Together we can

Annual Performance Report
2012 - 2013

ANNUAL PERFORMANCE REPORT
2012 - 2013

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Message from the Board of Trustees

On behalf of the Board of Trustees of Eastern Health I am very pleased to provide this Annual Performance Report for 2012-13.

The fiscal year 2012-13 marks the second year of Eastern Health's Strategic Plan *Together We Can*. This plan has outlined specific goals, objectives and indicators associated with each of our four priority areas: quality and safety, access, sustainability and population health. This approach permits Eastern Health to clearly outline the progress the organization is making and highlights areas where improvement is required.

I am proud of Eastern Health and the many individuals and groups both internal and external to the organization who work hard to strive for *Healthy People, Healthy Communities.* Public involvement in the health and community services sector has increased tremendously over the past few decades. The Board of Eastern Health welcomes the participation of citizens in decisions that impact on their health and the determinants of health.

This Annual Performance Report is one way that the organization documents its commitment to its Strategic Plan and the progress that it has made. In particular, I acknowledge all of the employees, physicians and volunteers who have worked so hard at ensuring that the organization achieves its goals.

The Board of Trustees of Eastern Health is accountable for the preparation of the Annual Performance Report, the results and any variances encountered.

Michael J. O'Keefe
Chair, Board of Trustees

Board of Trustees
Top row: Michael J. O'Keefe - Chair, William Abbott, William C. Boyd, Dr. Alice Collins, Frank Davis - Vice Chair
Bottom row: Ed Drover, Earl Elliott, Sister Sheila O'Dea, Cindy Goff, Shirley Rose

1. Overview

As the largest integrated health authority in Newfoundland and Labrador, Eastern Health serves a regional population of approximately 306,000 (Census 2012) and provides the full continuum of health and community services, including public health, long-term care, community services and hospital care. Health and community-based services are offered through community-based offices, hospitals, nursing homes and medical clinics.

In addition to its regional responsibilities, Eastern Health is responsible for provincial tertiary level health services through both its academic health care facilities and provincial programs such as cancer care and mental health and addictions. Eastern Health also partners with a number of organizations – particularly Memorial University of Newfoundland and the College of the North Atlantic – to educate the next generation of health professionals, advance knowledge, conduct research and improve patient, client and resident care.

For the fiscal year 2012-13 the organization had a budget of approximately $1.3 billion, 12,810 employees, and over 720 members of medical staff (approximately 244 of whom are salaried).

Eastern Health benefitted from approximately 1,200 volunteers who provided more than 52,000 hours of volunteer work, from friendly visiting with residents to fund-raising. Eastern Health operated 2,739 beds for 2012-13: 1,668 long-term care; 904 acute care; 95 critical care; 62 rehabilitative; and 10 palliative care.

Foundations have a significant relationship with Eastern Health through their contribution of time and resources to raise funds for our facilities and services. Eastern Health's six foundations are overseen by volunteer boards of directors: 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.

Auxiliaries are associated with most of Eastern Health's facilities. These groups provide direct services (e.g., gift shops, volunteer resources) and help to raise funds for equipment and services.

Overview

1.1. The Region

The geographic boundaries for Eastern Health include the island portion of the province east of (and including) Port Blandford. This area includes the entire Avalon, Burin and Bonavista Peninsulas as well as Bell Island, within a total of 21,000 km^2. In total, the Eastern Health region includes 111 incorporated municipalities, 69 local service districts and 66 unincorporated municipal units.

Eastern Health operates sites in the communities noted on the map in Figure 1:

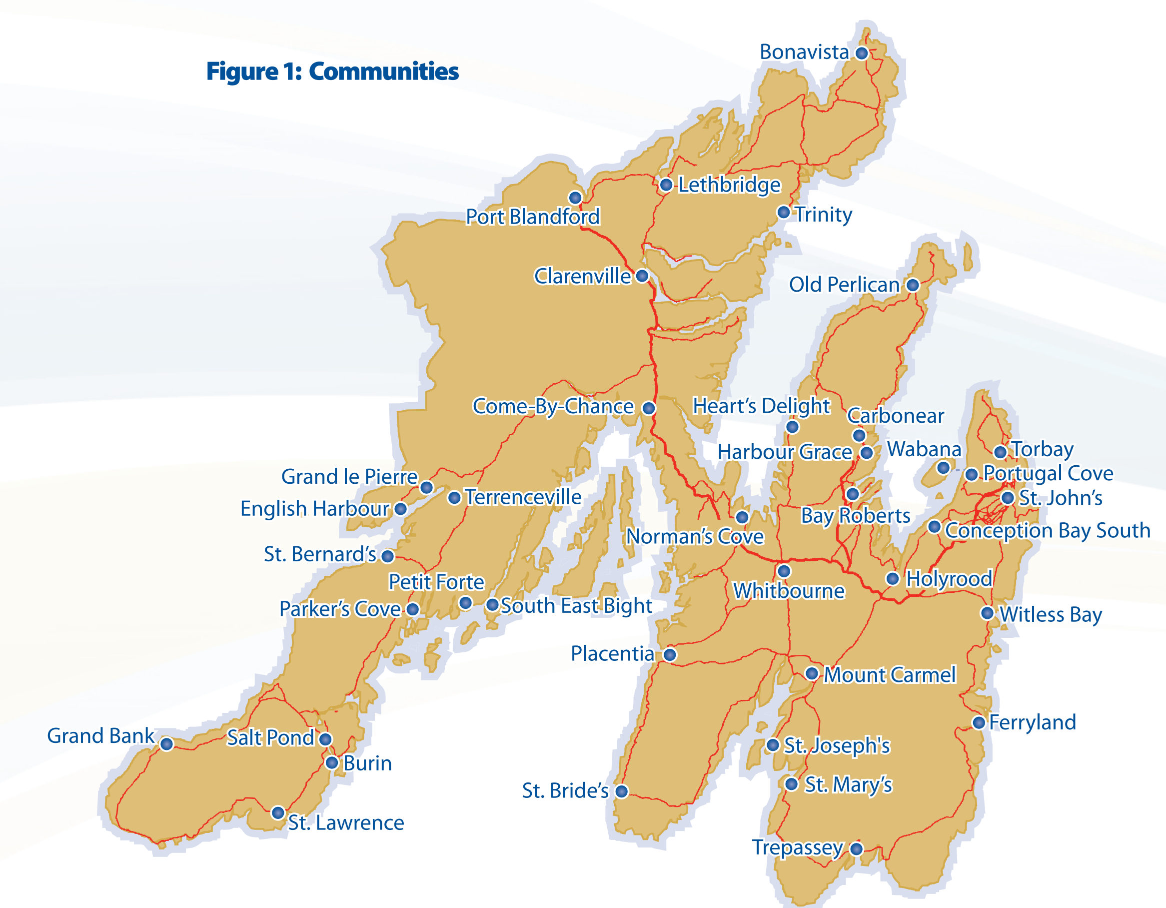
1.2. Vision

The vision of Eastern Health is *Healthy People, Healthy Communities.* This vision acknowledges that both the individual and the community have important roles to play in maintaining good health. Healthy communities enhance the health of individuals, and when individuals are healthy, communities are generally healthy.

1.3. Mission

By March 31, 2017, Eastern Health will have improved programs and services to increase its safety, quality, accessibility, efficiency and sustainability and to contribute to the overall health of the population.

Figure 1: Communities



1.4. Values

Eastern Health's core values provide meaning and direction to its employees, physicians and volunteers as they deliver quality programs and services. The Board of Trustees of Eastern Health reaffirmed the values of the organization during its most recent strategic planning initiatives.
The values are:

Respect
Recognizing, celebrating and valuing the uniqueness of each patient, client, resident, employee, discipline, workplace and community that together are Eastern Health.

Integrity
Valuing and facilitating honesty and open communication across employee groups and communities as well as with patients, clients and residents of Eastern Health.

Fairness
Valuing and facilitating equity and justice in the allocation of our resources.

Connectedness
Recognizing and celebrating the strength of each part, both within and beyond the structure, that creates the whole of Eastern Health.

Excellence
Valuing and promoting the pursuit of excellence in Eastern Health.

1.5. Lines of Business

Eastern Health's lines of business are the programs and services delivered to our patients, clients, residents and their families. These programs and services improve the health and well-being of individuals and communities throughout the entire 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;
4) Advance Knowledge

Various health and community services are offered throughout the region and, in some cases, throughout the province. Each program and service has its own access criteria, and local health providers work with individuals to determine the most appropriate services based on identified needs. A detailed listing of Eastern Health's lines of business is available in the organization's Strategic Plan and at www.easternhealth.ca.

1.6. Employees

Eastern Health has 12,810 employees[1]. Over 82 per cent of employees are female. Figure 2 shows Eastern Health employees by classification.

Figure 2: Eastern Health Employees by Classification

45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

5.3% - Allied Health
1.0% - Clinical Clerks
3.6% - CUPE
5.2% - Management
43.9% - NAPE
5.6% - NAPE LX (Lab/Xray)
0.8% - NAPE CH (Community Health)
1.4% - Nape HP (Health Professionals)
1.7% - Non Bargaining
27.1% - NLNU
2.0% - PAIRN (Interns/Residents)
1.5% - Salaried Medical
0.9% - Special Contract and Students

1 The number of employees provides a general "snapshot", as this number can fluctuate through the year (e.g., during summer hiring). This number is provided as of March 31, 2013.

1.7. Provincial Mandate

In addition to the regional mandate, Eastern Health has unique provincial responsibilities for tertiary level institutional services including:

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

In an effort to bring services closer to where people live, the organization also administers provincial outreach programs:

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

The organization also administers distinctive provincial services to other areas of the province, including:

- 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 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 Synagis® Program – Respiratory Syncytial Virus (RSV)
- Stem Cell Transplantation

The organization has distinctive roles in education and research that are associated with its position within the academic health sciences community. The organization's primary education and research partner is Memorial University of Newfoundland.

