquiry as they apply to patient care, including cancer care, within the province's health care system. The objective of this program of funding is to increase the scope and scale of research and evaluation activities that can improve care for patients in this province, including those with cancer.

Similarly, Eastern Health collaborated with Cancer Care Nova Scotia and the Prince Edward Island Cancer Treatment Centre, with funding from the Canadian Partnership Against Cancer (through Health Canada) to improve patient experiences. This collaboration resulted in a Screening for Distress Program, which focuses on person-centred care and supports active involvement of patients and their families in decision-making about individual options and the care process. The program will help health care professionals identify and address physical, psychological, emotional, social, practical and spiritual challenges cancer patients face, thereby improving patients' quality of life.

Highlights and Accomplishments

During 2014-15, Eastern Health's operational and work plans focused on ensuring that ***quality and safety*** is threaded throughout the organization; that residents have ***access*** to the right interventions at the right time and the right place; ***sustainability*** by striving for a healthier workplace; and ***population health*** by promoting healthy lifestyles and preventing health problems before they occur. The following section outlines some of Eastern Health's key highlights, accomplishments and good news stories over the past year, all of which demonstrate the organization's commitment to the Government of Newfoundland and Labrador's strategic directions as communicated by the Minister of Health and Community Services.

New President and Chief Executive Officer (CEO)

Eastern Health welcomed a new President and CEO, David Diamond, on November 1, 2014. Mr. Diamond joined Eastern Health following an extensive career within the health system in Alberta and brought with him over 25 years of health care experience. Mr. Diamond replaced interim CEO, Don Keats, who temporarily held the position during the transition period upon the departure of the outgoing CEO, Vickie Kaminski, following her five years of leadership.

Bridge the gAPP

Eastern Health launched its first health-related mobile app, Bridge the gAPP, to support and promote mental wellness amongst youth in Newfoundland and Labrador. The free mobile app covers a variety of topics that are important to youth experiencing mental health issues. The app is an initiative of Eastern Health's Bridges Program, a community-based mental health service that provides therapy and support to youth between the ages of 13 to 18. The idea for the app was inspired by the program's waiting room, which is filled with artwork created by patients, including drawings, poems, quotes and songs. Through an interactive component, Bridge the gAPP gives youth the opportunity to encourage their peers to ask for help. The app also provides youth access to a number of mental health resources. The development of Bridge the gAPP was made possible through a $50,000 grant from the Canada Post Community Foundation, as well as funding from the Janeway Children's Hospital Foundation. Information about the app is also available at **www.bridgethegAPP.ca**. This initiative demonstrated the organization's commitment to the Government of Newfoundland and Labrador's strategic direction of Access.

Ebola Preparedness

Eastern Health developed and implemented protocols to ensure it is prepared to manage Ebola cases should they present in the region or province. During 2014-15, the organization developed contact tracing documentation; conducted Ebola preparedness education for employees, including instruction on enhanced Personal Protective Equipment; reviewed and enhanced supply of required equipment; and developed patient/family education materials. Furthermore, Eastern Health participated in simulated emergency preparedness exercises across the region in collaboration with other Regional Health Authorities, HCS and the Medical Officers of Health (MOH). A detailed preparedness exercise was held at the Health Sciences Centre and the Janeway Children's Health and Rehabilitation Centre. It involved a team of relevant experts who followed a patient through various scenarios and provided guidance and support to the employees who would care for the patient.

UR a Parent

In November 2014, Eastern Health launched the UR a Parent campaign to promote positive parenting. Initiatives covered under the campaign include a website covering a variety of topics such as milestones, brain development, challenging behaviours and reading skills; Facebook ads for target demographics; and communications during routine two- and six-month baby check-ups encouraging parents to visit the website **www.easternhealth.ca/URaParent.**

Adult Central Intake for Mental Health and Addictions

During September 2014, Eastern Health announced the implementation of an adult central intake service. This initiative aims to improve access for clients to mental health and addictions services in the St. John's region; streamline referrals from physicians and other health care professionals; enhance navigation through the system via a single point of entry; and monitor service wait lists in order to identify ways to improve them. Eight primary mental health and addictions services were included in central intake: Addictions Outpatient Services, Community Connections, Community Mental Health Counselling, LeMarchant House, START Clinic, Strengths Team (Case Management), Terrace Clinic and Outpatient Psychiatry. This initiative demonstrated Eastern Health's commitment to Government's strategic direction of Access.

Stroke Direct Transport Protocol

Improved access to the ***right intervention for the right client at the right time and in the right place*** has been identified as one of Eastern Health's key priorities in its 2014-2017 Strategic Plan. Similarly, the Government of Newfoundland and Labrador has identified Rural Health and Wait Times as focus areas under their strategic direction of Access. In line with these priorities, the organization implemented a new stroke direct transport protocol during August 2014. Keeping with national best practices for emergency stroke care, patients suspected of a stroke will now be directly transferred to one of five Regional Stroke Centres rather than the geographically-closest emergency facility. Regional Stroke Centres with capacity for thrombolytic therapy (e.g. CT scanner and physicians who can administer tPA, a drug that can stop a stoke cause by a blood clot) are located at the Health Sciences Centre and St. Clare's Mercy Hospital (St. John's), Carbonear General Hospital, Dr. G. B. Cross Memorial Hospital (Clarenville) and Burin Peninsula Health Care Centre.

Molecular Imaging

The organization began phase two construction of the new molecular imaging facility at the Health Sciences Centre in June 2014. This new facility houses a PET/CT scanner and a medical cyclotron, a device used to create medical isotopes needed for PET/CT imaging. PET/CT imaging combines two tests: the CT provides structural information about human anatomy, while PET provides functional information about how the patient's organ systems work and function. While a PET/CT scanner is a vital diagnostic tool most commonly used to detect, assess and determine treatment for a large number of cancers, this technology is also used for the assessment and diagnosis of cardiac disease and some neurological disorders (e.g., Alzheimer's disease and Parkinson's disease). The project is in line with Government's strategic direction of Access and the focus on Infrastructure.

New Long-term Care Facility

Eastern Health opened its new long-term care facility in St. John's, which replaced the Hoyles-Escasoni Complex, on September 15, 2014. The new facility has 460 beds and is comprised of four separate linked buildings, with space for recreation therapy, physiotherapy, occupational therapy, spirituality, support services and utilities. The facility also has protective care units for individuals with dementia, continued services for bariatric care, enhanced short stay services (e.g. respite and convalescence care) as well as specialized behavioural services for seniors. The project is also in line with Government's strategic direction of Access and the focus on Infrastructure.

New Protective Community Care Residence

A new 12-bed protective community care residence officially opened in Bonavista in October 2014. Through an investment of approximately $2.6 million, local residents have increased access to specialized care designed to meet the unique needs of individuals with dementia. The protective community care residence is designed to provide a home-like environment, supported by specifically trained staff, for individuals with dementia. The facility includes an onsite residential style kitchen, dining facilities, and lounge and recreation areas.

New Youth Treatment Centre (Tuckamore Centre)

The new Youth Treatment Centre in Paradise opened on September 24, 2014. Tuckamore Centre supports youth with complex mental health needs and can accommodate up to 12 young people ages 12 to 18. The facility has three separate living quarters, each containing four bedrooms with private bathrooms, a kitchen and lounge area. The centre also has a school area, a multipurpose room, a gym and physical fitness room and a dedicated space for overnight stays for visiting family. The centre provides a safe environment for young people with structure and routine, incorporating everyday life experiences as a guide to daily living and coping skills. The new centre aligns with Government's strategic direction of Access and the focus on Mental Health and Addictions.

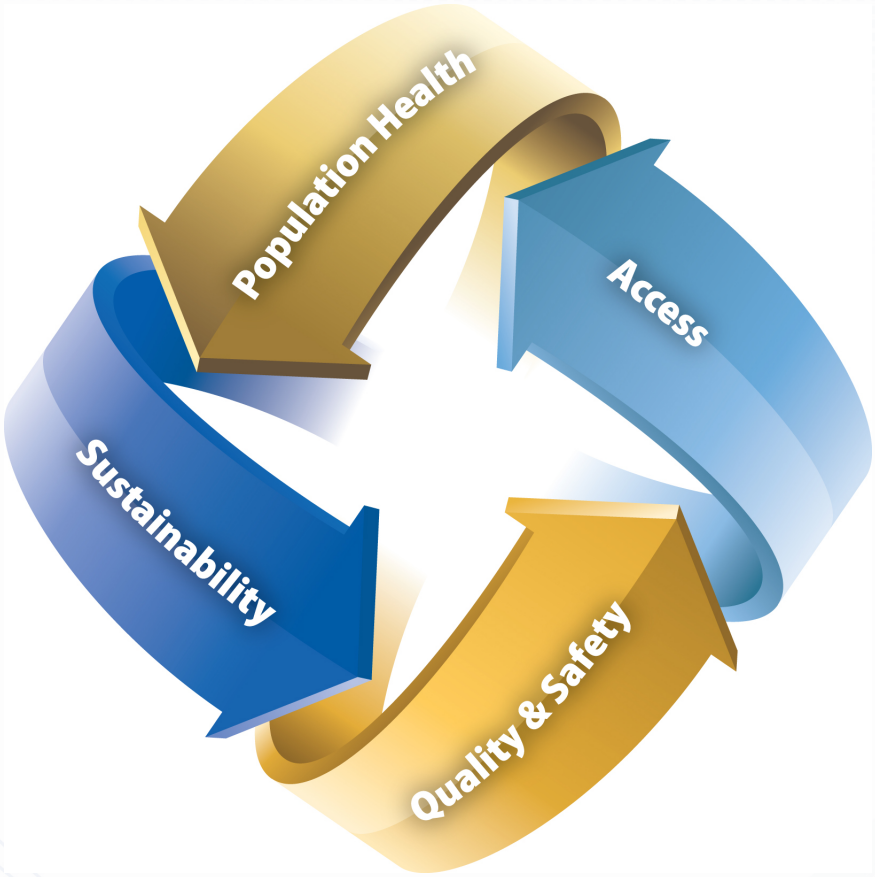
Continued Operational Improvement

Eastern Health worked with representatives from Health Care Management (HCM) during 2014-15 to complete further benchmarking, building upon the process improvement initiatives undertaken by the organization over the past two years. HCM again compared Eastern Health's performance with that of peers within Newfoundland and Labrador and Ontario to identify variances and opportunities to reduce costs/eliminate inefficiencies. The benchmarking review identified potential operational improvements throughout the organization's programs and services, it also identified many areas that are now achieving, or are significantly closer to meeting, the goal of operating at Median Performance[9] compared with high performing national peers. Eastern Health is continuing to work on identified areas for improvement and providing managers with ongoing information and analysis on operations to support continued improvement. This extensive work demonstrates Eastern Health's commitment to Government's Strategic Direction of An Accountable, Sustainable, Quality Health and Community Services System.

[9] Median performance refers to the organizations that perform in the middle, with half of their peers performing better and the other half performing worse.

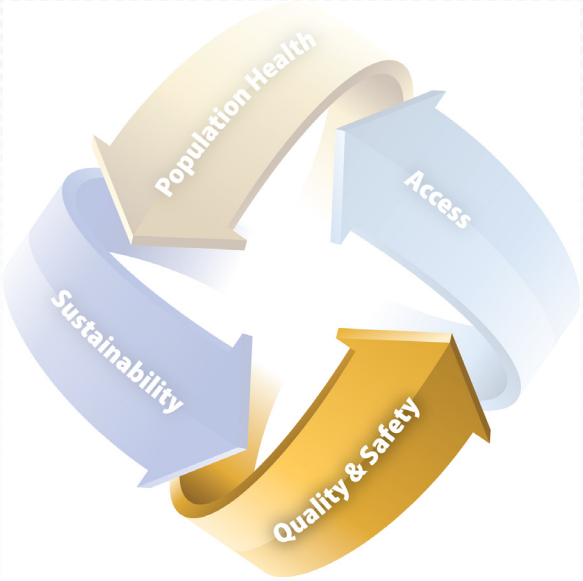
Report on Performance

Eastern Health's strategic plan, *Together We Can*, was developed for 2014-17 as per the legislative requirements of the *Transparency and Accountability Act*. The plan is available at www.easternhealth.ca. For this planning period, four priority issues were identified: **Quality and Safety, Access, Sustainability**, and **Population Health**.



The various components of the plan are supported through an Operational Plan as well as numerous work plans within individual program areas across the organization. Appendix II provides definitions for all indicators identified.

Quality and Safety



In striving to provide a caring and compassionate environment, Eastern Health's strategic priority of Quality and Safety must be threaded throughout the organization. Creating a strong culture of quality and safety provides a firm foundation for all services and care provided, whether in the community, acute care sites or long-term care facilities.

Through monitoring of and acting on meaningful indicators, Eastern Health is demonstrating a commitment to a stronger culture of quality and safety and providing evidence that a focus on quality and safety is an integral part of the organization's daily operations. This priority also aligns with the Provincial Government's Strategic Direction of an Accountable, Sustainable, Quality Health and Community Services System.

Goal

By March 31, 2017, Eastern Health will have improved the culture of quality and safety throughout the organization.

Year 1 Objective

- By March 31, 2015, Eastern Health will have finalized its Safety Culture Strategy.

Measure

- Safety Culture Strategy finalized

2014-15 Quality And Safety Indicators

Planned Indicators	*Actual Performance*
Finalized a Safety Culture Strategy	Eastern Health finalized its safety culture strategy during 2014-15. This strategy, entitled ***Safety Culture Strategy: Safer Together,*** outlines a systematic approach that is intended to contribute to a stronger, more consistent safety culture throughout Eastern Health. Initiatives undertaken in 2014-15 included Walk-the-Talk[10] and Quality and You[11] initiatives led through the Quality, Patient Safety and Risk Management department to introduce the strategy and focus on key quality and safety messages relevant to each program and service area. Programs and departments incorporated the strategy into their Operational Plans and report bi-annually on the progress of their specified safety initiatives.
Developed and monitored the following indicators: ▪ Rate of hand hygiene compliance ▪ Percentage of Medication Reconciliation compliance (Accreditation Canada ROP) ▪ Hospital Standardized Mortality Ratio (HSMR)	During 2014-15, Eastern Health developed and monitored specific Quality and Safety indicators including: rate of hand hygiene compliance; the percentage of Medication Reconciliation compliance (Accreditation Canada ROP); and the Hospital Standardized Mortality Ratio (HSMR). ***Rate of hand hygiene compliance*** Eastern Health continued to monitor hand hygiene compliance and implemented a number of interventions aimed at improving the rate of compliance, including: ▪ Developed a new Hand Hygiene Strategy that provided a review of each program's past audit results and a "How to Improve Compliance Guide"; ▪ Encouraged programs to include hand hygiene compliance in their Operational Plans; and ▪ Completed year one of the Hand Hygiene Compliance Pilot Project and developed plans for full implementation. The 2014/2015 Hand Hygiene compliance target was set at 75 per cent. The percentage of hand hygiene compliance from the Pilot Project was **58.24 per cent** during this timeframe. ***Percentage of Medication Reconciliation compliance (Accreditation Canada Required Organizational Practice)*** Medication Reconciliation (MedRec) criteria for success includes ensuring the Best Possible Medication History (BPMH) is collected at admission; patients/families are a source in collecting the BPMH; BPMH is compared to the admitting orders; and, medication discrepancies are identified and resolved. The following initiatives were implemented in 2014-15: ▪ Continued roll out and compliance monitoring of MedRec; ▪ Electronic MedRec auditing and reporting process were explored to

[10] During a Walk the Talk, Eastern Health Executive and program leadership bring the discussion of patient and staff safety to frontline work areas. This initiative involves all levels of the organization and creates a space for collaborative solutions to address safety concerns in various programs and departments throughout Eastern Health.

[11] Quality and You recognizes that every day Eastern Health staff follow well-established practices that ensure clients are provided optimal services. The goal is to promote excellence and integrity at the program level by having staff identify and document their own best practices with their colleagues and manager.

improve compliance monitoring; and
- Education and support on the MedRec auditing process was provided, and analysis and feedback were disseminated to units/programs on compliance rates.

The target percentage of MedRec Compliance (Acute Care Inpatient Units) for this fiscal year was 75 per cent. Eastern Health achieved **64.72 per cent** compliance in 2014/15.

Hospital Standardized Mortality Ratio (HSMR)
In 2014-15, Eastern Health developed processes to monitor HSMR, starting with the development of a HSMR Steering Committee and a Quality Review Working Group.

Multiple initiatives were undertaken during the past year, including:
- Developed processes to review quality of the HSMR data. Initial review has indicated quality coding issues and potential gaps in clinical documentation that support coding standards. This has led to a coding review with editing of applicable files and initiation of physician presentations on documentation requirements;
- The HSMR working group initiated chart reviews to identify documentation and quality of care areas requiring improvement; and
- Eastern Health worked with the Canadian Institute for Health Information (CIHI) to access HSMR data to support enhanced organizational reporting and monitoring needs.

HSMR analysis and data published is conducted by CIHI. The 2014-15 year end data will not be available until September 2015.

Developed tools and processes to track workplace "near miss" incidents

A "near miss" incident is an undesired event that, under slightly different circumstances, could have resulted in personal injury, property damage or loss[12]. Identifying near miss incidents provides the opportunity to prevent future injury by putting remedial measures in place where possible.

In 2014-15, Eastern Health developed tools and processes to track workplace "near miss" incidents.

Tool Development:
Eastern Health participated in the working group with representatives from all four RHAs to develop a paper-based incident/accident (I/A) reporting and investigation form. This group:
- Conducted an environmental scan of comparable forms in other health authorities across the province/country; and
- Reviewed information from a number of key sources including Industrial Accident Prevention Association (IAPA), Systematic Cause Analysis Technique (SCAT), Canadian Centre for Occupational Health and Safety (CCOHS) and Service NL.

Eastern Health's IA form will be made available as a writable PDF and accessible through the intranet electronically.

The organization also participated in a provincial review to assess the development of electronic reporting tools as an alternative to the current paper-

[12] Source: Newfoundland and Labrador Workplace Health and Safety Compensation Commission

based system. This involved:

- Reviewing the feasibility of using electronic systems that are currently in use for other purposes as the platform for an electronic reporting tool.

Process Development:

Furthermore, Eastern Health developed processes to track workplace "near miss" incidents to ensure that the information is available to aide decision-making and prevent accidents before they occur. For example:

- Conducted trend analysis to identify high volume risks. This information is reported regularly to Eastern Health programs at their respective Quality and Safety meetings and through an annual report that is generated by the Occupational Health, Safety and Rehabilitation Department for all of Eastern Health;
- Started making I/A reports available to mangers on Eastern Health's intranet as well as Cognos[13]; and
- Initiated ongoing communication to increase awareness of the importance of reporting near miss incidents prior to an accident, including manager training on I/A investigations.

Begun development of a framework for business continuity of programs and services

Eastern Health developed and approved its Business Continuity Planning (BCP) Administrative Plan Framework during 2014-15. The framework outlines the ability of the organization to build resilience and continue core services during disasters and emergencies (e.g. adverse weather, power outages, and natural disasters). Work completed to develop the BCP framework included:

- Reviewed international research and best practices on standards from sources such as the Disaster Recovery Institute (DRI) International, the International Organization for Standardization (ISO) and CSA International;
- Conducted an environmental scan of contingency plans across all Eastern Health programs to determine what plans and strategies, if any, were in place;
- Completed certification level training through DRI Canada;
- Drafted and Approved the Administrative Strategy; and
- Developed and began the BCP Framework's five phase program from this strategy.

In addition to developing and approving the framework, significant progress has been made over the past year towards implementing the five phases:

- Sixteen employees ("subject matter experts") completed BCP certification requirements from the Disaster Recovery Institute Canada;
- The next steps regarding the process for conducting the Business Impact Analysis (BIA) were reviewed;
- A BCP information package was developed and released to help educate staff and to prepare for the business continuity processes in each program; and
- Ebola preparedness planning and training was undertaken in 2014-15, which has greatly enhanced business continuity planning, as well as Eastern Health's level of preparedness for other public health infectious disease events.

[13] Cognos is Eastern Health's business intelligence and performance management software.

Discussion of Results:
Eastern Health is committed to ensuring quality and safety throughout the organization. Eastern Health continues to focus efforts on improving Hand Hygiene and MedRec compliance targets. For instance, the organization has been trending towards reaching its annual target set for MedRec compliance and has exceeded its target during the last month of the fiscal year (78.0 per cent in March). The organization will continue to support programs with their MedRec auditing processes throughout the next fiscal year to work towards reaching this goal and beyond (e.g., providing support, education, and awareness of results).

Year 2 Objective

- By March 31, 2016, Eastern Health will have implemented its Safety Culture Strategy.

Measure

- Safety Culture Strategy implemented

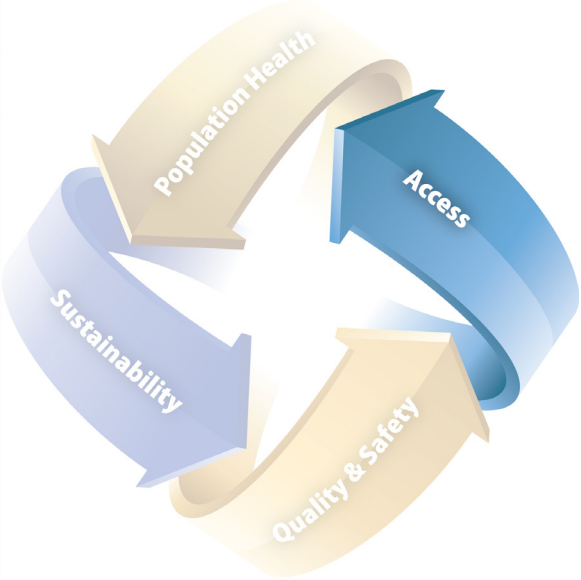
Indicators Planned for 2015-16

- Implemented Eastern Health's Safety Culture Strategy: Safer Together
- Improved on the following indicators:
  - Increased the rate of hand hygiene compliance
  - Increased the percentage of Medication Reconciliation compliance (Accreditation Canada ROP)
  - Improved Hospital Standardized Mortality Ratio (HSMR)
- Implemented tools and processes to increase reporting of workplace 'near miss' incidents
- Developed Eastern Health's Business Continuity Plan for priority program areas[14]

[14] Priority Program areas are determined by the Business Impact Analysis process currently underway.

Access

Access is a Strategic Issue that involves a broad view: it is not just about wait times but also having the ***right intervention for the right client at the right time and in the right place***. As such, it involves improving the client experience throughout the continuum, since access to long-term care beds, to community services and to acute care interventions all impact one another.



Improving access requires a shift in thinking and decision-making, or shifting from a "silo" approach within individual programs to focusing on collaboration and client-centred care across the organization and with partner agencies. Clients should transition smoothly from one form of care to another and improving access in one part of the system should not negatively affect another.

By strengthening its initiatives to improve access to community-based services such as Mental Health and Addictions, Community Supportive Services and Allied Health, Eastern Health will demonstrate how improvements can be made for clients throughout the continuum of care. Eastern Health's Access priority also aligns with the Provincial Government's Strategic Direction of Access.

Goal

By March 31, 2017, Eastern Health will have improved access by providing the right intervention at the right time and in the right place.

Year 1 Objective

- By March 31, 2015, Eastern Health will have implemented initiatives to address challenges related to Alternate Level of Care.

Measure

- Implemented initiatives

2014-15 Access Indicators

Planned Indicators	*Actual Performance*
Explored the "Home First" philosophy	Eastern Health explored the "Home First" philosophy during 2014-15. This philosophy focuses on improving quality of life for clients by providing resources in the community so they can stay at home rather than in a hospital setting. The following activities were implemented this past year in support of the "Home First" philosophy: ▪ Developed an Eastern Health Home First Strategy based on this philosophy; and ▪ Formed a Home First Steering Committee, which includes representation from HCS. The committee held regular meetings to help advance the strategy.
Completed further analysis and process improvements to address identified challenges	Over the course of 2014-15, Eastern Health completed further analysis and process improvements to address identified challenges in Alternate Level of Care (ALC) and patient flow. ALC refers to patients who are in hospital even though they no longer need hospital care (e.g. waiting to transfer to another facility), which, in turn, affects bed availability and wait times. During 2014-15, Eastern Health provided more timely access to ALC data through enhanced Cognos reporting. These enhancements provided decision makers with daily access to real time data. Eastern Health was able to complete further analysis on the underlying reasons for ALC, which helped to inform the following process improvements to address identified challenges: ▪ Implemented a Community Rapid Response Team (CRRT) at the Health Sciences Centre and St. Clare's Mercy Hospital to help prevent inappropriate hospital admissions. The CRRT is a pilot project involving a strengthened and structured partnership between Home and Community Care and the Emergency Departments. It provides enhanced support to individuals in community settings and assists those who are medically stable to return home upon presentation to the Emergency Department, thereby avoiding hospitalization where possible; and ▪ Implemented lean methodology, with a coaching and facilitation model, to improve discharge planning processes primarily at the Health Sciences Centre.
Developed and monitored the following indicators: ▪ Rate of admissions for Ambulatory Care Sensitive Conditions ▪ Alternate Level of Care (ALC) days as a percent of total adult patient days ▪ Length of Stay ▪ ER Wait Time – Time to Physician Initial Assessment	Eastern Health developed and monitored the following indicators over 2014-15: ***Rate of admissions for Ambulatory Care Sensitive Conditions*** Ambulatory care sensitive conditions are specific chronic medical conditions that when treated effectively in community settings should not advance to hospitalizations. Hospitalization for an ambulatory care sensitive condition is considered to be a measure of access to appropriate primary health care. During 2014-15, the Rate of Acute Care Admissions for Ambulatory Care Sensitive Conditions (per 100,000 population) was **493.7**. Eastern Health's current target is 480; thus there are a number of initiatives underway to improve in this indicator. These include: ▪ Explored data related to this indicator to identify areas where enhanced primary care and acute care can collaborate or expand to benefit this population; and

- Collaborated with Canada Health Infoway and HCS on a remote patient monitoring initiative for patients with COPD and Congestive Heart Failure. Processes are being finalized that will see 700 patients monitored from home in the coming year.