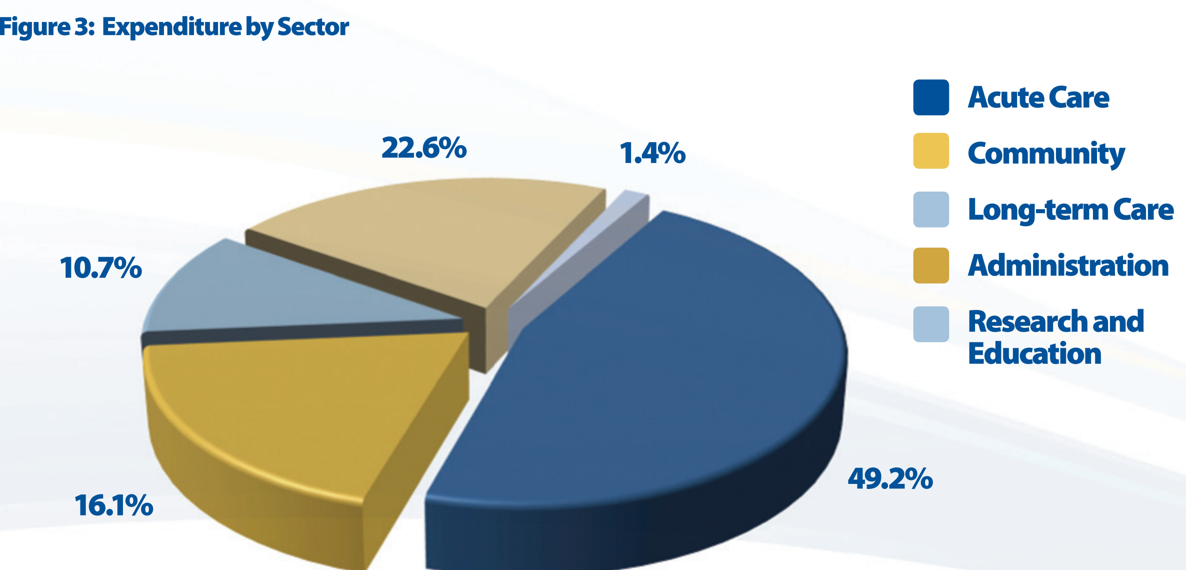
1.8. Revenues and Expenditures

Eastern Health's budget for 2012-13 was $1.3 billion. The Government of Newfoundland and Labrador's Budget 2012 announced new initiatives to reduce emergency department wait times and joint replacement surgery wait times. Investments have also been made to enhance dialysis services, improve breast cancer screening and better serve adults who lack the capacity to care for themselves. New funding focusing on long-term care and community supports has also been targeted.

Additionally, Budget 2012 provided funding to address current service level adjustments such as salary related increases, inflation/utilization increases, home support rate increases and home support growth.

Financially Eastern Health finished the period ending March 31, 2013 with an $8.3 million deficit. Figure 3 provides Eastern Health's expenditures by sector for 2012-13.

Figure 3: Expenditure by Sector

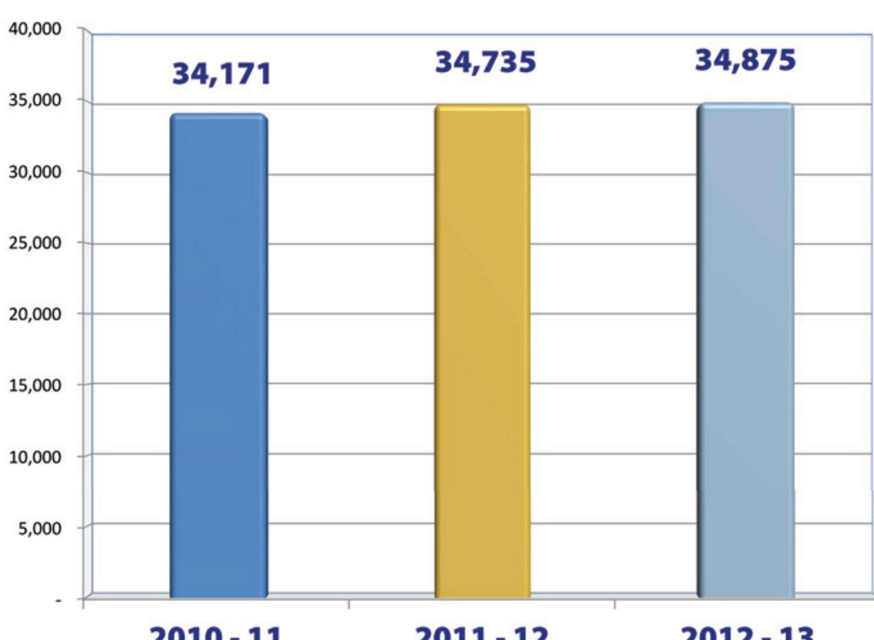


1.9. Other Key Performance Indicators

Eastern Health tracks numerous key performance indicators. The following figures provide some of the statistics from the organization over the past three fiscal years[2].

Figure 4 shows that acute care admissions were 34,875 for 2012-13, which were consistent with the previous two years.

Figure 4: Acute Care Admissions



2 Eastern Health is standardizing and automating the data provided in this report. The data set used is in compliance with the Standards for Management Information Systems in Canadian Health Service Organizations (MIS Standards), a set of national standards used across the health care system to collect and report financial and statistical data from health service organizations. There may be some variance from previously reported data.

Figure 5 indicates that acute care inpatient days in 2012-13 totalled 300,064, consistent with the previous two years.

Figure 5: Acute Care Inpatient Days

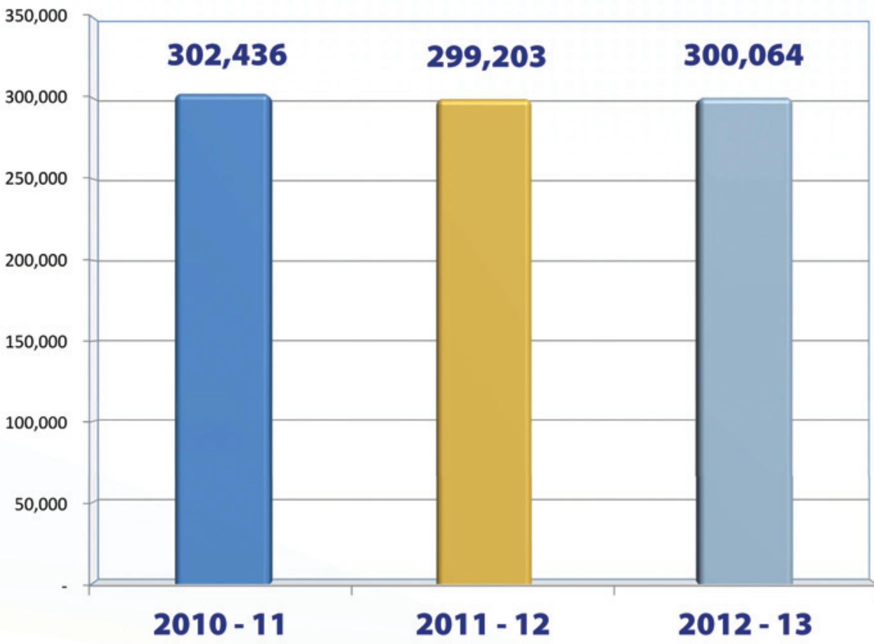
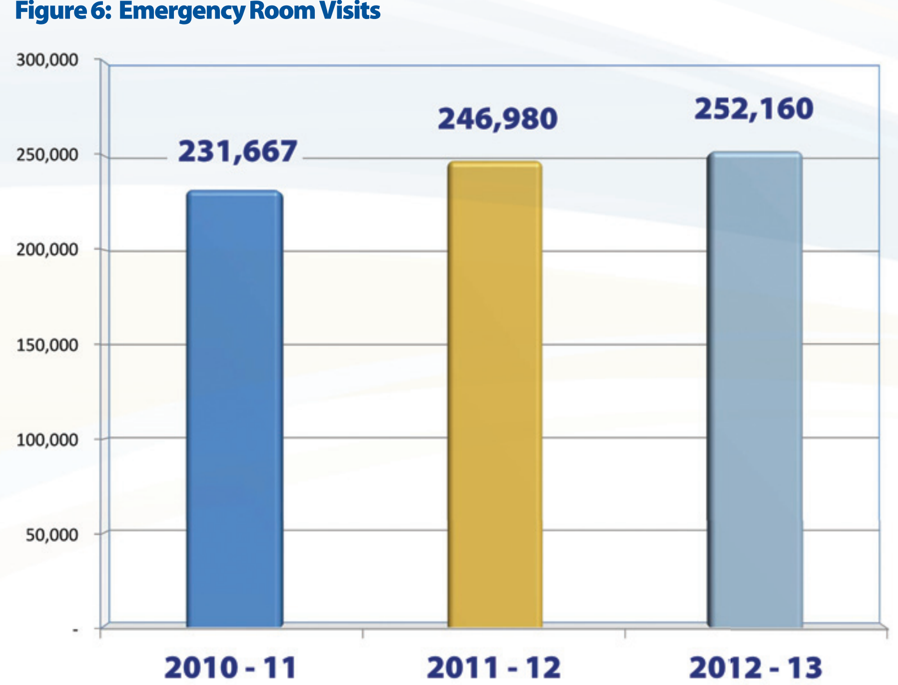