Alternate Level of Care (ALC) days as a per cent of total adult patient days
High ALC rates indicate patients are not being cared for in an ideal setting (such as their home, assisted living or residential care) and can contribute to congested Emergency Departments and to surgery cancellations.

During 2014-15, Eastern Health's ALC days as a per cent of total adult patient days was 13.27. The target was 10.00, therefore there numerous initiatives underway to improve in this indicator, which include the following:

- A detailed review resulting in 16 action items to improve patient flow, all are in process of implementation. This includes working on system issues that are beyond the span of control of front line staff and units. For example, a five-week kaizen[15] (i.e. "change for the better") initiative at Health Sciences Centre led to a 45 per cent decrease in ALC days;
- An additional 15 beds were opened in Chancellor Park, thereby increasing long-term care capacity available to Eastern Health; and
- Eastern Health's Home Support Program expanded its criteria to include ALC patients. Previously, the program targeted seniors and adults with physical and/or intellectual, disabilities; therefore the expansion of program criteria enabled a number of ALC patients to avail of home supports upon discharge from acute care.

Length of Stay
During 2014-15, **44.86 per cent** of typical inpatients with Eastern Health exceeded their expected length of stay. The current target is set at 40 per cent or less.

Eastern Health continues to work towards reducing the actual length of stay (LOS) in hospital to meet the national average of the Expected Length of Stay (ELOS) of comparable patients, as established by CIHI methodologies. During 2014-15, this work included:

- Completed a clinical utilization review for applicable clinical programs, which outlined action plans to decrease the percentage of patients exceeding the ELOS;
- Developed Patient Order Sets, which are a standardized list of treatments for patients with a specific condition. All relevant treatments are listed on one sheet. Patient Order Sets work towards reducing the length of stay in hospital as they ensure all treatments being ordered are in one place, and can be done when needed to reduce delays; and
- Implemented Real Time Demand Capacity (RTDC) at Health Sciences Centre (medicine, surgery and cardiac programs) and St. Clare's Mercy Hospital (medicine program). RTDC uses lean principles and kaizen events, which involve team-based approaches that focus on predicting and managing daily demands to help reduce LOS.

ER Wait Time – Time to Physician Initial Assessment

[15] Kaizen is the practice of continuous improvement in quality, processes, productivity, safety and leadership.

During 2014-15, Eastern Health developed and monitored indicators measuring the time from first contact in the Emergency Department to Physician (or Nurse Practitioner) Initial Assessment.

The recognized benchmark is for 90 per cent of Emergency Department patients to have a Physician Initial Assessment within three hours of arrival. During 2014-15, approximately **56.01 per cent** of Eastern Health's patients were seen within three hours.

Ongoing work to identify issues delaying provision of health care required by patients presenting to the Emergency Department within an appropriate time included:

- Implemented lean initiatives to improve flow within the Health Sciences Centre Emergency Department and to improve the functioning of the Rapid Assessment Zone;
- Piloted a Physician-Registered Nurse model in triage to improve access to Physician Initial Assessment; and
- Held three-day kaizen events at Carbonear General Hospital and Dr. G. B. Cross Memorial Hospital, which resulted in improved space for assessment and treatment of low acuity patients, reorganization of functional areas, and improved visual cues to promote patient flow within the emergency departments.

Discussion of Results:
Eastern Health has and continues to make improvements throughout the organization to ensure clients, patients and residents have access to the right intervention at the right time and the right place. Although the number of patients exceeding their expected length of stay in hospital did not reach the target of 40 per cent, the organization has been trending towards achieving this goal and remains committed to making improvements in this area. For example, Eastern Health continues to make LOS the focus of clinical utilization review for several programs and is implementing lean process improvements and kaizan events focusing on LOS at the Health Sciences Centre (medicine, surgery, and cardiac programs) and St. Clare's Mercy Hospital (medicine program).

Similarly, although the organization was unable to meet the recognized benchmark for Emergency Department patients to have a Physician Initial Assessment within three hours of arrival, there is a strong commitment to improve performance on this indicator and a number of process improvement initiatives will continue into the new fiscal year.

Year 2 Objective

- By March 31, 2015, Eastern Health will have implemented initiatives to address challenges related to Alternate Level of Care.

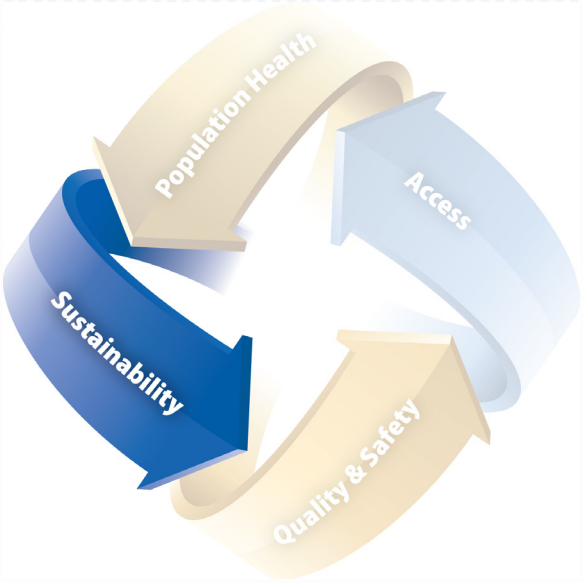
Measure

- Further implemented initiatives

Indicators Planned for 2015-16

- Implemented Eastern Health's Home First Strategy
- Implemented process improvements to address access challenges throughout Eastern Health
- Improved access as demonstrated through the following indicators:
  - Decreased rate of admissions for Ambulatory Care Sensitive Conditions
  - Decreased Alternate Level of Care (ALC) days as a per cent of total adult patient days
  - Decreased length of acute hospital stay to meet appropriate Expected Length of Stay
  - Decreased ER Wait Time – Time to Physician Initial Assessment

Sustainability



Undoubtedly, Eastern Health's greatest resource has been and continues to be its people: the employees, physicians and volunteers who are dedicated to client care. However, employee and physician engagement have been challenging in recent years, and the organization recognizes that a renewed sense of pride for "living the Eastern Health values" is needed.

Research provides a strong rationale for investing in employee and workplace health, as they are "inextricably linked to productivity, high performance and success."[16] In 2007, Eastern Health joined the Excellence Canada[17] Progressive Excellence Program (PEP) - Healthy Workplace. This program focuses on a wide range of healthy workplace planning and programming in the areas of workplace culture, supportive environment, physical environment, occupational health and safety, as well as health and lifestyle practices.

Sick leave continues to be a significant aspect of sustainability within Eastern Health. Sick leave and sick leave replacement costs the organization over $55 million annually. In addition to the obvious budgetary considerations, having high sick leave means the full complement of staff is not always available, and this presents challenges as the organization strives to address its other strategic priorities of quality, safety, access and population health.

Eastern Health's Sustainability priority is in line with the Provincial Government's Strategic Direction of An Accountable, Sustainable, Quality Health and Community Services System.

Goal — **By March 31, 2017, Eastern Health will have a healthier workplace.**

Year 1 Objective

- By March 31, 2015, Eastern Health will have begun developing and implementing strategies leading to a healthier workplace.

Measure

- Begun developing and implementing strategies

[16] Source: Maclead and Shamian, 2013, www.longwoods.com/content/23355
[17] Formerly known as the National Quality Institute

2014-15 Sustainability Indicators

Planned Indicators	*Actual Performance*
Begun implementation of Level III of Excellence Canada's Healthy Workplace program based on identified priorities of mental health, respectful workplace and physical health.	During 2014-15, Eastern Health began implementation of Level III of Excellence Canada's Healthy Workplace Program based on identified priorities of mental health, respectful workplace and physical health. To advance this priority, the following initiatives were completed by the organization during the past year: ▪ Prepared for the Fall 2015 submission of Level III of the Healthy Workplace Program; ▪ Developed a Healthy Workplace toolkit, which provides guidance and resources to employees and managers around the three priority areas of mental health, physical health and respectful workplace; ▪ Increased focus on mental health in the workplace, mainly through an orientation session for HR managers on the Canadian Standards Association's Psychological Health and Safety Standards and through implementing the Mental Health First Aid training program for all managers; ▪ Programs identified a wide range of healthy workplace action items toward achieving the overall Healthy Workplace goal through Eastern Health's Operational Planning process; and ▪ Prepared for an updated employee engagement survey to be conducted in Fall 2015, prior to the Level III verification visit required by representatives of Excellence Canada.
Updated Healthy Workplace Plan	Eastern Health finalized and released its updated Healthy Workplace Plan during 2014-15. This plan is built on Excellence Canada's Healthy Workplace Program framework and includes Eastern Health's Healthy Workplace priority areas: mental health, physical health and respect in the workplace. In addition, Eastern Health updated its Healthy Workplace Intranet page to support the Healthy Workplace plan and make it accessible to employees.
Begun initiatives related to employee engagement	Eastern Health began initiatives related to improving employee engagement throughout 2014-15. ▪ Programs were encouraged to focus on employee engagement during the Operational Planning process; ▪ Based on feedback gathered through a number of avenues, including employee surveys, lack of access to leave has been an identified problem leading to decreased employee engagement. Eastern Health successfully negotiated a 90-day pilot project with the Registered Nurses' Union Newfoundland & Labrador (RNUNL) to increase access to short-term annual leave. The pilot is expected to begin in the Fall of 2015; and ▪ Increased focus on leadership development opportunities, in particular through embarking on the Canadian College of Health Leaders Program entitled Learning LEADerS: Lead Self; Engage Others; Achieve Results; Develop Coalitions; and Systems Transformation. This program helps ensure effective leaders with the skill, knowledge and capabilities to lead Eastern Health into the future.

Begun development of a Sick Leave Reduction Strategy	Eastern Health began development of a Sick Leave Reduction Strategy during the 2014-15 fiscal year. In particular, the organization: ▪ Reviewed its Attendance Management Program and Policy and the Recovery Management process. This included a jurisdictional scan of best practices across Canada, as well as auditing internal processes. A working team has been formed to develop and implement policy changes based on review recommendations; ▪ Completed a pilot project in long-term care sites with high rates of sick leave within Eastern Health. Interventions included increased focus on attendance management, regular staff meetings to emphasize attendance, and regular visual notices of sick leave statistics for those sites; ▪ Human Resources program developed "Help Teams" that work with the top 10 programs with the highest overtime within Eastern Health, as there is often a direct correlation between high rates of overtime and high rates of sick leave due to replacement costs. These Help Teams focus on identifying the root causes or underlying reasons for high overtime and the related high rate of sick leave and try to address how to reduce them within each of the identified programs. For example, Help Teams identified flexible scheduling and an option to reduce the use of sick leave and related overtime for some programs.
Monitored rate of sick leave	Eastern Health monitored its rate of sick leave in 2014-15: total sick leave hours per Benefit[18] Full Time Equivalent (FTE) was **162.67 hours**[19]. Monitoring this rate was part of the broader Sick Leave Reduction Strategy which focuses on aligning Eastern Health's sick leave usage with the national benchmark (see above).

Discussion of Results:
Sustainability of the organization is certainly intertwined with the other strategic priorities identified, as the health system must be sustainable to continuously improve and positively impact the health of the population over the long term. One aspect of sustainability has been to reduce the rate of sick leave in the organization. Eastern Health's sick leave usage is still significantly higher than the national benchmark. The organization is exploring the details of its sick leave to gain a better understanding of the high rates and to identify preventative measures to support a sustainable workforce.

Year 2 Objective

- By March 31, 2016, Eastern Health will have further implemented strategies leading to a healthier workplace.