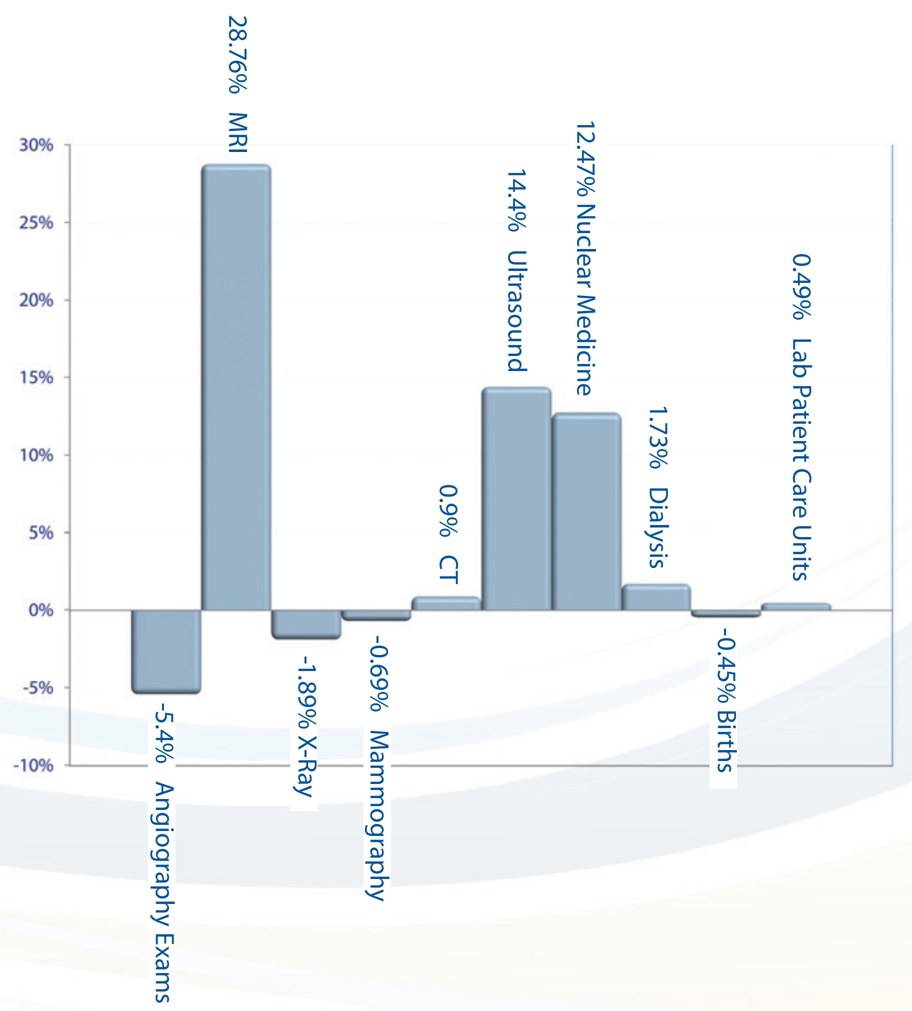
Figure 6 shows the number of Emergency Room visits for the past three years which continue to increase to 252,160 visits in 2012-13, a 2.1 per cent increase over 2011-12.

Figure 6: Emergency Room Visits



The volume comparisons chart in Figure 7[3] shows some of the areas where Eastern Health has experienced service delivery volume changes for the year ending March 31, 2013, versus the year ending March 31, 2012. Increases in the volumes of MRI exams can be attributed to the operationalization of a third MRI system (St. Clare's) resulting in an additional 16 hours per week day of MRI access/capacity. Restructuring of the daily exam scheduling template and establishment of daily exam targets per technologist resulted in increased capacity and increased exam volumes for ultrasound. Increases in nuclear medicine occurred due to the restructuring of the daily exam scheduling template and an increase in the number of cardiac procedures performed each week. Similarly, a decrease in the volume of angiography exams occurred due to the restructuring of the daily exam scheduling template.

Figure 7: Volume Comparisons Chart



3 The MIS Standardized Diagnostic Imaging Workload Units (WLU) were revised effective April 01, 2013. With the move to Imaging and Therapeutic System (ITS) in October 2012 (Meditech Consolidation), the Diagnostic Imaging program moved to the new workload units. A percentage of the increases being noted may be as a result of workload counts from the period of October 09, 2012 to March 31, 2013. The revision to the workload measurement included changes in exam counts in some instances. Given this change year over year comparisons may not be accurate.

Acute care ambulatory encounters include all outpatient activity in Eastern Health's acute care sites: people who come in for any outpatient services, from blood tests to X-rays to clinic appointments, to emergency room visits, to day surgery (i.e., procedures that do not require admission). As seen in Figure 8, there was an increase of 3.6 per cent in the acute care ambulatory encounters in 2012-13 compared to the previous year.

Figure 8: Acute Care Ambulatory Encounters

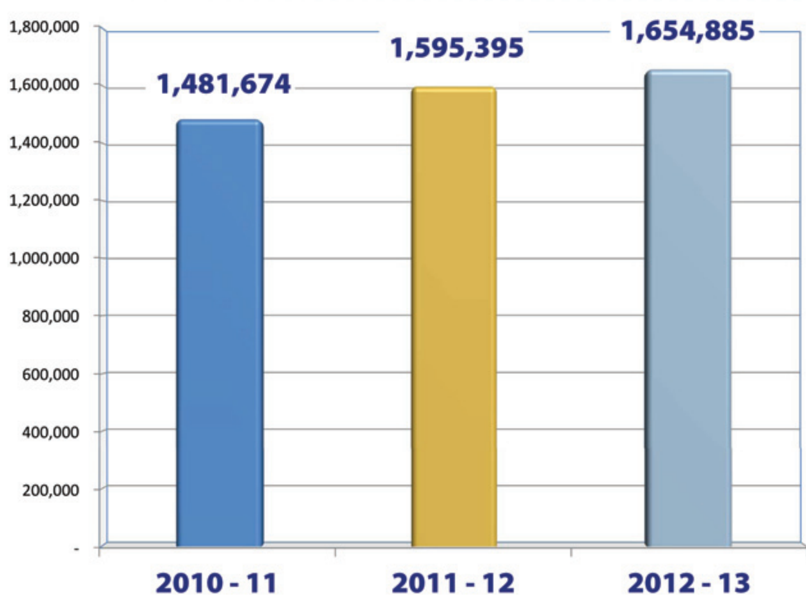


Figure 9 shows that long-term care resident days have continued to increase over the past three years and by 4,502 resident days in 2012-13 over 2011-12.

Figure 9: Long-term Care Resident Days

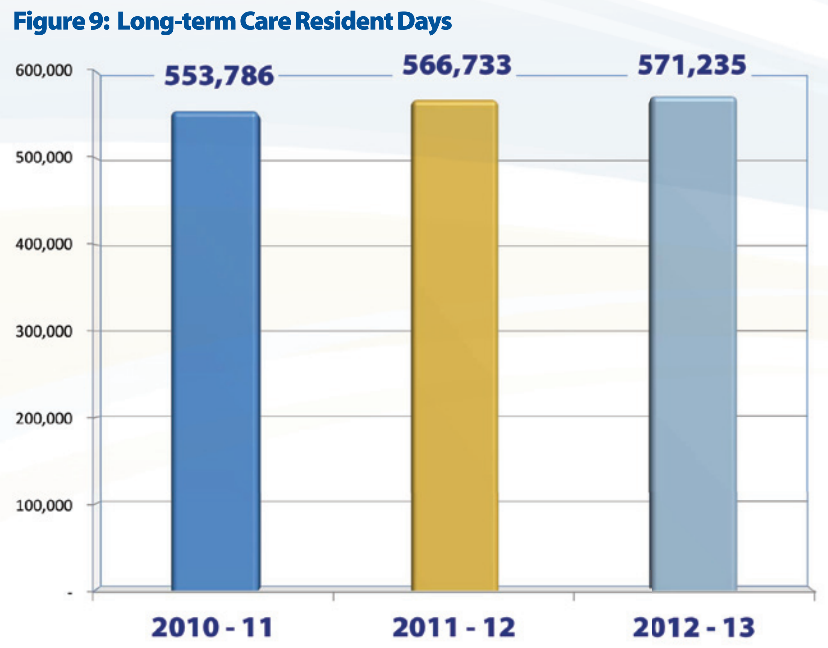


Figure 10 shows the number of community health service events from 2010-11 to 2012-13.[4]

Figure 10: Community Health Service Events

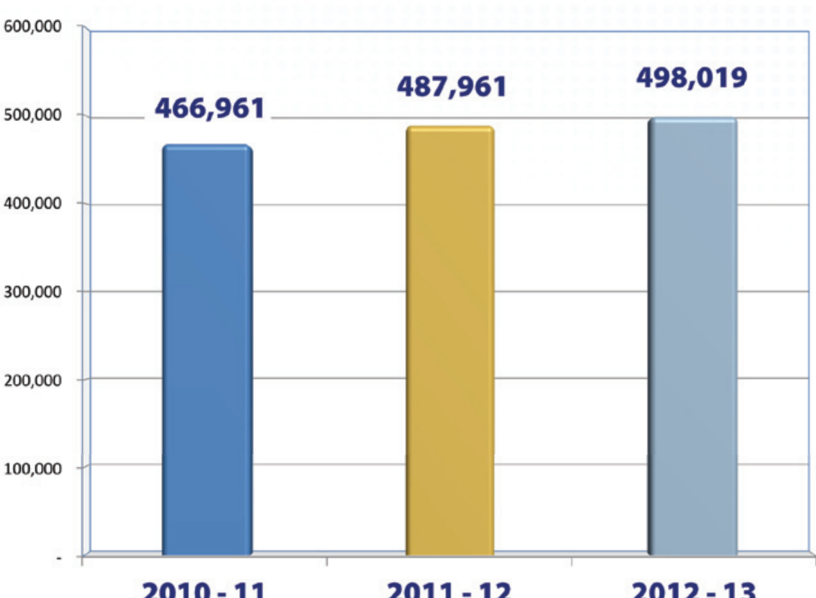
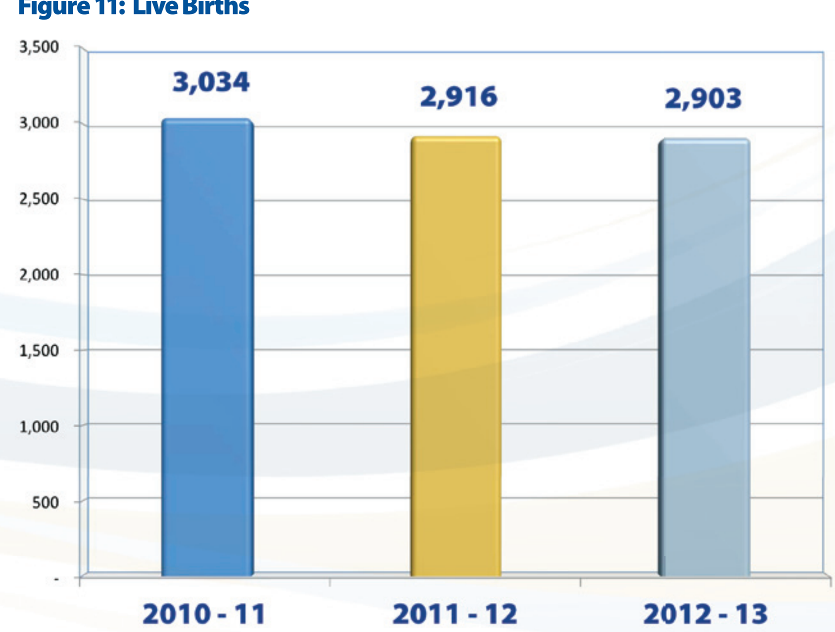


Figure 11 outlines the number of live births at Eastern Health facilities over the past three years which have remained relatively unchanged over the past three years.

Figure 11: Live Births



4 Caution must be exercised when reviewing the data from the community sector. This data is calculated by entries into the Client Referral Management System (CRMS), an electronic database system. Not all program data is entered electronically in CRMS. Some service events are collected manually and this information is not included in the figures provided in this document, resulting in an under-reporting of service events. A service event is used as a measure for a patient or client visit in the community.

2. Shared Commitments

Embedded in Eastern Health's vision and values is recognition of and commitment to the importance of establishing partnerships for the mutual benefit of the organization and the individuals and communities it serves. The organization acknowledges the strength of each component that exists within and beyond the structure that is Eastern Health.

Eastern Health is committed to aligning its priorities with the Provincial Government's Strategic Directions by working closely with officials from the Department of Health and Community Services (DOHCS) on a range of activities. Eastern Health also has a close working relationship with the provincial Department of Child, Youth and Family Services through a memorandum of understanding which outlines the working relationship between the two entities and helps ensure continued collaboration.

Eastern Health has many external partners, such as professional associations, regulatory boards, unions, schools, police, ambulance service providers, and research affiliates. Eastern Health has partnerships with over 40 educational institutions and organizations to help educate the next generation of health providers. The organization has a particularly strong affiliation with Memorial University of Newfoundland to achieve its mandate of education and research. Eastern Health has close links with the Newfoundland and Labrador Centre for Applied Health Research (NLCAHR), the Newfoundland and Labrador Centre for Health Information (NLCHI) and the Health Research Ethics Authority.

Eastern Health has approximately 1,200 volunteers, dedicated to enhancing the quality of life for patients, clients, residents and their families. Volunteers include approximately 16 active auxiliaries and six foundations that are associated with various health and long-term care sites throughout the region. In addition to the efforts of its volunteers, Eastern Health benefits from the commitment of numerous volunteer agencies and community partners, such as Lions Clubs, Kinsmen, Bell Aliant Pioneers, the St. John Ambulance Therapy Dog Program, and various faith-based groups.

Close connections continue between Eastern Health and the faith-based owner boards for long-term care services in the St. John's area and Clarke's Beach. Eastern Health recognizes the work of these boards in providing long-term care services and will continue to work collaboratively to define each other's roles and accountabilities.

Based on a 1994 agreement between France and Canada, Eastern Health maintains a unique relationship with the hospital/health centres in Saint-Pierre et Miquelon. There is a tripartite agreement with Caisse de Prévoyance Sociale (CPS) and Centre Hospitalier F. Dunan (CHFD) to provide services to the people of these French islands.

The provincial Public Health Laboratory (PHL) had been a Division of Department of Health and Community Services with financial, human resources, purchasing and infrastructure support provided by Eastern Health for many decades. In January 2013, the administrative and technical oversight for the PHL was transferred to the Laboratory Medicine Program of Eastern Health. The mandate of the PHL is at the population health level, to support protecting and promoting the health and well-being of Newfoundlanders and Labradorians.

During 2012-13, there are many examples of Eastern Health's work with its external partners. They are broad-ranging and vary from program-specific to organization-wide. Examples include the Board of Trustees meeting with community partners to improve navigation of the health and community services sector. As part of this session, Board members heard from a number of community partners about the importance of making access to services as timely and seamless as possible. This particular event is an example of how Eastern Health is moving forward the Strategic Directions of *Access to Priority Services* and *Accountability and Stability in the Delivery of Health and Community Services.*

From the perspective of the Strategic Direction of *Population Health*, Eastern Health has worked extensively with many partner organizations on a number of initiatives, including the Wellness Coalitions to provide guidance on a number of topics to improve population health, such as healthy eating. The organization also works with various municipalities on Health Emergency Management to ensure readiness and contingency plans are in place in the event of an emergency.

Partnerships such as those with the St. John's Native Friendship Centre to enhance services to the aboriginal community further the Strategic Direction of *Access to Priority Services* and *Population Health.*

3. Highlights and Accomplishments

This section of the report highlights some of the accomplishments achieved by Eastern Health during 2012-13. These highlights are presented according to the Strategic Directions of government as communicated by the Minister of Health and Community Services: *Population Health; Access to Priority Services* and *Accountability and Stability in the Delivery of Health and Community Services*. These accomplishments also reflect Eastern Health's values of respect, integrity, fairness, connectedness and excellence.

Population Health

In addition to the Report on Performance section of this report that outlines progress related to Eastern Health's strategic priority of Population Health, the following are some of the accomplishments Eastern Health has achieved in this area in 2012-13. These highlights demonstrate Eastern Health's commitment to the Strategic Direction of *Population Health*. Focus areas of this Strategic Direction are: Aboriginal Health, Cancer Care, Communicable Disease, Chronic Disease Management, Environmental Health, Health Emergency Management, Healthy Aging, Healthy Eating/Physical Activity, Injury Prevention, Maternal/Newborn Health, Smoking Rates and Protection from Environmental Smoke and Wellness.

Many of the highlights listed here focus on activities that are meant to result in a healthier population by educating the public about healthy living, preventing chronic and acute illness, injury and disease as well as working collaboratively with communities. They support the focus areas and Strategic Direction of Population Health.

- Launched a Chronic Disease Prevention and Management Strategy based on the provincial *Expanded Chronic Care Model.*
- Offered Chronic Disease Self-Management workshops with 26 new lay leaders trained; 19 workshops offered with 155 individuals completing the series.
- Released the final report of the Trinity-Conception Community Health Needs Assessment, the fifth and final needs assessment conducted within Eastern Health's geographical jurisdiction.

- Organized a Board of Trustees Partnership Event with external stakeholder groups to discuss navigation of the health and community services system. From that arose a number of action items which are ongoing.
- Developed *Working in Health Promoting Ways, Where We Live, Work, Learn and Play,* a comprehensive plan designed to support the integration of health promotion into practice and improve the health of the population served by Eastern Health.
- Completed a Regional Health Status Report.
- Launched ***B4UR Pregnant*** project designed to inform all women of child-bearing age about the benefits of preparing for and having a healthy pregnancy.
- Produced multi-media resource materials for Grief and Bereavement Information and Support Program.
- Increased outreach services to a number of community agencies including, Choices for Youth, Salvation Army, Stella's Circle, the St. John's Native Friendship Centre, Thrive and Community Centres.
- Partnered with schools and community agencies to offer *Friends for Life*, an anxiety prevention and intervention program targeting elementary students, and *Strengthening Families*, an evidence-based substance abuse prevention program.
- Created a new Lactation Consultant position, with funding from the Department of Health and Community Services, and held breastfeeding training for Public Health staff.

Access to Priority Services

The Provincial Government has defined a Strategic Direction of *Access to Priority Services* in a number of focus areas. These focus areas include: access management, long-term care and community supports, mental health and addictions services, pharmacare initiatives, pre-hospital/emergency and rural health. These highlights show some of the work that Eastern Health has done in 2012-13 in support of the Strategic Direction of *Access to Priority Services:*

Wait Times

- Installed a third Magnetic Resonance Imaging (MRI) scanner.
- Reduced non-urgent wait times for access to MRI, CT and Ultrasound. The median wait time for CT at the end of the first quarter of 2008-09 was 112 days and March 2013 it was 13 days. The median wait time in 2009-10 for ultrasound was 176 days and in March 2013 it was 44 days. The MRI median wait time in 2011-12 was 151 days and for March 2013 it was 37 days.
- Continued to achieve national benchmarks for access to radiation services with 96-98 per cent of newly diagnosed cancer patients commencing radiation treatment within the 28-day benchmark.
- Installed a new, high precision radiation treatment which will allow for shorter patient treatments, and improved patient access. This advanced technology improves the existing treatments including Stereotactic Radiosurgery.
- Decreased the number of longest waiting patients for hip and knee replacement surgery by 40 cases.

Highlights and Accomplishments

- Improved capacity for orthopedic surgery by 56 per cent (3,514 additional patients) as compared with 2011-12. This improvement is based on continued implementation of the Orthopedic Central Intake process so that all patient referrals are screened and triaged for appropriateness and acuity, and prioritized for booking.
- Reduced wait times for a number of community-based mental health and addictions services through waitlist reviews, increasing the number of groups offered and introducing brief intervention models such as at the Harbour Grace office where mental health counseling wait times decreased from up to eight months to four months.
- Reduced wait time at the Opioid Treatment Centre between April 1, 2012 to December 31, 2012 from 18 months to six months.
- Regionalized kidney and dialysis services resulting in a more efficient delivery of care. Wait lists have been eliminated across Eastern Health by allowing a fluid movement of patients and care givers to meet demand. Pre-renal care has been introduced into our rural sites to allow for improved access and care.
- Implemented non-physician clinics within the HIV program thereby eliminating the wait list.
- Reduced wait times in a number of areas in the Medicine program through process improvement projects, including Neurology Division Movement Disorders Clinic which decreased wait time from 12 months to two months for Parkinson's patient referrals and three months for Multiple Sclerosis (MS) new patient referrals; Patient standard of care post Thyroid Cancer surgery to receive Radioactive Iodine (RAI) patient treatments has decreased from six months to three months; decreased wait time for a lung test in the Pulmonary Function Laboratory from six months to six weeks.
- Median wait times for urgent cardiac catheterization were reduced from four days in 2011-12 to two days in 2012-13 by adding a third procedure room and adding two dedicated cardiac catheterization beds.
- Increased service volumes in the Ambulatory Treatment Unit at the Health Sciences Centre by 20 per cent by re-organizing the schedule and reassessing the timelines for treatment.
- Implemented a Tele-ophthalmology Program at the Burin Peninsula Health Care Centre to decrease wait time and travel time for patients.

Program Enhancements

- Implemented an Emergency Department Access project in city hospitals. This includes matching staffing hours to times of patient presentation and commencement of Lean (maximizing value through continuous improvement efforts) thinking processes.
- Implemented a travelling vascular clinic in association with the Regional Health Authorities (RHAs) throughout the province, improving services through closer ongoing monitoring and increased collaboration with health care professionals throughout the province.
- Received notice the Cancer Care program's Tele-Oncology service was deemed a leading practice nationally following an environmental scan commissioned by the Canadian Partnership Against Cancer (CPAC).

- Completed an evaluation of NAVNET, a coordinated effort between government departments and community agencies to reduce systems-barriers and increase service access for individuals with complex needs.
- Redeveloped and relocated the Adult Insulin Pump Clinic to the Major's Path Diabetes Centre. A new multidisciplinary team approach allows patients to see the diabetes educator, dietitian and family practice physician during their visit.
- Implemented a Tele-stroke pilot and program at the Carbonear General Hospital linking physicians with neurologists at the Health Sciences Centre.
- Consolidated Palliative Care Services and increased the capacity of delivery of palliative care services through provision of a Learning Essential Approach to Palliative Care (LEAP).