Measure

- Further implemented strategies

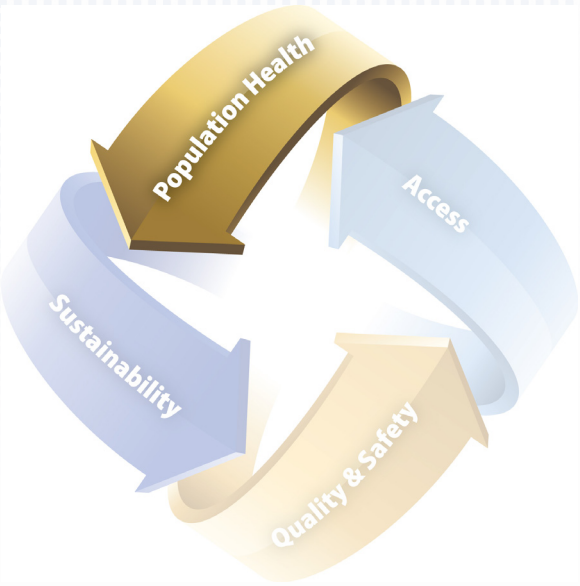
[18] Employees with sick leave benefits
[19] This number excludes unpaid sick leave hours for temporary call-in/temporary part time employees

Indicators Planned for 2015-16

- Submitted for Level III and begun implementation of the next level[20] of Excellence Canada's Healthy Workplace program
- Implemented Eastern Health's updated Healthy Workplace Plan
- Improved rate of employee engagement
- Implemented Eastern Health's Sick Leave Reduction Strategy
- Decreased rate of sick leave

[20] Note that Excellence Canada is in the process of changing the name of the various levels within its Healthy Workplace program.

Population Health



Focusing on Population Health involves a long-term vision and commitment toward improving the overall health of the population. This approach emphasizes promoting healthy lifestyles to prevent future health problems and to improve the health of those with chronic disease. It also requires focusing on community needs, especially for the most vulnerable populations, such as the frail elderly and individuals with low incomes.

There are multiple inter-related factors that affect the health of individuals and communities, many of which are outside of Eastern Health's control, such as income, housing, education, employment, early childhood development and the physical environment. These factors are the ***"Determinants of Health"*** and they involve many complex social issues and community stakeholders, including all levels of government (municipal, provincial and federal), schools, private industry and not-for-profit organizations. Certainly, everyone has a role to play in their health and the health of their communities and strong partnerships are integral to achieving success over the long term.

A Population Health approach requires strong leadership and long-term commitment throughout the organization, as many of today's interventions may not affect overall population health changes until years from now. This priority is in line with the Provincial Government's Strategic Direction of Population Health.

Goal

By March 31, 2017, Eastern Health will have demonstrated its commitment to improving the overall health of the population.

Year 1 Objective

- By March 31, 2015, Eastern Health will have identified opportunities to expand and coordinate Population Health initiatives.

Measure

- Opportunities identified

2014-15 Population Health Indicators

Planned Indicators	*Actual Performance*
Identified opportunities for collaborative practice related to the Chronic Disease Prevention and Management Strategy.	Eastern Health identified opportunities for collaborative practice related to the Chronic Disease Prevention and Management (CDPM) Strategy throughout 2014-15. A key driver in identifying opportunities for collaborative practice related to this strategy involved formal meetings between Senior leadership and key program leaders including a "Call to Action Day" which entailed identifying common priorities and ways to improve collaboration to achieve progress. In addition, numerous opportunities for collaborative practice relating to CDPM were identified. For example: ▪ Eastern Health increased its internal collaboration to help prevent inappropriate hospital admissions related to chronic disease through implementation of Chronic Disease Inpatient Community Case Management at both the Health Sciences Centre and St. Clare's Mercy Hospital; ▪ Eastern Health collaborated with an additional 15 community groups across the province, including Family Resource Programs, to further expand the Janeway Lifestyles Program *Good Health for EveryBODY*. This program, designed to help children develop healthy lifetime habits from a young age, is being offered through community leaders trained by professionals of the Janeway Lifestyle Program; and ▪ The self-management program, Improving Health: *My Way*, was expanded through the identification of, and collaboration with, partner agencies throughout the region (e.g. the Port Union Town Hall, the Rabbittown Community Centre and the Winterton Recreation Centre). This collaborative practice with partner agencies included recruiting seven new volunteer leaders and training 30 existing leaders in the new curriculum (developed at the Stanford Patient Education Research Centre). During the past year, 124 participants successfully completed the program (69 per cent completion rate).
Begun updating the Health Status Report based on 2011 Census	During 2014-15, Eastern Health began updating the Health Status Report based on 2011 Census in addition to other operational data sources such as CIHI. The organization is working toward having the most current information available so that it will be as useful as possible to internal and external stakeholders.
Monitored selected Population Health indicators: ▪ Rate of participation of all Provincial Cancer Screening Programs	During 2014-15, Eastern Health monitored selected Population Health indicators, specifically the Rate of Participation of all Provincial Cancer Screening Programs (i.e. Colon, Cervical and Breast). This monitoring involved the most recent data available for all three programs. Early detection and diagnosis of cancer leads to earlier treatment and reduced deaths from the disease. The NL Colon Cancer Screening Program targets individuals 50-74 years of age who are at average risk for colorectal cancer. During the fiscal year of

2014-15 the program received requests for more than 4630 test kits, with a response rate of kits to be analyzed of approximately **76 per cent.**[21]

The NL Cervical Screening Program targets woman ages 20-69 years having at least one Pap test in three years. The most recent data available is for the 2011-13 timeframe, at **64 per cent**.

The NL Breast Screening Program targets women ages 40-74 years. There are three breast screening centres in the province: one in Eastern Health, Central Health and Western Health. The most recent participation data available includes all three sites for both the 2013 and 2014 calendar years, at **57 per cent.**

Discussion of Results:
Eastern Health was able to move forward on all Population Health indicators. During 2014-15, the organization began updating the Health Status Report based on 2011 Census, as committed, and began further work to enhance the reporting processes during this time. Based on feedback from key stakeholders, representatives from both Eastern Health and Newfoundland and Labrador Centre for Health Information (NLCHI) met to explore a sustainable and efficient process to access health data and indicator reports. It is anticipated that in the future an alternate and collaborative approach will support more up-to-date information and improved access to future health status reports. Enhanced Health Status reporting processes are now being used, including reviewing Statistics Canada's "peer groups" to compare Eastern Health with other RHAs in Canada that have similar socio-demographic characteristics (e.g., employment).

Eastern Health also continued its focus on cancer screening. The organization will be working towards development of a new Provincial Cancer Screening Model in the 2015-16 fiscal year in keeping with the provincial review of cancer screening commissioned by the Provincial Government in 2013.

Year 2 Objective

- By March 31, 2016, Eastern Health will have further implemented and coordinated Population Health initiatives.

Measure

- Further implemented and coordinated initiatives

Indicators Planned for 2015-16

- Implemented and coordinated Population Health initiatives, with emphasis on:
  - Eastern Health's Chronic Disease Prevention and Management Strategy
  - Eastern Health's Health Promotion Plan
- Initiated innovative ways for Health Status Reporting
- Begun development of a new Provincial Cancer Screening Model

[21] The Colon Cancer Screening Program was launched in late July 2012 in Western Health, with expansion into Central Health in 2013 and Labrador-Grenfell Health in 2014. Full program implementation in the final health region, Eastern Health is planned for 2015-16, which will coincide with the expansion of endoscopy capacity at St. Clare's Mercy Hospital.

Opportunities and Challenges Ahead

As the largest integrated health authority in Newfoundland and Labrador, providing both regional and provincial services, Eastern Health undoubtedly faces many challenges on a number of levels. Fortunately, at the same time the organization has many opportunities to capitalize and position itself as a leader in the health and community services sector.

In the first instance, Eastern Health must balance many competing demands in a complex and ever-changing environment. This includes the challenges associated with providing a wide range of programs and services across a geographically dispersed region and within limited financial resources. At the same time, the population's demographics continue to present challenges and will continue for some years to come, as many of the region's communities experience outmigration and aging, with fewer people to take on leadership and/or support roles. Eastern Health must respond to service demands based on this changing environment, while also realizing the impact of demographics on its own labour force.

Additionally, the poor health indicators of Newfoundland and Labrador present significant concerns. As outlined under the Population Health section of this report, this region's health status presents problems at both individual and health system levels in terms of dealing with the burden of disease. Certainly, there are no "quick fixes" for improving the health of the population and long-term, consistent efforts are required from a number of stakeholders to bring about meaningful changes in this region and province. In addition to the health system, the public also has a pivotal role to play. We have to work as a society to increase our knowledge of, and attitudes and behaviours towards, living healthier lifestyles.

Yet, within the context of all these challenges, Eastern Health has many opportunities to make improvements and influence changes for the better in the communities it serves. In particular, many individuals and groups had input into the development of Strategic and Operational Plans, which helps to increase ownership and reinforce how every person has an important role in helping to achieve the organization's goals.

Eastern Health also has opportunities to improve the client experience throughout the continuum of health and community services. For example, emphasis on "Home First" within the Access priority entails innovative approaches and a shift to more collaborative, client-centred care.

The organization is working to strengthen and renew partnerships throughout the region, and even beyond its boundaries, to achieve the vision of ***Healthy People, Healthy Communities***. Examples of strong, ongoing partnerships include Eastern Health's Mobile Crisis Response Team's close collaboration with the Royal Newfoundland Constabulary, Royal Canadian Mounted Police, the Schizophrenia Society of Newfoundland and Labrador, the Canadian Mental Health Association, the Consumers' Health Awareness Network Newfoundland and Labrador and the Newfoundland and Labrador Sexual Assault Crisis and Prevention Centre. The organization will continue to identify potential opportunities for future partnerships over the next reporting period.

As Eastern Health transitions into the second year of its Strategic Plan, the organization will build on the success of year one and measure future progress based on the indicators identified in the Report on Performance Section for 2014-15. In so doing, Eastern Health will continue on the path toward its overall mission for 2011-17: *improving programs and services to increase safety, quality, accessibility, efficiency and sustainability and to contribute to the overall health of the population*.

Appendix I

Regional Mandate

Eastern Health is responsible for the delivery and administration of health services and community services in its health region and provincially as designated by the Minister of Health and Community Services. The organization will deliver its programs and services within fiscal capabilities and in accordance with the *Regional Health Authorities Act* and other relevant regulations. The *Regional Health Authorities Act* outlines the responsibility of health authorities as the following:

Responsibility of Authority

16. (1) An authority is responsible for the delivery and administration of health and community services in its health region in accordance with this Act and the regulations.
(2) Notwithstanding subsection (1), an authority may provide health and community services designated by the minister on an inter-regional or province-wide basis where authorized to do so by the minister under section 4.
(3) In carrying out its responsibilities, an authority shall:
    (a) 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;
    (b) assess health and community services needs in its region on an on-going basis;
    (c) develop objectives and priorities for the provision of health and community services which meet the needs of its region and which are consistent with provincial objectives and priorities;
    (d) manage and allocate resources, including funds provided by the government for health and community services, in accordance with this Act;
    (e) ensure that services are provided in a manner that coordinates and integrates health and community services;
    (f) collaborate with other persons and organizations, including federal, provincial and municipal governments and agencies and other regional health authorities, to coordinate health and community services in the province and to achieve provincial objectives and priorities;
    (g) 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;
    (h) provide information to the residents of the region respecting
    - the services provided by the authority,
    - how they may gain access to those services, and
    - how they may communicate with the authority respecting the provision of those services by the authority;
    (i) monitor and evaluate the delivery of health and community services and compliance with prescribed standards and provincial objectives and in accordance with guidelines that the minister may establish for the authority under paragraph 5 (1)(b); and comply with directions the minister may give.

Appendix II

Definitions of Both Quantitative and Qualitative Indicators from the Report on Performance Section

The following list of definitions explains the purpose behind all the indicators used for the Report on Performance Sector of the Annual Performance Report: what each means and why we measure it. These definitions are listed in the order in which they appear in the report.

Quality and Safety

Finalized a Safety Culture Strategy: Our integrated Safety Plan includes the development of a Safety Culture Strategy, which helps to demonstrate our commitment to the safety of our patients, residents, clients, communities, employees, agents, students, volunteers, and visitors. This is based on the understanding that an effective safety culture is linked to all aspects of safety – patient safety, employee health and safety, as well as safe equipment, buildings, and policies.

Rate of hand hygiene compliance: Hand Hygiene is the single most effective way to prevent the spread of hospital-acquired infections. Audits of hand hygiene compliance occur during a particular period of time: Infection Prevention and Control conducts an audit of hand hygiene compliance before and after initial patient/environment contact, after body fluid exposure risk and before aseptic procedure. Compliance rate does not necessarily mean that health care providers do not wash their hands; rather, the audit tool measures whether health care providers are washing their hands at the right times and in the right way.

Percentage of Medication Reconciliation compliance (Accreditation Canada ROP): This indicator identifies the audit results of the Medication Reconciliation (MedRec) process as determined by Accreditation Canada criteria. Compliance means that on a monthly audit (random selection of minimally five charts per unit) the MedRec process was achieved on at least 75% of the charts audited. The criteria for success include: (1) The Best Possible Medication History (BPMH) was collected at admission; (2) Patient/family were a source in collecting the BPMH; (3) BPMH was compared to the admitting orders; and, (4) Medication discrepancies were identified and resolved.

Hospital Standardized Mortality Ratio (HSMR): The Hospital Standardized Mortality Rate (HSMR) is a ratio of the actual number of deaths in a hospital to the number that would have been expected. An HSMR equal to 100 suggests that there is no difference between a local mortality rate and the average national experience, given the types of patients cared for.

The HSMR is based on diagnosis groups that account for 80 per cent of all deaths in acute care hospitals, excluding patients identified as receiving palliative care. The number of expected deaths is derived from the average experience of acute care facilities that submit to CIHI's Discharge Abstract Database (DAD). It is adjusted for other factors affecting mortality, such as age, sex and length of stay. While the HSMR takes into consideration many of the factors associated with the risk of dying it cannot adjust for every factor. Therefore, the HSMR is most useful to individual hospitals to track their own mortality trends. The HSMR can be used to track the overall change in mortality resulting from a broad range of factors, including changes in the quality and safety of care delivered.

Developed tools and processes to track workplace "near miss" incidents: All reports of near misses (incidents) and accidents are investigated and remedial measures taken to prevent these from happening again. Therefore reporting near misses are opportunities for preventing loss to people, equipment, and/or materials. It is to our advantage to report any time there is a chance that loss may have happened under slightly different circumstance (near misses).

Begun development of a framework for business continuity of programs and services: Business Continuity Planning enables an organization to build resilience and continue core services during disasters and emergency situations.

Access

Explored the "Home First" philosophy: Home First Philosophy focuses on improving quality of life for clients by providing resources in the community. This helps to ensure the right care is provided to the right client in the right place at the right time by the right provider.

Completed further analysis and process improvements to address identified challenges: Ongoing analysis and process improvements across Eastern Health help to address identified challenges and improve overall access in a number of ways. In particular, Alternate Level of Care (ALC) refers to patients who are in hospital even though they no longer need hospital care. Beds occupied by ALC patients are not available to other patients who need hospital care. High ALC rates indicate patients are not being cared for in an ideal setting (such as home, assisted living or residential care) and contribute to congested emergency departments.

Rate of admissions for Ambulatory Care Sensitive Conditions: Hospitalization for an ambulatory care sensitive condition (i.e. Diabetes, Angina, Hypertension, Heart Failure, Pulmonary Edema, Asthma, Chronic Obstructive Pulmonary Disease, Grand Mal Status and other Epileptic Convulsions) is considered to be a measure of access to appropriate primary health care. While not all admissions for these conditions are avoidable, it is assumed that appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care. Eastern Health measures the crude rate of Ambulatory Care Sensitive Conditions (crude rate is an overall rate of disease in the population, but it doesn't take into account possible risk factors including ages of the population). Eastern Health set the target for 2014-15 to be below 480 admissions per 100,000 people for the year.

Alternate Level of Care (ALC) days as a per cent of total adult patient days: Alternate Level of Care (ALC) refers to patients who are in hospital even though they no longer need hospital care. Beds occupied by ALC patients are not available to other patients who need hospital care. This measure is the percentage of ALC days as a proportion of total adult patient days. High ALC rates indicate patients are not being cared for in an ideal setting (such as home, assisted living or residential care) and contribute to congested emergency departments and OR cancellations.

Length of Stay: The Canadian Institute for Health care Information (CIHI) calculates expected length of stay (ELOS) each year based on data submitted from across Canada. ELOS is the average acute length of stay in hospital for typical patients with the same Case Mix Grouping, age category, co-morbidity level and intervention factors. It is recognized that any value above ELOS indicates patients have stayed longer than expected.

ER Wait Time – Time to Physician Initial Assessment: The purpose of this indicator is to target and improve time to the initial assessment by the Physician or Nurse Practitioner. The accepted

benchmark is that 90 per cent of all patients would receive an initial assessment within three hours or arrival to the ER, based on National CAEP Guidelines (Canadian Association of Emergency Physicians).

Sustainability

Begun implementation of Level III of Excellence Canada's Healthy Workplace program based on identified priorities of mental health, respectful workplace and physical health: Since joining Excellence Canada's Progressive Excellence Program (PEP) Healthy Workplace in 2007 we have achieved Levels I and II, which entail planning and commitment. Level III focuses on implementation of healthy workplace priorities identified by Eastern Health itself, mainly through employee input: mental health, respectful workplace and physical health.

Updated Healthy Workplace Plan: Excellence Canada's Progressive Excellence Program (PEP) Healthy Workplace criteria require an updated Healthy Workplace Plan. Updating and implementing the Healthy Workplace Plan is one step in supporting and building on healthy workplace initiatives throughout Eastern Health, helping us to build a healthy and engaged workforce that is empowered to provide the best possible service to clients.

Begun initiatives related to employee engagement: Based on low levels of engagement measured through recent employee engagement surveys, we recognize we need region-wide actions/initiatives to address engagement. As well, we need initiatives at program and department levels.

Begun development of a Sick Leave Reduction Strategy: A reduction in sick leave is one of the main indicators of a healthy workplace. Sick Leave usage, both paid and unpaid, has steadily risen despite the introduction of the Attendance Management Program in 2009. Compliance rate for the Attendance Management Program is lower than expected at 59 per cent. In addition to costing approximately $55 million in Sick Leave and replacement costs on a yearly basis, quality of care could be impacted by inability to always replace staff on sick leave

Monitored rate of sick leave: This is indicative of the amount of Sick Leave being taken by staff at Eastern Health and allows us to see trends. Sick leave usage is one of the main indicators of a healthy workplace. Current benchmark is 8.75 hours per benefit employee per month. This equates to 105 hours per benefit employee per year. This is the average annual sick leave for the health sector in Canada as published by the Conference Board of Canada.

Population Health

Identified opportunities for collaborative practice related to the Chronic Disease Prevention and Management Strategy: Preventing and managing chronic disease takes teamwork and requires a collaborative approach to reach solutions. Eastern Health and the health care system are increasingly faced with the needs of individuals living with chronic disease and the rise in associated risk factors. Leadership, partnerships and reinvestment are critical factors required to implement a coordinated, systematic approach to effective chronic disease prevention and management that will positively impact the health status of individuals and communities served by Eastern Health.

Begun updating the Health Status Report based on 2011 Census: The Health Status Report is intended to reflect population health issues and trends over time. Our current 2012 report was based on 2006 Census data. Acquisition of more recent Census information as well as data from additional sources will allow programs to identify progress, current and emerging issues and to identify potential

interventions. Our intent is to create a reasonably comprehensive report of data that can be regularly updated through automated processes but that also meets the needs of Public Health and Health Promotion programs as well as other selected program areas across the system by ensuring that data is interpreted appropriately.

Provincial Cancer Screening Programs: Eastern Health is responsible for implementing and managing the Provincial Cancer Screening Program (i.e. Colon, Cervical and Breast). Early detection and diagnosis of cancer leads to earlier treatment and reduced deaths from the disease.

The NL Colon Cancer Screening program is a self-referred screening program available to those between the ages of 50-74 and at average risk for colorectal cancer. Residents who are eligible receive a home fecal test kit in the mail, and return the samples via the mail for analysis. Clients with a negative test result are re-screened every two years, while those with a positive result are navigated through to follow-up colonoscopy.

The Colon Cancer Screening program participation rate when calculated will be influenced by a number of factors, such as:

- Individuals who have had previous colonoscopy procedures in the last 5 years and are under active care by a specialist would need to be omitted from the target audience;
- Individuals with genetic or familial links to colorectal cancer would need to be omitted from the target audience; and
- When participation is calculated the denominator (eligible population) would be divided by 2 as individuals are eligible for average risk screening every two years.

The Cervical Screening Program targets woman ages 20-69 years having at least one Pap test in three years. The most recent data available is for the 2011-13 timeframe: **64 per cent.** This data represents the raw participation rate, which excludes repeat screens and has not be adjusted for age standardization or hysterectomy status.

The Breast Screening Program offers breast screening services to women aged 40-74 years. There are three breast screening centres in the province: one in Eastern Health, Central Health and Western Health. Women between the ages of 50-74 may self-refer to breast screening. Women between the ages of 40 and 49 require a referral from their doctor to make an appointment for breast screening services.

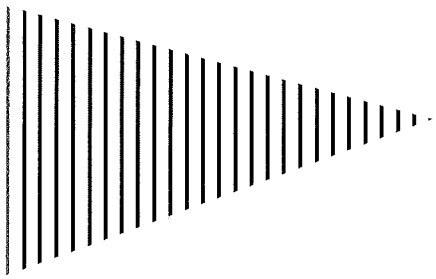
Appendix III

Audited Financial Statements

Non-consolidated Financial Statements

Eastern Regional Health Authority – Operating Fund

March 31, 2015



Building a better working world

Eastern Regional Health Authority – Operating Fund

TABLE OF CONTENTS

March 31, 2015

STATEMENT OF MANAGEMENT RESPONSIBILITY

The accompanying non-consolidated financial statements of the **Eastern Regional Health Authority – Operating Fund** [the "Authority"] as at and for the year ended March 31, 2015 have been prepared by management in accordance with Canadian public sector accounting standards and the integrity and objectivity of these non-consolidated financial statements are management's responsibility. Management is also responsible for all the notes to the non-consolidated financial statements and schedules.

In discharging its responsibilities for the integrity and fairness of the non-consolidated financial statements, management developed and maintains systems of internal control to provide reasonable assurance that transactions are properly authorized and recorded, proper records are maintained, assets are safeguarded, and the Authority complies with applicable laws and regulations.

The Board of Trustees [the "Board"] is responsible for ensuring that management fulfils its responsibilities for financial reporting and is ultimately responsible for reviewing and approving the non-consolidated financial statements. The Board carries out this responsibility principally through its Finance Committee [the "Committee"]. The Committee meets with management and the external auditors to review any significant accounting and auditing matters, to discuss the results of audit examinations, and to review the non-consolidated financial statements and the external auditors' report. The Committee reports its findings to the Board for consideration when approving the non-consolidated financial statements.

The external auditors, Ernst & Young LLP, conduct an independent examination in accordance with Canadian generally accepted auditing standards and express an opinion on the non-consolidated financial statements as at and for the year ended March 31, 2015.

George Butt, CPA, CA
Vice President, Corporate Services

Chris O'Grady, CPA, CGA
Director of Financial Services

INDEPENDENT AUDITORS' REPORT

To the Board of Trustees of the
Eastern Regional Health Authority

We have audited the non-consolidated financial statements of the **Eastern Regional Health Authority – Operating Fund**, which comprise the non-consolidated statement of financial position as at March 31, 2015, and the non-consolidated statements of operations and accumulated deficit, 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 non-consolidated financial statements

Management is responsible for the preparation and fair presentation of these non-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 non-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 non-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 non-consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the non-consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the non-consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation and fair presentation of the non-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 entity'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 non-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 non-consolidated financial statements present fairly, in all material respects, the financial position of the **Eastern Regional Health Authority – Operating Fund** as at March 31, 2015, and the results of its operations, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis of presentation and restrictions on use

Without modifying our opinion, we draw attention to note 2 to the non-consolidated financial statements, which describes the basis of presentation of the non-consolidated financial statements of the **Eastern Regional Health Authority – Operating Fund**. These non-consolidated financial statements have been prepared for specific users and may not be suitable for another purpose.