Equipment and Infrastructure

- Implemented over 60 new haematology, biochemistry and coagulation analyzers in laboratory sites where the testing occurs.
- Participated in four long-term care infrastructure projects: long-term care facilities in St. John's and Carbonear and Protective Community Residences (Dementia Care Bungalows) in Bonavista and Clarenville.

Accountability and Stability in the Delivery of the Health and Community Services

Ensuring a sustainable health care sector is extremely important to ensure future delivery of services. The need to provide good stewardship around financial and human resources is a priority for Eastern Health. Within this Strategic Direction, there are a number of focus areas: clinical/administrative guidelines/program standards, evaluation of legislation, programs and services, health research, information management and technology; performance measurement/monitoring; provincial health human resources; and, quality and safety. The following are some of the accomplishments Eastern Health has made in 2012-13 in support of this Strategic Direction and identified focus areas:

- Launched operational improvement initiatives to be implemented over a two-year period to save $43 million and reduce 550 full-time equivalents (FTEs) through attrition. During the first year, 2012-13, realized savings of nearly $20 million and reduced 180.1 FTEs.
- Received the first results from the organization-wide Experience of Care Survey. Feedback was very positive and interactions with healthcare professionals received the highest ratings. Inpatients and outpatients in Acute Care had an overall satisfaction level of 83.9 and 82.7 respectively, (out of a possible 100), while those who received Emergency Services gave a score of 72.9 out of a possible 100.
- Achieved Excellence Canada Level II Healthy Workplace designation, which focuses on planning and programming in the areas of workplace culture and supportive environment, physical environment and occupational health and safety, and health and lifestyles practices.

Highlights and Accomplishments

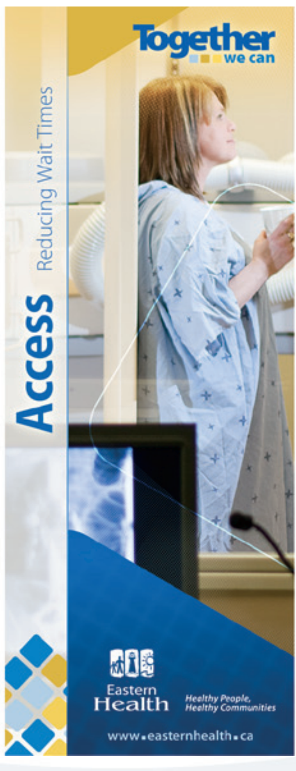
- Conducted a second Employee Engagement Survey and developed action plans to address identified issues.
- Initiated implementation of a Leadership Framework to enhance leadership capability. In partnership with the *Canadian College of Health Leaders* (CCHL) and *Leaders for Life*, the LEADS (***Leading in a Caring Environment***) Workshop, a component of the Leadership Framework, has been developed to equip leaders with the skills to lead in the health services environment.
- Achieved Ontario Laboratory Association (OLA) accreditation for all laboratories in Eastern Health, a requirement that fulfills a recommendation of the Cameron Commission of Inquiry on Hormone Receptor Testing.
- Prevented diversions outside the province of infants requiring care in the Neo-natal Intensive Care Unit (NICU) by cross-training nurses.
- Developed an Eastern Health Safe Surgery Checklist based on the World Health Organization's (WHO) *Safe Surgery Saves Lives* campaign aimed at improving patient safety in operating rooms.
- Introduced an online job board and application system, eRecruit, to streamline the application process and reduce recruitment turnaround times.
- Recruited members of the public to participate in ethics committees and established an Eastern Health Ethics Community Interest Network.
- Introduced the *MORE OB®* program, an education and quality improvement initiative, for labour and delivery at four sites for obstetrics which has reduced C-section rates from a high of 36 per cent to 29 per cent this past year.
- Introduced an Early Intervention Grievance Model which has been piloted by the Newfoundland and Labrador Nurses Union (NLNU) with the purpose of resolving workplace issues prior to filing a grievance, resulting in the number of grievances filed to 499, the lowest number since 2008-09.
- Provided *Personal Health Information Act* (PHIA) education for over 5,000 employees.
- Held Privacy Awareness Week and had over 4,000 employees complete confidentiality oaths/affirmations.
- Incorporated 148 physicians into a speech recognition process, enabling health care team members to provide and finalize electronic clinical documentation using voice recognition.
- Eleven of 17 long-term care sites are submitting to the Canadian Institute of Health Information (CIHI) Continuing Care Reporting System (CCRS), a national comparative tool to evaluate, monitor and plan care being provided.

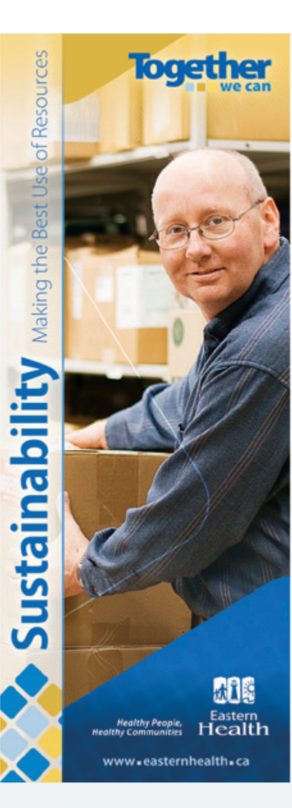
4. Report on Performance

The vision of Eastern Health is *Healthy People, Healthy Communities.*

The Eastern Health strategic plan, *Together We Can*, was developed for 2011-14 as per the legislative requirements of the *Transparency and Accountability Act*. The plan is available at www.easternhealth.ca.

For the 2011-14 planning period, the Board of Trustees identified four priority issues: Quality and Safety, Access, Sustainability, and Population Health. This section of the report outlines each of these priority issues and the progress made towards achieving the goals and the objectives of 2012-13.





4.1. Quality and Safety

Quality and safety is a key priority for Eastern Health.

The backbone of any health organization is its commitment to quality and safety. Eastern Health has been working on a number of indicators in order to measure and show evidence of improvement. In last year's Annual Performance Report, Eastern Health established baseline measures for a number of indicators. Ensuring good data is key to showing evidence of improvement.

The three-year goal and second-year objective, measure and indicators are outlined in the tables below.

Goal: By March 31, 2014, Eastern Health will have increased the safety and quality of its programs and services for the benefit of its patients, residents, clients, employees, physicians, volunteers and students.
Objective: By March 31, 2013, Eastern Health will have monitored its Safety Plan and further established professional peer review.
Measure: Safety Plan monitored and professional peer review further established.

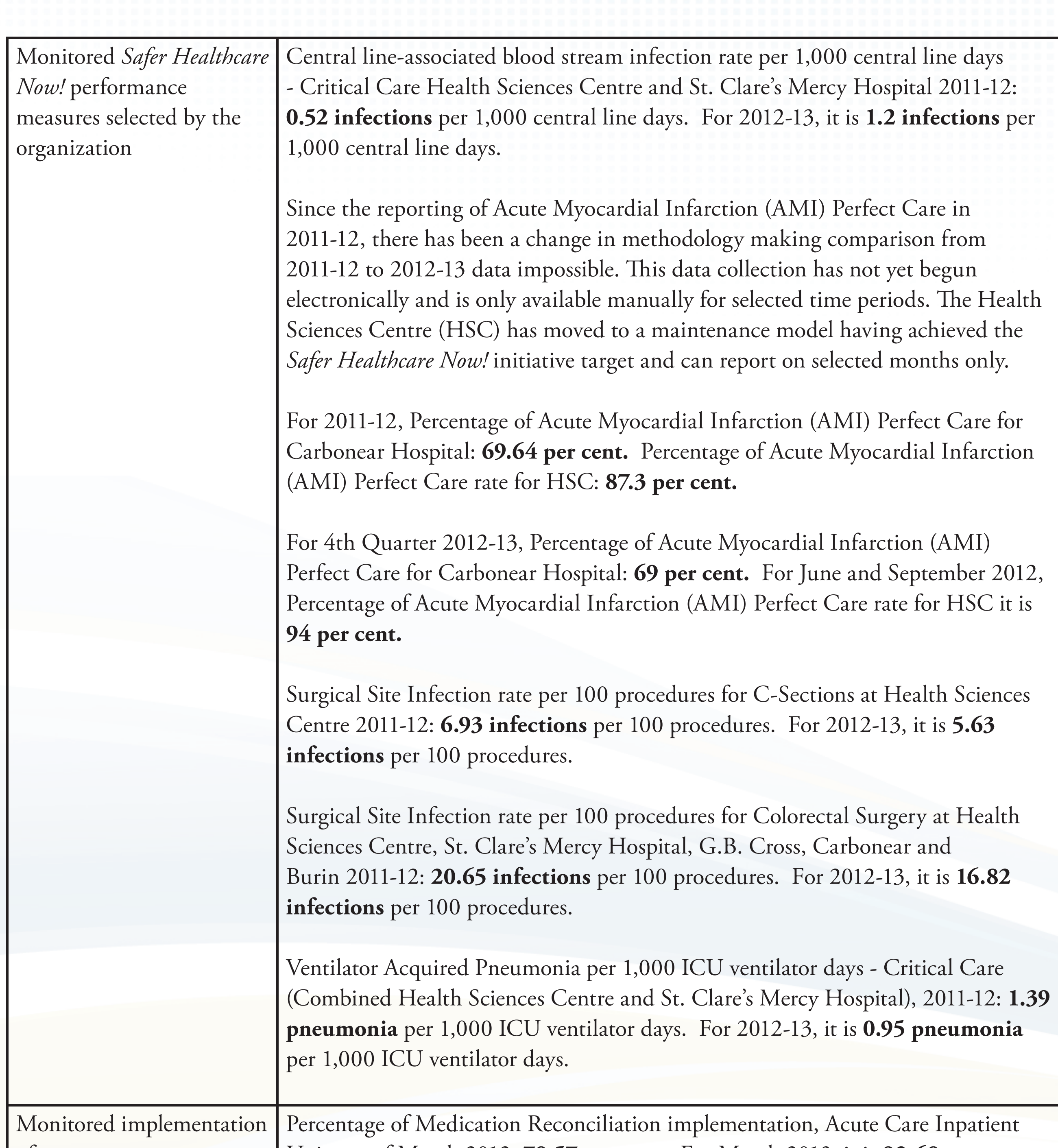
Planned for 2012-13	Actual Performance for 2012-13[5]
Monitored the Safety Plan as evidenced by the following measures:	
Established baseline measures using 2012-13 data for total number of occurrences, close calls, occurrences not resulting in harm to the client, and occurrences resulting in harm to the client (adverse events)	There were 18,605 occurrences reported during the 2012-13 fiscal year. Follow-up on each occurrence varies greatly and may consist of documenting the occurrence for tracking and trending purposes, conducting a root cause analysis, conducting a process improvement or engaging in a quality case review.[6] Closed Occurrences[7] While Eastern Health continues to encourage reporting of occurrences, the degree to which clients experience harm is a key indicator for clinical safety; to decrease the number of adverse events that result in harm while increasing the reporting of close calls. During the 2012-2013 fiscal year, the closed occurrences indicate: - 11 per cent of closed occurrences were close calls or not client related, in other words they did not reach a client. - 75 per cent of occurrences did not result in harm to the client. - 14 per cent of occurrences resulted in harm to the client. 98 per cent of those were considered minor/temporary harm and included incidents such as abrasions.