Ernst & Young LLP

St. John's, Canada
June 25, 2015

Chartered Professional Accountants

Eastern Regional Health Authority – Operating Fund

NON-CONSOLIDATED STATEMENT OF FINANCIAL POSITION

As at March 31
[in thousands of dollars]

	2015 $	2014 $
Financial assets		
Cash	**20,124**	—
Accounts receivable *[note 3]*	**19,767**	25,050
Due from government/other government entities *[note 4]*	**88,200**	106,646
Advance to General Hospital Hostel Association	**989**	1,120
Sinking fund investment *[note 11]*	**16,447**	14,969
	145,527	147,785
Liabilities		
Bank indebtedness	—	3,319
Accounts payable and accrued liabilities *[note 7]*	**119,772**	107,061
Due to government/other government entities *[note 8]*	**9,323**	21,770
Employee future benefits		
Accrued sick leave *[note 17]*	**59,285**	59,636
Accrued severance pay *[note 16]*	**110,806**	110,799
Accrued vacation pay	**49,922**	47,769
Deferred contributions *[note 9]*		
Deferred capital grants	**83,732**	80,190
Deferred operating contributions	**16,323**	20,883
Long-term debt *[note 10]*	**135,526**	136,468
	584,689	587,895
Net debt	(439,162)	(440,110)
Non-financial assets		
Tangible capital assets *[note 5]*	**344,013**	339,085
Supplies inventory	**15,312**	15,537
Prepaid expenses	**4,764**	4,876
	364,089	359,498
Accumulated deficit	(75,073)	(80,612)

Contingencies *[note 14]*
Contractual obligations *[note 15]*
Operating facility *[note 6]*

See accompanying notes

Approved by the Board:

Director

Director

NON-CONSOLIDATED STATEMENT OF OPERATIONS AND ACCUMULATED DEFICIT

Year ended March 31
[in thousands of dollars]

	Budget	2015	2014
	$	$	$
	[note 20]		
Revenue			
Provincial plan	1,232,070	**1,232,070**	1,175,985
Medical Care Plan	77,389	**77,434**	75,697
Other	37,765	**41,500**	39,422
Provincial plan capital grant *[note 9]*	—	**31,878**	22,121
Resident	18,995	**18,479**	17,711
Inpatient	12,688	**12,422**	13,302
Outpatient	8,966	**8,225**	8,061
Other capital contributions *[note 9]*	—	**7,025**	5,758
	1,387,873	**1,429,033**	1,358,057
Expenses *[note 21]*			
Patient and resident services	375,108	**385,335**	361,334
Client services	230,653	**228,683**	218,638
Diagnostic and therapeutic	191,644	**191,343**	188,356
Support	174,794	**177,125**	165,898
Ambulatory care	153,369	**154,303**	145,620
Administration	116,436	**118,403**	115,988
Medical services	99,134	**99,923**	100,465
Amortization of tangible capital assets *[note 5]*	—	**33,975**	42,556
Research and education	17,002	**16,124**	15,735
Interest on long-term debt	11,090	**9,276**	9,354
Other	18,643	**7,195**	5,322
Employee future benefits			
Accrued severance pay expense (recovery)	—	**7**	(3,579)
Accrued sick leave recovery	—	**(351)**	(3,782)
Accrued vacation pay expense	—	**2,153**	180
	1,387,873	**1,423,494**	1,362,085
Annual surplus (deficit)	—	**5,539**	(4,028)
Public Health Laboratory transfer	—	—	(219)
Accumulated deficit, beginning of year	—	**(80,612)**	(76,365)
Accumulated deficit, end of year	—	**(75,073)**	(80,612)

See accompanying notes

NON-CONSOLIDATED STATEMENT OF CHANGES IN NET DEBT

Year ended March 31
[in thousands of dollars]

	Budget	2015	2014
	$	$	$
	[note 19]		
Annual surplus (deficit)	—	**5,539**	(4,028)
Changes in tangible capital assets			
Acquisition of tangible capital assets	—	**(38,903)**	(27,879)
Amortization of tangible capital assets	—	**33,975**	42,556
(Increase) decrease in net book value of tangible capital assets	—	**(4,928)**	14,677
Changes in other non-financial assets			
Net decrease (increase) in prepaid expenses	—	**112**	(823)
Net decrease (increase) in supplies inventory	—	**225**	(140)
Decrease (increase) in other non-financial assets	—	**337**	(963)
Decrease in net debt	—	**948**	9,686
Net debt, beginning of year	—	**(440,110)**	(449,079)
Public Health Laboratory transfer	—	—	(717)
Net debt, end of year	—	**(439,162)**	(440,110)

See accompanying notes

Eastern Regional Health Authority – Operating Fund

NON-CONSOLIDATED STATEMENT OF CASH FLOWS

Year ended March 31
[in thousands of dollars]

	2015 $	2014 $
Operating transactions		
Annual surplus (deficit)	**5,539**	(4,028)
Adjustments for:		
Amortization of tangible capital assets	**33,975**	42,556
Capital grants – provincial and other	**(38,903)**	(27,879)
Increase (decrease) in accrued severance pay	**7**	(3,579)
Decrease in accrued sick leave	**(351)**	(3,782)
Amortization of deferred charges		
Net change in non-cash assets and liabilities related to operations *[note 12]*	**25,465**	(16,555)
Cash provided by (used in) operating transactions	**25,732**	(13,267)
Capital transactions		
Acquisition of tangible capital assets	**(38,903)**	(27,879)
Capital asset contributions	**38,903**	27,879
Cash provided by capital transactions	**—**	—
Investing transactions		
Sinking fund payments	**(1,478)**	(1,463)
Cash used in investing transactions	**(1,478)**	(1,463)
Financing transactions		
Repayment of long-term debt	**(942)**	(2,005)
Repayment of advance to General Hospital Hostel Association	**131**	128
Cash used in financing transactions	**(811)**	(1,877)
Net increase (decrease) in cash during the year	**23,443**	(16,607)
Cash (bank indebtedness), beginning of year	**(3,319)**	13,288
Cash (bank indebtedness), end of year	**20,124**	(3,319)
Supplemental disclosure of cash flow information		
Interest paid	**9,271**	9,348

See accompanying notes

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

1. NATURE OF OPERATIONS

The Eastern Regional Health Authority ["Eastern Health" or the "Authority"] is responsible for the governance of health services in the Eastern Region of the Province of Newfoundland and Labrador [the "Province"].

The mandate of Eastern Health spans the full health continuum, including primary and secondary level health and community services for the Eastern Region [Avalon, Bonavista and Burin Peninsulas, west to Port Blandford], as well as tertiary and other provincial programs/services for the entire Province. The Authority also has a mandate to work to improve the overall health of the population through its focus on public health as well as on health promotion and prevention initiatives. Services are both community and institutional based. In addition to the provision of comprehensive health care services, Eastern Health also provides education and research in partnership with all stakeholders.

Effective April 1, 2013, the operations of Public Health Laboratory ["PHL"] were transferred to Eastern Health. PHL was not a separate legal entity; it was a component of the provincial government of the Province. Prior to April 1, 2013, separate financial statements of PHL were prepared. From April 1, 2013 onwards, the assets, liabilities, revenues and expenses associated with the operations and activities of PHL have been recorded by Eastern Health.

Eastern Health is a registered charity and, while registered, is exempt from income taxes.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of accounting

The non-consolidated financial statements have been prepared in accordance with Canadian public sector accounting standards ["PSAS"] established by the Public Sector Accounting Standards Board of the Chartered Professional Accountants of Canada. The significant accounting policies used in the preparation of these non-consolidated financial statements are as follows:

Basis of presentation

These non-consolidated financial statements reflect the assets, liabilities, revenue and expenses of the Operating Fund. Trusts administered by Eastern Health are not included in the non-consolidated statement of financial position *[note 13]*. These non-consolidated financial statements have not been consolidated with those of other organizations controlled by Eastern Health because they have been prepared for the Authority's Board of Trustees and the Department of Health and Community Services [the "Department"]. Since these non-consolidated financial statements have not been prepared for general purposes, they should not be used by anyone other than the specified users. Consolidated financial statements have also been issued.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

Revenue recognition

Provincial plan revenue without eligibility criteria and stipulations restricting its use are recognized as revenue when the government transfers are authorized.

Government transfers with stipulations restricting their use are recognized as revenue when the transfer is authorized and the eligibility criteria are met by the Authority, except when and to the extent the transfer gives rise to an obligation that constitutes a liability. When the transfer gives rise to an obligation that constitutes a liability, the transfer is recognized in revenue when the liability is settled.

Medical Care Plan ["MCP"], inpatient, outpatient and residential revenues are recognized in the period services are provided.

The Authority is funded by the Department for the total of its operating costs, after deduction of specified revenue and expenses, to the extent of the approved budget. The final amount to be received by the Authority for a particular fiscal year will not be determined until the Department has completed its review of the Authority's financial statements. Adjustments resulting from the Department's review and final position statement will be considered by the Authority and reflected in the period of assessment. There were no changes from the previous year.

Other revenue includes dietary revenue, shared salaries and services and rebates and salary recoveries from Workplace, Health, Safety and Compensation Commission of Newfoundland and Labrador [the "Commission"]. Rebates and salary recovery amounts are recorded once the amounts to be recorded are known and confirmed by the Commission.

Expenses

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

Asset classification

Assets are classified as either financial or non-financial. Financial assets are assets that could be used to discharge existing liabilities or finance future operations and are not to be consumed in the normal course of operations. Non-financial assets are acquired, constructed or developed assets that do not provide resources to discharge existing liabilities but are employed to deliver healthcare services, may be consumed in normal operations and are not for resale.

Cash

Cash includes cash on hand and balances with banks that fluctuate from positive to negative.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

Inventory

Inventory is valued at the lower of cost and replacement cost, determined on a first-in, first-out basis.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Certain tangible capital assets, including buildings utilized by the Authority, are not reflected in these non-consolidated financial statements as legal title is held by the Government of Newfoundland and Labrador [the "Government"]. The Government does not charge the Authority any amounts for the use of such assets. Certain additions and improvements made to such tangible capital assets are paid for by the Authority and are reflected in the non-consolidated financial statements of the Authority.

Contributed tangible capital assets represent assets that are donated or contributed to the Authority by third parties. Revenue is recognized in the year the assets are contributed and have been recognized at fair value at the date of contribution.

Amortization is calculated on a straight-line or declining balance basis at the rates set out below.

It is expected that these rates will charge operations with the total cost of the assets less estimated salvage value over the useful lives of the assets as follows:

Land improvements	10 years
Buildings and improvements	40 years
Equipment	5 – 7 years
Equipment under capital leases	7 – 10 years

Gains and losses on disposal of individual assets are recognized in operations in the period of disposal.

Construction in progress is not amortized until the project is substantially complete, at which time the project costs are transferred to the appropriate asset class and amortized accordingly.

Impairment of long-lived assets

Tangible capital assets are written down when conditions indicate that they no longer contribute to the Authority's ability to provide goods and services, or when the value of future economic benefits associated with the tangible capital assets is less than their net book value. The net write-downs are accounted for as expenses in the non-consolidated statement of operations and accumulated deficit.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

Capital and operating leases

A lease that transfers substantially all of the benefits and risks associated with ownership of property is accounted for as a capital lease. At the inception of a capital lease, an asset and an obligation are recorded at an amount equal to the lesser of the present value of the minimum lease payments and the asset's fair value. Assets acquired under capital leases are amortized on the same basis as other similar capital assets. All other leases are accounted for as operating leases and the payments are expensed as incurred.

Employee future benefits

Accrued severance

Employees are entitled to severance benefits as stipulated in their conditions of employment. The right to be paid severance pay vests with employees with nine years of continual service with Eastern Health or another public sector employer. Severance is payable when the employee ceases employment with Eastern Health or the public sector employer, upon retirement, resignation or termination without cause. The severance benefit obligation has been actuarially determined using assumptions based on management's best estimates of future salary and wage changes, employee age, years of service, the probability of voluntary departure due to resignation or retirement, the discount rate and other factors. Discount rates are based on the Province's long-term borrowing rate. Actuarial gains and losses are deferred and amortized over the average remaining service life of employees, which is 14 years.

Accrued sick leave

Employees of Eastern Health are entitled to sick leave benefits that accumulate but do not vest. Eastern Health recognizes the liability in the period in which the employee renders service. The obligation is actuarially determined using assumptions based on management's best estimates of the probability of use of accrued sick leave, future salary and wage changes, employee age, the probability of departure, retirement age, the discount rate and other factors. Discount rates are based on the Province's long-term borrowing rate. Actuarial gains and losses are deferred and amortized over the average remaining service life of employees, which is 14 years.

Accrued vacation pay

Vacation pay is accrued for all employees as entitlement is earned.

Pension costs

Employees are members of the Public Service Pension Plan and/or the Government Money Purchase Plan [the "Plans"] administered by the Government. The Plans, which are defined benefit plans, are considered multi-employer plans. Contributions to the Plans are required from both the employees and Eastern Health. The annual contributions for pensions are recognized as an expense as incurred and amounted to $43,294,468 for the year ended March 31, 2015 [2014 – $38,827,731].

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

Sinking funds

Sinking funds established for the partial retirement of Eastern Health's sinking fund debenture are held and administered in trust by the Government.

Contributed services

Volunteers contribute a significant amount of their time each year assisting Eastern Health in carrying out its service delivery activities. Due to the difficulty in determining fair value, contributed services are not recognized in these non-consolidated financial statements.

Financial instruments

Financial instruments are classified in one of the following categories: [i] fair value or [ii] cost or amortized cost. The Authority determines the classification of its financial instruments at initial recognition.

Senior unsecured debentures and other long-term debt are initially recorded at fair value and subsequently measured at amortized cost using the effective interest rate method. Transaction costs related to the issuance of long-term debt are capitalized and amortized over the term of the instrument.

Cash and bank indebtedness are classified at fair value. Other financial instruments, including accounts receivable, sinking fund investment, accounts payable and accrued liabilities, due to/from government/other government entities and long-term debt are initially recorded at their fair value and are subsequently measured at amortized cost, net of any provisions for impairment.

Use of estimates

The preparation of non-consolidated financial statements in conformity with PSAS requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities as at the date of the non-consolidated financial statements, and the reported amounts of revenue and expenses during the reporting period. Areas requiring the use of management estimates include the assumptions used in the valuation of employee future benefits. Actual results could differ from these estimates.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

3. ACCOUNTS RECEIVABLE

Accounts receivable consist of the following:

	2015					
			Past due			
	Total	Current	1-30 days	31-60 days	61-90 days	Over 90 days
	$	$	$	$	$	$
Services to patients, residents and clients	**14,892**	**1,166**	**3,471**	**2,669**	**808**	**6,778**
Other	**7,819**	**873**	—	—	—	**6,946**
Gross receivables	**22,711**	**2,039**	**3,471**	**2,669**	**808**	**13,724**
Less impairment allowance	**2,944**	—	—	—	—	**2,944**
Net accounts receivable	**19,767**	**2,039**	**3,471**	**2,669**	**808**	**10,780**

	2014					
			Past due			
	Total	Current	1-30 days	31-60 days	61-90 days	Over 90 days
	$	$	$	$	$	$
Services to patients, residents and clients	16,523	926	3,065	3,139	1,692	7,701
Other	11,968	4,450	—	—	—	7,518
Gross receivables	28,491	5,376	3,065	3,139	1,692	15,219
Less impairment allowance	3,441	—	—	—	—	3,441
Net accounts receivable	25,050	5,376	3,065	3,139	1,692	11,778

4. DUE FROM GOVERNMENT/OTHER GOVERNMENT ENTITIES

	2015	2014
	$	$
Government of Newfoundland and Labrador	**80,061**	105,249
Other government entities	**8,139**	1,397
	88,200	106,646

Outstanding balances at the year-end are unsecured, interest free and settlement occurs in cash. For the year ended March 31, 2015, the Authority has not recorded any impairment of receivables relating to amounts above [2014 – nil].

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

5. TANGIBLE CAPITAL ASSETS

	Land and land improvements $	Buildings and improvements $	Equipment $	Equipment under capital leases $	Construction in progress $	Total $
2015						
Cost						
Opening balance	**2,810**	**381,391**	**481,372**	**15,445**	**39,389**	**920,407**
Additions (transfers)	**155**	**32,898**	**32,873**	**—**	**(27,023)**	**38,903**
Closing balance	**2,965**	**414,289**	**514,245**	**15,445**	**12,366**	**959,310**
Accumulated amortization						
Opening balance	**492**	**172,400**	**392,985**	**15,445**	**—**	**581,322**
Additions	**—**	**9,761**	**24,214**	**—**	**—**	**33,975**
Closing balance	**492**	**182,161**	**417,199**	**15,445**	**—**	**615,297**
Net book value	**2,473**	**232,128**	**97,046**	**—**	**12,366**	**344,013**

	Land and land improvements $	Buildings and improvements $	Equipment $	Equipment under capital leases $	Construction in progress $	Total $
2014						
Cost						
Opening balance	2,810	362,377	459,470	15,445	49,317	889,419
Opening - PHL	—	—	3,109	—	—	3,109
Additions (transfers)	—	19,014	18,793	—	(9,928)	27,879
Closing balance	2,810	381,391	481,372	15,445	39,389	920,407
Accumulated amortization						
Opening balance	492	152,951	367,267	15,445	—	536,155
Opening - PHL	—	—	2,611	—	—	2,611
Additions	—	19,449	23,107	—	—	42,556
Closing balance	492	172,400	392,985	15,445	—	581,322
Net book value	2,318	208,991	88,387	—	39,389	339,085

During fiscal 2014, certain building and equipment in the amount of $9,995,000 were no longer in productive use due to conditions indicating that future economic benefits associated with the underlying assets were less than the net book value. The write-down was included in amortization expense.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

6. OPERATING FACILITY

The Authority has access to lines of credit totalling $64,000,000 in the form of revolving demand loans and/or overdrafts at its financial institutions, which was unused as at March 31, 2015 [unused at 2014 – $64,000,000]. The Authority's ability to borrow has been approved by the Province's Minister of Health and Community Services.

7. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

	2015 $	2014 $
Accounts payable and accrued liabilities	**76,278**	66,747
Salaries and wages payable	**41,494**	38,089
Employee/employer remittances	**2,000**	2,225
	119,772	107,061

8. DUE TO GOVERNMENT/OTHER GOVERNMENT ENTITIES

	2015 $	2014 $
Federal government	**2,625**	11,826
Government of Newfoundland and Labrador	**5,935**	7,914
Other government entities	**763**	2,030
	9,323	21,770

9. DEFERRED CONTRIBUTIONS

	2015 $	2014 $
Deferred capital grants [a]		
Balance at beginning of year	**80,190**	65,984
Receipts during the year	**42,445**	42,085
Recognized in revenue during the year	**(38,903)**	(27,879)
Balance at end of year	**83,732**	80,190
Deferred operating contributions [b]		
Balance at beginning of year	**20,883**	12,910
Receipts during the year	**1,268,435**	1,252,090
Recognized in revenue during the year	**(1,272,995)**	(1,244,117)
Balance at end of year	**16,323**	20,883

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

[a] Deferred capital grants represent transfers from government and other government entities received with associated stipulations relating to the purchase of capital assets, resulting in a liability. These grants will be recognized as revenue when the related assets are acquired or constructed and the liability is settled.

[b] Deferred operating contributions represent externally restricted Government transfers with associated stipulations relating to specific projects or programs, resulting in a liability. These transfers will be recognized as revenue in the period in which the resources are used for the purpose specified.

10. LONG-TERM DEBT

	2015 $	2014 $
Sinking fund debenture, Series HCCI, 6.9%, to mature on June 15, 2040, interest payable semi-annually on June 15 and December 15 [the "Debenture"].	**130,000**	130,000
Royal Bank of Canada (Central Kitchen), 6.06% loan, unsecured, matured May 2014, payable in monthly instalments of $101,670.	—	208
Newfoundland and Labrador Housing Corporation ["NLHC"] (Placentia Health Centre), 2.75% mortgage, maturing in December 2020, repayable in blended monthly instalments of $18,216, secured by land and building with a net book value of $2,536,678.	**1,162**	1,346
Canadian Imperial Bank of Commerce loan (Dr. A. A. Wilkinson Memorial Health Centre), unsecured, bearing interest at the prime lending rate less 0.625 basis points, maturing in August 2016, repayable in monthly instalments of $21,200 plus interest.	**358**	612
NLHC (Inter Faith Citizens Home), 10% mortgage, maturing in December 2028, repayable in blended monthly instalments of $8,955, secured by land and building with a net book value of $866,447.	**815**	841

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

	2015 $	2014 $
NLHC (Access House) 2.40% mortgage, maturing in July 2020, repayable in blended monthly instalments of $1,022, secured by property with a net book value of $50,477.	**61**	72
Canada Mortgage and Housing Corporation ["CMHC"], (Blue Crest Cottages), 8.0% mortgage, maturing in November 2025, repayable in blended monthly instalments of $7,777, secured by land and buildings with a net book value of $2,805,738.	**674**	712
CMHC (Golden Heights Manor Seniors Home), 10.5% mortgage, maturing in August 2027, repayable in blended monthly instalments of $7,549, maturing in August 2027.	**636**	660
CMHC (Golden Heights Manor Seniors Home), 1.12% mortgage, maturing in June 2023, repayable in blended monthly instalments of $19,246.	**1,820**	2,017
	135,526	136,468

Future principal repayments to maturity are as follows:

	$
2016	763
2017	630
2018	544
2019	564
2020	585
Thereafter	132,440
	135,526

11. SINKING FUND

A sinking fund investment, established for the partial retirement of the Debenture *[note 10]*, is held in trust by the Government. The balance as at March 31, 2015 included interest earned in the amount of $5,981,612 [2014 – $5,251,000].

The semi-annual interest payments on the Debenture are $4,485,000. The annual principal payment to the sinking fund investment until the maturity of the Debenture on June 15, 2040 is $747,500. The semi-annual interest payments and mandatory annual sinking fund payments on the Debenture are guaranteed by the Government.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

12. NET CHANGE IN NON-CASH ASSETS AND LIABILITIES RELATED TO OPERATIONS

	2015 $	2014 $
Accounts receivable	**5,283**	6,874
Supplies inventory	**225**	(140)
Prepaid expenses	**112**	(823)
Accounts payable and accrued liabilities	**12,711**	985
Due from/to government/other government entities	**5,999**	(45,828)
Accrued vacation pay	**2,153**	315
Deferred capital grants	**3,542**	14,206
Deferred operating contributions	**(4,560)**	7,973
Public Health Laboratory cash flow change	—	(117)
	25,465	(16,555)

13. TRUST FUNDS

Trusts administered by the Authority have not been included in these non-consolidated financial statements as they are excluded from the Government reporting entity. As at March 31, 2015, the balance of funds held in trust for residents of long-term care facilities was $4,220,965 [2014 – $4,285,180]. These trust funds consist of a monthly comfort allowance provided to residents who qualify for subsidization of their boarding and lodging fees.

14. CONTINGENCIES

A number of legal claims have been filed against the Authority. An estimate of loss, if any, relative to these matters is not determinable at this time and no provision has been recorded in the accounts for these matters. In the view of management, the Authority's insurance program adequately addresses the risk of loss in these matters.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

15. CONTRACTUAL OBLIGATIONS

The Authority has entered into a number of multiple year operating leases, contracts for the delivery of services and the purchase of assets. These contractual obligations will become liabilities in the future when the terms of the contracts are met. The table below relates to the unperformed portion of the contracts:

	2016 $	2017 $	2018 $	2019 $	2020 $	Thereafter $
Future operating lease payments	13,290	11,942	10,878	10,047	8,664	56,714
Managed print services	2,635	2,000	2,000	2,000	2,000	—
Vehicles	322	181	127	66	—	—
	16,247	14,123	13,005	12,113	10,664	56,714

16. ACCRUED SEVERANCE PAY

The Authority provides a severance payment to employees upon retirement, resignation or termination without cause. In 2015, cash payments to retirees for the Authority's unfunded employee future benefits amounted to approximately $8,607,000 [2014 – $7,775,000]. The last actuarial valuation for both the accrued severance pay and accrued sick leave was performed effective March 31, 2012, and an extrapolation of that valuation has been performed to March 31, 2015.