5 Appendix I provides definitions of the quantifiable indicators and provides clarity around what the indicator means and why we measure it.

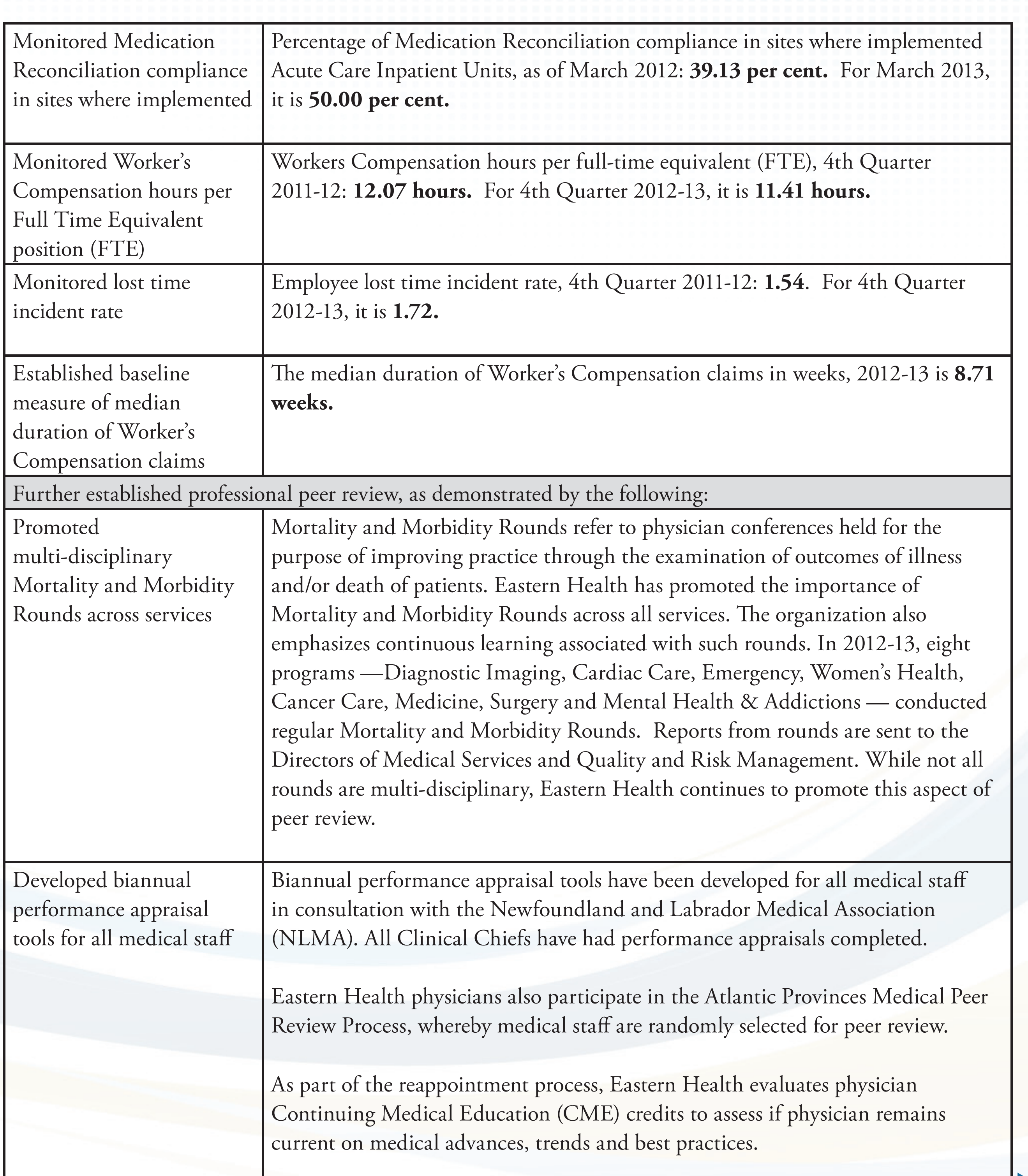
6 Occurrences were reported during the 2012-13 year but closed in the first 21 days of April 2013 in order for those occurrences reported near the end of the year time to be investigated and closed.

7 A closed occurrence is an occurrence that has been investigated, coded and required actions taken, if necessary. The occurrence is then closed by a Quality and Clinical Safety Leader in the electronic reporting system.

Monitored readmission to selected services	Percentage of Unscheduled Readmissions 8-28 days post discharge for combined Medicine, Surgery and Mental Health program types for Health Sciences Centre, St. Clare's Mercy Hospital and Waterford – as per cent of cases 2011-12: **3.82 per cent**. For 2012-13, it is **3.48 per cent**. Percentage of Unscheduled Readmissions within 7 days of discharge for combined Medicine, Surgery and Mental Health program types for Health Sciences Centre, St. Clare's Mercy Hospital and Waterford – as per cent of cases 2011-12: **2.21 per cent**. For 2012-13, it is **2.46 per cent**.
Monitored Alternate Level of Care days as a percentage of total patient days	Alternate Level of Care (ALC) days as a percent of total adult patient days (Medicine and Surgery only, Health Sciences Centre and St. Clare's Mercy Hospital), 2011-12: **12.03 days**. For 2012-13, it is **15.29 days**.
Monitored rate of Methicillin-Resistant *Staphylococcus Aureus* (MRSA) infection	Rate of MRSA infections in long-term care (2011-12): **0.89 infections** per 10,000 patient/resident days. For 2012-13, it is **1.11 infections** per 10,000 patient/resident days. Rate of new MRSA infections in acute care, health care associated infections for 10,000 patient days (excluding Janeway) 2011-12: **5.91 infections** per 10,000 patient/resident days. For 2012-13, it is **5.41 infections** per 10,000 patient/resident days.
Monitored hand hygiene compliance	Rate of hand hygiene compliance (Spring 2011 Audit): **52.6 per cent of observations practised appropriate hand hygiene**. Rate of hand hygiene compliance (Summer 2012 Audit): **49 per cent of observations practised appropriate hand hygiene**. Audits of hand hygiene compliance occur during a particular period of time. Compliance rate does not necessarily mean that health care workers do not wash their hands. The audit tool measures whether health care providers are washing their hands at the right times and in the right ways during a particular time period.



Monitored *Safer Healthcare Now!* performance measures selected by the organization	Central line-associated blood stream infection rate per 1,000 central line days - Critical Care Health Sciences Centre and St. Clare's Mercy Hospital 2011-12: **0.52 infections** per 1,000 central line days. For 2012-13, it is **1.2 infections** per 1,000 central line days. Since the reporting of Acute Myocardial Infarction (AMI) Perfect Care in 2011-12, there has been a change in methodology making comparison from 2011-12 to 2012-13 data impossible. This data collection has not yet begun electronically and is only available manually for selected time periods. The Health Sciences Centre (HSC) has moved to a maintenance model having achieved the *Safer Healthcare Now!* initiative target and can report on selected months only. For 2011-12, Percentage of Acute Myocardial Infarction (AMI) Perfect Care for Carbonear Hospital: **69.64 per cent.** Percentage of Acute Myocardial Infarction (AMI) Perfect Care rate for HSC: **87.3 per cent.** For 4th Quarter 2012-13, Percentage of Acute Myocardial Infarction (AMI) Perfect Care for Carbonear Hospital: **69 per cent.** For June and September 2012, Percentage of Acute Myocardial Infarction (AMI) Perfect Care rate for HSC it is **94 per cent.** Surgical Site Infection rate per 100 procedures for C-Sections at Health Sciences Centre 2011-12: **6.93 infections** per 100 procedures. For 2012-13, it is **5.63 infections** per 100 procedures. Surgical Site Infection rate per 100 procedures for Colorectal Surgery at Health Sciences Centre, St. Clare's Mercy Hospital, G.B. Cross, Carbonear and Burin 2011-12: **20.65 infections** per 100 procedures. For 2012-13, it is **16.82 infections** per 100 procedures. Ventilator Acquired Pneumonia per 1,000 ICU ventilator days - Critical Care (Combined Health Sciences Centre and St. Clare's Mercy Hospital), 2011-12: **1.39 pneumonia** per 1,000 ICU ventilator days. For 2012-13, it is **0.95 pneumonia** per 1,000 ICU ventilator days.
Monitored implementation of Medication Reconciliation across the region	Percentage of Medication Reconciliation implementation, Acute Care Inpatient Units, as of March 2012: **78.57 per cent**. For March 2013, it is **92.68 per cent.**



Monitored Medication Reconciliation compliance in sites where implemented	Percentage of Medication Reconciliation compliance in sites where implemented Acute Care Inpatient Units, as of March 2012: **39.13 per cent.** For March 2013, it is **50.00 per cent.**
Monitored Worker's Compensation hours per Full Time Equivalent position (FTE)	Workers Compensation hours per full-time equivalent (FTE), 4th Quarter 2011-12: **12.07 hours.** For 4th Quarter 2012-13, it is **11.41 hours.**
Monitored lost time incident rate	Employee lost time incident rate, 4th Quarter 2011-12: **1.54**. For 4th Quarter 2012-13, it is **1.72.**
Established baseline measure of median duration of Worker's Compensation claims	The median duration of Worker's Compensation claims in weeks, 2012-13 is **8.71 weeks.**
Further established professional peer review, as demonstrated by the following:	
Promoted multi-disciplinary Mortality and Morbidity Rounds across services	Mortality and Morbidity Rounds refer to physician conferences held for the purpose of improving practice through the examination of outcomes of illness and/or death of patients. Eastern Health has promoted the importance of Mortality and Morbidity Rounds across all services. The organization also emphasizes continuous learning associated with such rounds. In 2012-13, eight programs —Diagnostic Imaging, Cardiac Care, Emergency, Women's Health, Cancer Care, Medicine, Surgery and Mental Health & Addictions — conducted regular Mortality and Morbidity Rounds. Reports from rounds are sent to the Directors of Medical Services and Quality and Risk Management. While not all rounds are multi-disciplinary, Eastern Health continues to promote this aspect of peer review.
Developed biannual performance appraisal tools for all medical staff	Biannual performance appraisal tools have been developed for all medical staff in consultation with the Newfoundland and Labrador Medical Association (NLMA). All Clinical Chiefs have had performance appraisals completed. Eastern Health physicians also participate in the Atlantic Provinces Medical Peer Review Process, whereby medical staff are randomly selected for peer review. As part of the reappointment process, Eastern Health evaluates physician Continuing Medical Education (CME) credits to assess if physician remains current on medical advances, trends and best practices.