The accrued benefit liability and benefits expense of the severance pay are outlined below:

	2015 $	2014 $
Accrued benefit liability, beginning of year	**110,799**	113,908
Accrued benefit liability, beginning of year – PHL	—	470
Benefits expense		
Current service cost	**7,359**	7,697
Interest cost	**4,298**	4,116
Amortization of actuarial losses and other	**(3,043)**	(7,617)
	119,413	118,574
Benefits paid	**(8,607)**	(7,775)
Accrued benefit liability, end of year	**110,806**	110,799

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

	2015 $	2014 $
Current year benefits cost	**7,359**	7,697
Amortization of actuarial gain/loss during the year	**435**	1,021
Benefits interest expense	**4,296**	4,116
Total expense recognized for the year	**12,090**	12,834

The significant actuarial assumptions used in measuring the accrued severance pay benefit expense and liability are as follows:

Discount rate – benefit liability	2.90% as at March 31, 2015 3.90% as at March 31, 2014
Discount rate – benefit expense	3.90% in fiscal 2015 3.60% in fiscal 2014
Rate of compensation increase	0% for 2012, 0% for 2013, 2% for 2014, 3% for 2015, and 3.25% thereafter plus 0.75% for promotions and merit as at March 31, 2015
	0% for 2012, 0% for 2013, 2% for 2014, 3% for 2015, and 3.25% thereafter plus 0.75% for promotions and merit as at March 31, 2014

17. ACCRUED SICK LEAVE

The Authority provides sick leave to employees as the obligation arises and accrues a liability based on anticipation of sick days accumulating for future use. In 2015, cash payments to employees for the Authority's unfunded sick leave benefits amounted to approximately $8,477,000 [2014 – $8,149,000]. The last actuarial valuation for both the accrued severance pay and accrued sick leave was performed effective March 31, 2012, and an extrapolation of that valuation has been performed to March 31, 2015.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

The accrued benefit liability and benefits expense of the sick leave are outlined below:

	2015 $	2014 $
Accrued benefit liability, beginning of year	**59,636**	63,288
Accrued benefit liability, beginning of year – PHL	**—**	130
Benefits expense		
Current service cost	**6,114**	6,274
Interest cost	**2,280**	2,249
Amortization of actuarial losses and other	**(268)**	(4,156)
	67,762	67,785
Benefits paid	**(8,477)**	(8,149)
Accrued benefit liability, end of year	**59,285**	59,636

	2015 $	2014 $
Current year benefits cost	**6,114**	6,274
Amortization of actuarial gain/loss during the year	**98**	417
Benefits interest expense	**2,280**	2,249
Total expense recognized for the year	**8,492**	8,940

The significant actuarial assumptions used in measuring the accrued sick leave benefit expense and liability are as follows:

Discount rate – benefit liability	2.90% as at March 31, 2015 3.90% as at March 31, 2014
Discount rate – benefit expense	3.90% in fiscal 2015 3.60% in fiscal 2014
Rate of compensation increase	2% for 2014, 3% for 2015, and 3.25% thereafter plus 0.75% for promotions and merit as at March 31, 2015
	2% for 2014, 3% for 2015, and 3.25% thereafter plus 0.75% for promotions and merit as at March 31, 2014

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

18. RELATED PARTY TRANSACTIONS

The Authority's related party transactions occur between the Government and other government entities. Other government entities are those who report financial information to the Province. Transactions between the Authority and related parties are conducted as arm's-length transactions.

Transfers from the Government consist of funding payments made to the Authority for both operating and capital expenditures. Transfers from other related government entities are payments made to the Authority from the Medical Care Plan and Workplace Health and Safety Compensation Commission. Transfers to other related government entities consist of payments made by the Authority to long-term care facilities, Central Regional Health Authority, Labrador Regional Health Authority and Western Regional Health Authority. Transactions are settled at prevailing market prices under normal trade terms.

The Authority had the following transactions with the Government and other government controlled entities:

	2015 $	2014 $
Transfers from the Province	**1,275,763**	1,215,089
Transfers from other government entities	**86,204**	87,335
Transfers to other government entities	**(107,995)**	(96,852)
	1,253,972	1,205,572

19. FINANCIAL INSTRUMENTS AND RISK MANAGEMENT

Financial risk

The Authority is exposed to a number of risks as a result of the financial instruments on its non-consolidated statement of financial position that can affect its operating performance. These risks include credit risk and liquidity risk. The Authority's Board of Trustees has overall responsibility for the oversight of these risks and reviews the Authority's policies on an ongoing basis to ensure that these risks are appropriately managed. The Authority is not exposed to interest rate risk as the majority of its long-term debt obligations are at fixed rates of interest. The source of risk exposure and how each is managed is outlined below:

Credit risk

Credit risk is the risk of loss associated with a counterparty's inability to fulfil its payment obligation. The Authority's credit risk is primarily attributable to accounts receivable. Eastern Health has a collection policy and monitoring processes intended to mitigate potential credit losses. Management believes that the credit risk with respect to accounts receivable is not material.

Liquidity risk

Liquidity risk is the risk that the Authority will not be able to meet its financial obligations as they become due. The Authority has an authorized credit facility [the "Facility"] of $64,000,000. As at March 31, 2015, the Authority had $64,000,000 in funds available on the Facility [2014 - $64,000,000]. To the extent that the Authority does not believe it has sufficient liquidity to meet current obligations, consideration will be given to obtaining additional funds through third-party funding or from the Province, assuming these can be obtained.

Interest rate risk

The Authority is exposed to interest rate risk with respect to its long-term debt because the fair value of the debt will fluctuate due to changes in market interest rates. A change in the interest rate on the long-term debt would have no impact on the non-consolidated financial statements since debt has a fixed rate of interest and is measured at amortized cost.

20. BUDGET

The Authority prepares an initial budget for a fiscal period that is approved by the Board of Trustees and the Government [the "Original Budget"]. The Original Budget may change significantly throughout the year as it is updated to reflect the impact of all known service and program changes approved by the Government. Additional changes to services and programs that are initiated throughout the year would be funded through amendments to the Original Budget and an updated budget is prepared by the Authority. The updated budget amounts are reflected in the budget amounts as presented in the non-consolidated statement of operations and accumulated deficit [the "Budget"].

The Original Budget and the Budget do not include amounts relating to certain non-cash and other items including tangible capital asset amortization, the recognition of provincial capital grants and other capital contributions, adjustments required to the accrued benefit obligations associated with severance and sick leave, and adjustments to accrued vacation pay as such amounts are not required by Government to be included in the Original Budget or the Budget. The Authority also does not prepare a full budget in respect of changes in net debt as the Authority does not include an amount for tangible capital asset amortization or the acquisition of tangible capital assets in the Original Budget or the Budget.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2015
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

The following presents a reconciliation between the Original Budget and the final Budget as presented in the non-consolidated statement of operations and accumulated deficit for the year ended March 31, 2015:

	Revenue $	Expenses $	Annual surplus $
Original Budget	**1,286,736**	**1,286,736**	—
Adjustments during the year for service and program changes, net	**83,116**	**83,116**	—
Revised Original Budget	**1,369,852**	**1,369,852**	—
Stabilization fund approved by the Government	**18,021**	**18,021**	—
Final Budget	**1,387,873**	**1,387,873**	—

21. EXPENSES BY OBJECT

This disclosure supports the functional display of expenses provided in the non-consolidated statement of operations and accumulated deficit by offering a different perspective of the expenses for the year. The following presents expenses by object, which outlines the major types of expenses incurred by the Authority during the year.

	2015 $	2014 $
Salaries	**730,851**	705,903
Supplies – other	**262,531**	234,587
Direct client costs	**134,643**	128,808
Employee benefits	**121,567**	106,296
Supplies – medical and surgical	**59,019**	62,826
Drugs	**50,655**	49,438
Amortization of tangible capital assets	**33,975**	42,556
Maintenance	**20,977**	22,317
Interest on long-term debt	**9,276**	9,354
Total expenses	**1,423,494**	1,362,085

22. COMPARATIVE FIGURES

Certain comparative figures have been reclassified from statements previously presented to conform to the presentation adopted for the current year.

SUPPLEMENTARY SCHEDULES

NON-CONSOLIDATED SCHEDULE OF EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2015 $ *[unaudited]*	2014 $ *[unaudited]*
Patient and resident services		
Acute care	**206,127**	199,067
Long-term care	**161,961**	144,673
Other patient and resident services	**17,247**	17,594
	385,335	361,334
Client services		
Community support programs	**179,116**	166,709
Family support programs	**3,236**	10,259
Health promotion and protection	**17,743**	16,881
Mental health and addictions	**28,588**	24,789
	228,683	218,638
Diagnostic and therapeutic		
Other diagnostic and therapeutic	**85,472**	84,750
Clinical laboratory	**56,776**	54,642
Diagnostic imaging	**49,095**	48,964
	191,343	188,356
Support		
Facilities management	**72,526**	64,451
Food services	**31,706**	30,859
Other support	**32,328**	30,987
Housekeeping	**30,812**	29,410
Laundry and linen	**9,753**	10,191
	177,125	165,898
Ambulatory care		
Outpatient clinics	**89,884**	82,262
Emergency	**34,368**	32,529
Dialysis	**16,861**	16,003
Other ambulatory	**13,190**	14,826
	154,303	145,620

NON-CONSOLIDATED SCHEDULE OF EXPENSES FOR GOVERNMENT REPORTING [Cont'd]

Year ended March 31
[in thousands of dollars]

	2015	2014
	$	$
	[unaudited]	*[unaudited]*
Administration		
Other administrative	**40,398**	37,736
Materials management	**20,723**	18,998
Systems support	**23,990**	19,444
Human resources	**14,630**	13,793
Executive offices	**6,891**	14,346
Finance and budgeting	**10,479**	10,852
Emergency preparedness	**1,292**	819
	118,403	115,988
Medical services		
Physician services	**79,429**	78,305
Interns and residents	**20,494**	22,160
	99,923	100,465
Other		
Undistributed	**7,195**	5,322
Research and education		
Education	**13,587**	13,043
Research	**2,537**	2,692
	16,124	15,735
Interest on long-term debt	**9,276**	9,354
Total shareable expenses	**1,387,710**	1,326,710

NON-CONSOLIDATED SCHEDULE OF REVENUE AND EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2015 $ *[unaudited]*	2014 $ *[unaudited]*
Revenue		
Provincial plan	**1,232,070**	1,175,985
Medical Care Plan	**77,434**	75,697
Inpatient	**12,422**	13,302
Resident	**18,479**	17,711
Outpatient	**8,225**	8,061
Other	**40,769**	38,707
	1,389,399	1,329,463
Expenses		
Compensation		
Salaries	**730,851**	705,903
Employee benefits	**119,758**	113,477
	850,609	819,380
Supplies		
Other	**262,531**	234,587
Medical and surgical	**59,019**	62,826
Drugs	**50,655**	49,438
Plant operations and maintenance	**20,977**	22,317
	393,182	369,168
Direct client costs		
Community support	**129,730**	122,601
Family support	**2,997**	4,356
Mental health and addictions	**1,916**	1,851
	134,643	128,808
Lease and long-term debt		
Long-term debt – interest	**9,276**	9,354
Long-term debt – principal	**1,689**	2,753
	10,965	12,107
	1,389,399	1,329,463
Surplus (deficiency) for government reporting	—	—
Long-term debt – principal	**1,689**	2,753
Surplus (deficiency) before non-shareable items	**1,689**	2,753

NON-CONSOLIDATED SCHEDULE OF REVENUE AND EXPENSES FOR GOVERNMENT REPORTING [Cont'd]

Year ended March 31
[in thousands of dollars]

	2015 $ *[unaudited]*	2014 $ *[unaudited]*
Adjustments for non-shareable items		
Provincial plan capital grant	**31,878**	22,121
Other capital contributions	**7,025**	5,758
Amortization of tangible capital assets	**(33,975)**	(42,556)
Interest on sinking fund	**731**	715
Accrued vacation pay	**(2,153)**	(180)
Accrued sick leave	**351**	3,782
Accrued severance pay (recovery)	**(7)**	3,579
	3,850	(6,781)
Annual surplus (deficiency) as per statement of operations and accumulated deficit	**5,539**	(4,028)

NON-CONSOLIDATED SCHEDULE OF CAPITAL TRANSACTIONS FUNDING AND EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2015	2014
	$	$
	[unaudited]	*[unaudited]*
Revenue		
Provincial plan	**43,693**	39,104
Deferred grants – previous year	**80,190**	65,984
Foundations and auxiliaries	**5,784**	4,630
Transfer from PHL	**—**	164
Transfer from operations	**2,576**	—
Transfer to operations	**(10,763)**	(2,817)
Transfer to other regions	**(86)**	(124)
Other	**1,241**	1,128
Deferred grants – current year	**(83,732)**	(80,190)
	38,903	27,879
Expenses		
Equipment	**32,873**	18,367
Construction in progress	**(27,023)**	(9,928)
Buildings	**32,898**	19,014
Vehicles	**—**	426
Land	**155**	—
	38,903	27,879
Surplus on capital transactions	**—**	—

NON-CONSOLIDATED SCHEDULE OF ACCUMULATED DEFICIT FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2015	2014
	$	$
	[unaudited]	*[unaudited]*
Assets		
Current assets		
Cash	**20,124**	—
Accounts receivable and due from government and other government entities	**107,967**	131,696
Supplies inventory	**15,312**	15,537
Prepaid expenses	**4,764**	4,876
	148,167	152,109
Advance to General Hospital Hostel Association	**989**	1,120
	149,156	153,229
Liabilities		
Current liabilities		
Bank indebtedness	—	3,319
Accounts payable and accrued liabilities and due to government and other government entities	**129,095**	128,831
Deferred revenue – operating revenue	**16,323**	20,883
Deferred revenue – capital grants	**83,732**	80,190
	229,150	233,223
Accumulated deficit from Public Health Laboratory	—	(18)
Accumulated deficit for government reporting	**(79,994)**	(80,012)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