Developed quality assurance initiatives within the Diagnostic Imaging program	Quality Assurance Program has been developed, implemented, and monitored within the Diagnostic Imaging (DI) program to Accreditation Canada Standards. An internal audit program includes trained internal auditors within the DI program to provide regularly scheduled audits. Other initiatives within this program include monitoring report turnaround times, issuing appropriateness guidelines for ordering of various diagnostic procedures such as echo-cardiogram, barium studies, CT coronary angiogram, CT colon and working on a radiation dose monitoring and reduction process.

Discussion of Results

Eastern Health is striving to provide a healthy work environment and is committed to implementing programs and initiatives that support building a culture of safety and quality. Based upon research indicating that organizations with more reporting of occurrences usually have a more effective culture of safety, Eastern Health is further strengthening its safety culture by encouraging the reporting of all adverse events, occurrences and close calls.
In addition, each quarter the Board of Trustees of Eastern Health receives an organizational scorecard outlining the indicators in the Strategic Plan, including the quality and safety indicators outlined above. This scorecard allows the Board to identify areas of concern and note areas where progress has been made. As well, establishing baselines and monitoring the indicators enables Eastern Health to identify where further work is required. For example, the organization is concerned with hand hygiene audit results. Since the audit results were known, significant communication has occurred around the importance of appropriate hand hygiene. The Occupational Health Safety and Rehabilitation Department and the Quality and Risk Management Department have also identified hand hygiene as a high priority for further action within Eastern Health's Safety Plan.
Eastern Health has also further established professional peer review across the organization, particularly as it pertains to Medical Services. Initiatives such as the development of a performance appraisal tool, the promotion of Morbidity and Mortality Rounds and the development of quality assurance programs fosters a culture of continuous learning and development. Such a commitment to professional peer review is further evidenced by the organization's recent enrollment in the National Surgical Quality Improvement Program (NSQIP) and software purchases (such as PeerVue) to assist with peer review and workflow solutions.

Eastern Health's strategic issue of Quality and Safety aligns with government's Strategic Direction of *Accountability and Stability of Health and Community Services*. In particular, the topic addresses the focus area of quality and safety. The outlined indicators within this priority area support the focus area of performance measurement/ monitoring.

Building on the progress made in 2012-13, Eastern Health has documented the following objective, measures and indicators for 2013-14:

2013-14 Objective, Measures and Indicators

Objective: By March 31, 2014, Eastern Health will have demonstrated effectiveness of its Safety Plan and further established regular clinic audits in all clinical programs.

Measures: Demonstrated effectiveness of Safety Plan and further established clinical audits

Indicators:
Demonstrated effectiveness of Safety Plan as evidenced by the following measures:

- Increased reporting of occurrences, close calls, occurrences not resulting in harm to the client, and occurrences resulting in harm to the client (adverse events).
- Decreased readmission to selected services.
- Decreased Alternate Level of Care Days as a percentage of total patient days.
- Decreased rate of MRSA infection.
- Increased hand hygiene compliance.
- Improved *Safer Healthcare Now!* performance measures selected by the organization.
- Increased rate of implementation of Medication Reconciliation across the region.
- Decreased Worker's Compensation hours per full-time equivalent position (FTE).
- Decreased lost time incident rate.
- Decreased median duration of Worker's Compensation claims.

Further established regular clinical audits as demonstrated by :

- Developed audit tools and processes as supported by programs such as Nursing Professional Practice and Allied Health Professional Practice

4.2. Access

Access to clinical health services has been identified as a significant issue throughout the organization. Patients, clients and residents want timely access to providers and services and health providers want the same thing to ensure healthy outcomes for their patients. Eastern Health serves a very diverse and geographically-dispersed population. An aging population, high rates of chronic disease and increased level of acuity can all put increased pressure on waitlists within the health sector.

Eastern Health has been working closely with the Department of Health and Community Services and other stakeholders to establish appropriate wait time targets. Research into best practices also helps determine acceptable wait times, and utilization of evidence will assist decision makers, health care providers and clients to understand the complexities associated with access to priority health care services.

In the 2011-12 Annual Performance Report, Eastern Health established a number of baseline wait times. Numerous strategies have been undertaken to meet, exceed and/or maintain benchmarks, many of which are national.

The overall three-year goal and 2012-13 objective, measure and indicators are outlined in the following tables.

Goal: By March 31, 2014, Eastern Health will have improved access to identified programs and services.
2012-13 Objective: By March 31, 2013, Eastern Health will have completed implementation of strategies to reduce wait times in identified programs/services and increase efficiency in under-utilized programs/services.
Measure: Implementation of strategies completed

Planned for 2012-13	Actual Performance for 2012-13[7]
Implemented strategies to reduce wait time and increase efficiency as evidenced by the following measures:	Eastern Health refined strategies to improve access and increase efficiency. The following baseline measures have been identified:
Established baseline wait time for access to long-term care beds	Manual data collection for wait time for access to long-term care beds is underway but is taking longer to compile than anticipated. Eastern Health's department of Healthcare Technology and Data Management (HTDM) has recently given priority to electronic data collection for waitlist management in long-term care. An initial meeting to commence this project is scheduled for July 2013, with the intention to improve the ability to extract wait time data in a timely and less labour intensive manner during the 2013-14 fiscal year. In the meantime, manual data collection will continue for urgent referrals for access to long-term care beds is underway. The first data available, which measures residents' median wait time in days for urgent long-term care placement (regional) for March 2013 is **23 days.**

7 Appendix I provides definitions of the quantifiable indicators and provides clarity around definitions of indicators.

Monitored wait time for non-urgent primary mental health and addictions	Average wait time in days for Priority 3 patients (scheduled/elective) to access Primary Mental Health and Addictions services (excludes child and adolescent specific clinics), 4th Quarter 2011-12, Regional: **176.10 days.** For 4th Quarter 2012-13, Regional, it is **175.5 days.**
Monitored wait time for specialists (non-urgent orthopaedics and urgent rheumatology)	Orthopedics Specialists Median Wait-Time-One (family physician request to initial specialist assessment) for priority 1 and 2 patients within target March 2012: **95.00 days.** For March 2013, it is **81.50 days.** Orthopedics Specialists Median Wait-Time-One (family physician request to initial specialist assessment) for priority 3 and 4 patients within target March 2012: **182 days.** For March 2013, it is **269 days**[8]. Percentage of urgent priority I patients seen by Rheumatology Specialists within 30 days, 4th quarter 2011-12: **11.10 per cent.** For 4th Quarter 2012-13, it is **13.7 per cent.**
Established baseline wait time for psychiatry	The Mental Health & Addictions Program continues to work towards implementation of electronic wait time reports; however, this process has taken longer than anticipated. Eastern Health's department of Healthcare Technology and Data Management (HTDM) has recently given priority to further developing Community Wide Scheduling to enable electronic wait time reports for Mental Health and Addictions. It is anticipated that a baseline wait time for psychiatry will be available by the end of the 2013-14 fiscal year.
Monitored wait time for therapeutic outpatient, community-based services and community supports (non-urgent)	Longest wait time in months to access Audiology as average of selected service sites March 2012: **5.25 months**. For March 2013, it is **4.88 months.**
Monitored wait time for knee replacement*	Percentage of Knee Replacements completed within benchmark of 182 days (city only): **82.16 per cent**. The measurement for this indicator had been determined to be 2006-07 data as per Federal/Provincial/Territorial agreement with the Department of Health and Community Services in 2005. In 2011-12, **44 per cent** of cases were completed within the benchmark. For 2012-13, that number is **74 per cent.**

8 In Q4 2012-2013, changes to orthopedic bookings in Meditech were implemented. Bookings for Priority 3-4 patients were delayed while the changes to the booking system were formalized. This had a temporary, negative impact on median wait times.

Monitored wait time for hip replacement*	Percentage of Hip Replacements completed within benchmark of 182 days (city only): **81.38 per cent.** The measurement for this indicator had been determined to be 2006-07 data as per Federal/Provincial/Territorial agreement with the Department of Health and Community Services in 2005. In 2011-12, **71 per cent** of cases were completed within the benchmark. For 2012-13, that number is **80 per cent.**
Monitored wait time for hip fracture surgery	Percentage of Hip Fracture surgeries completed within benchmark of 48 hours (city only): **74.33 per cent.** The measurement for this indicator had been determined to be 2006-07 data as per Federal/Provincial/Territorial agreement with the Department of Health and Community Services in 2005. In 2011-12, **85 per cent** of cases were completed within the benchmark. For 2012-13, that number is **82.3 per cent.**
Monitored wait time for cataract surgery (for patients who are at high risk)*	Percentage of Cataract Surgeries completed within benchmark of 112 days, for patients who are at high risk (local anaesthetic, first eye only; city only): **80.25 per cent.** The measurement for this indicator had been determined to be 2006-07 data as per Federal/Provincial/Territorial agreement with the Department of Health and Community Services in 2005. In 2011-12, **65 per cent** of cases were completed within the benchmark. For 2012-13, that number is **73.5 per cent.**
Monitored wait time for Coronary Artery Bypass Graft (CABG) surgery*	Percentage of Coronary Artery Bypass Grafts (CABG) surgery completed within benchmark of 182 days (city only): Bypass Only Inpatients: **100 per cent**, Bypass Only outpatients: **94.44 per cent.** The measurement for this indicator had been determined to be 2006-07 data as per Federal/Provincial/Territorial agreement with the Department of Health and Community Services in 2005. The methodology for reporting CABG changed in the 2009-2010 fiscal year. In that year Level III CABG Only surgery completed within 182 days: **98.1 per cent**. In 2012-13, that number is **100 per cent.**
Monitored wait time for cancer treatment (radiation)	Percentage of Cancer Treatments (radiation) started within benchmark of 28 days from ready to treat date (all disease sites): **79.68 per cent.** The measurement for this indicator had been determined to be 2006-07 data as per Federal/Provincial/Territorial agreement with the Department of Health and Community Services in 2005. In 2011-12, **96 per cent** of cases were completed within this benchmark. For 2012-13, that number is **96.4 per cent.**

Monitored wait time for breast, bladder, colorectal, lung, and prostate cancer surgeries*	The data for cancer surgeries are provided below. For 2011-12, the wait times for cancer surgeries was reported as following: **Percentage of Breast Cancer Surgeries** completed within 21 days as per internal Eastern Health target (city only) 2011-12: **79.1 per cent.** **Percentage of Bladder Cancer Surgeries** completed within 21 days as per internal Eastern Health target (city only) 2011-12: **57.7 per cent.** **Percentage of Colorectal Cancer Surgeries** completed within 21 days as per internal Eastern Health target (city only) 2011-12: **75.1 per cent.** **Percentage of Lung Cancer Surgeries** completed within 21 days as per internal Eastern Health target (city only) 2011-12: **56.5 per cent.** **Percentage of Prostate Cancer Surgeries** completed within 42 days as per internal Eastern Health target (city only) 2011-12: **68.2 per cent.** For 2012-13, the **Percentage of Breast Cancer Surgeries** completed within 21 days is **69.0 per cent.** The **Percentage of Bladder Cancer Surgeries** completed within 21 days is **46.1 per cent.** The **Percentage of Colorectal Cancer Surgeries** within 21 days is **68.5 per cent.** The **Percentage of Lung Cancer Surgeries** completed within 21 days is **59.3 per cent.** The **Percentage of Prostate Cancer Surgeries** completed within 42 days is **63.6 per cent.**
Monitored wait time for Diagnostics (Magnetic Resonance Imagine [MRI], Computerized Axial Tomography [CT], Ultrasound, Endoscopy, Cardiac Echocardiogram)	DI - Percentage of MRIs completed within 30 days - Non Urgent (city only) 2011-12: **4.55 per cent.** For 2012-13, it is **18.65 per cent.** DI - Percentage of CTs completed within 30 days - Non Urgent (Regional) 2011-12: **59.93 per cent.** For 2012-13, it is **64.55 per cent.** DI - Percentage of Ultrasounds completed within 30 days - Non Urgent (excludes Obstetrics and echocardiograms) (Regional) 2011-12: **20.72 per cent.** For 2012-13, it is **27.64 per cent.** Percentage of non-urgent (Priority 2) Endoscopies completed within 60 days, city only, fiscal annual data for 2011-12: **49.34 per cent.** For 2012-13, it is **39.17 per cent.** Average wait time in days for non-urgent Cardiac Echocardiograms (Cardiac Program only), 4th Quarter: **177 days.** For 4th Quarter 2012-13, it is **282 days.**
Monitored rate of patients who left without being seen in the Emergency Room	Percentage of Emergency Department patients who left the Emergency Department without being seen by a physician (Regional) 2011-12: **4.40 per cent.** For 2012-13, it is **4.72 per cent.**

* It is not possible to compare 2012-13 wait times to previous reports as the reporting methodology has changed. While all patients are included in the volumes of cases completed, calculations for wait times no longer include patients who had inactive wait times. The impact on comparing previously reported wait times may vary according to surgery type, volume of emergency cases and volume of waitlist patients who had a period of inactive wait times.

Discussion of Results

Over the past few years, Eastern Health has invested time and resources to ensure good collection of data to allow benchmarking of wait times and analysis to make change. In order to identify efficiencies, Eastern Health is looking at process improvements and identifying ways of doing things more efficiently. As noted in this section and the Highlights section, there have been significant gains in decreasing wait times in some areas. In other areas, additional efforts must be made to reduce wait times.

Eastern Health will continue the efforts made to improve access to services. This will range from ensuring the accuracy and integrity of the collection of wait list and wait time information to monitoring and initiating strategies to improve wait times. Some of the indicators reported in this section are noted with an asterisk (*) signifying that reporting methodologies have changed, making comparisons from 2011-12 to 2012-13 not possible. Eastern Health will be able to compare 2012-13 data with results in 2013-14 since there are no plans to change this methodology.

Monitoring the access indicators helps Eastern Health track both progress and challenges over time. Establishing baselines and monitoring various wait times helps the organization determine whether strategies implemented are as effective as anticipated. For example, the Central Intake process for orthopedic surgery has resulted in wait time improvements for priority I and II patients. This improvement is based on all patient referrals being screened and triaged for appropriateness and acuity, and prioritized for booking. Similarly, improved access to services and the optimal use of human and capital resources continue to be a primary focus for the Diagnostic Imaging Program. A number of initiatives within that department have been ongoing, including setting daily exam targets per technologist, implementing standardized regional Diagnostic Imaging requisitions and urgency categories, and establishing and monitoring productivity benchmarks for all modalities. Effort has also been put into capturing reliable data on the number of patients who do not present for their scheduled exam and efforts to reduce patient no-shows are ongoing, including making appointment reminder calls to patients three days prior to their appointment.

Access also means more than wait times. The organization is aware of the challenges of navigating the health and community services sector. The provincial cancer patient navigation program has been successfully implemented with six positions throughout the province. Cancer patient navigators assist patients, families and caregivers to respond to the challenges which go along with a suspected or confirmed cancer diagnosis. Similarly, the Aboriginal Patient Navigator Program assists aboriginal patients and their families.

The progress made in this area is in line with government's Strategic Direction: *Access to Priority Services.* In particular, by measuring wait times and identifying areas for improvement, Eastern Health is furthering the focus areas identified by government within this Strategic Direction: long-term care and community supports, pre-hospital/ emergency and access management.

Building on the progress made in 2012-13, Eastern Health has documented the following objective, measure and indicators for 2013-14:

2013-14 Objective, Measures and Indicators

Objective: By March 31, 2014, Eastern Health will have monitored strategies toward meeting and/or exceeding national benchmarks where they exist.

Measure: Strategies Monitored.

Indicators:
Monitored strategies toward meeting and/or exceeding national benchmarks where they exist, as evidenced by:

- Decreased wait time for access to long-term care beds.
- Decreased wait time for non-urgent primary mental health and addictions.
- Decreased wait time for specialists (non-urgent orthopaedics and urgent rheumatology).
- Established baseline wait time for psychiatry.
- Decreased wait time for therapeutic outpatient, community-based services and community supports (non-urgent).
- Decreased wait time for knee replacement.
- Decreased wait time for hip replacement.
- Decreased wait time for hip fracture surgery.
- Decreased wait time for cataract surgery (for patients who are at high risk).
- Decreased wait time for Coronary Artery Bypass Graft (CABG) surgery.
- Decreased wait time for cancer treatment (radiation). Decreased wait time for breast, bladder, colorectal, lung, and prostate cancer surgeries.
- Decreased wait time for Diagnostics (Magnetic Resonance Imagine [MRI], Computerized Axial Tomography [CT], Ultrasound, Endoscopy, Cardiac Echocardiogram).
- Decreased rate of patients who left without being seen in the Emergency Room.

4.3. Sustainability

Eastern Health recognizes the importance of working within its fiscal framework. The organization prioritizes the effective use of resources to ensure good stewardship of financial and human resources. As outlined in the 2011-12 report, substantial efforts were made toward identifying inefficiencies throughout the organization and these efforts have continued into 2012-13.

The three-year goal and second-year objective, measure and indicators are outlined in the tables below.

Goal: By March 31, 2014, Eastern Health will have strengthened its sustainability through the efficient utilization and monitoring of its fiscal and human resources.
2012-13 Objective: By March 31, 2013, Eastern Health will have implemented strategies to improve and monitor efficiency in identified programs.
Measure: Strategies Implemented

Planned for 2012-13	Actual Performance for 2012-13[8]
Monitored efficiency as evidenced by:	
Decreased budget variance across the region	Budget Variance 2011-12: **1.3 per cent ($17.3 million).**[9] For 2012-13: **0.637 per cent ($8.3 million).**
Decreased HR vacancy rate in selected areas	HR vacancy rate for difficult to fill positions (actively recruiting for minimum 2 months; does not include Casuals; 3rd Quarter 2011-12): **0.36 per cent.** For 3rd Quarter 2012-13, it is **8.72 per cent.** These indicators are not comparable and therefore it is not possible to determine if this indicator has been met. In 2011-12, all difficult-to-fill groups were used to determine the numerator of the indicator and the denominator was the total number of vacancies at Eastern Health which included difficult-to-fill and not difficult-to-fill groups. To have this indicator more accurately portray the challenges with difficult-to-fill positions, beginning in 2012-13 five groups were identified to be traditionally difficult to-fill positions: audiologists, clinical pharmacists, clinical psychologists, combined lab and X-ray technologists and prosthetists/ orthotists. The denominator that is now used is the total number of positions for these identified groups which gives a more accurate picture for this indicator. HR vacancy rate in Nursing (posted external; does not include Casuals); 3rd Quarter 2011-12: **1.31 per cent**. For 3rd Quarter 2012-13, it is **0.14 per cent**. HR vacancy rate in Nursing (posted internal; does not include Casuals); 3rd Quarter 2011-12: **2.90 per cent.** For 3rd Quarter 2012-13, that number is **1.86 per cent.**

8 Appendix I provides definitions of the quantifiable indicators and provides clarity around what the indicator means and why we measure it.
9 Eastern Health's Annual Performance Report 2011-12 reported a budget variance of 0.77 per cent. That variance amount was for the month of March 2012 only. The budget variance for the 2011-12 fiscal year was 1.3 per cent as noted above.

Discussion of Results

The progress made within this priority area supports government's Strategic Direction of *Improved Accountability and Stability in the Delivery of Health and Community Services.* In particular, the focus areas of health human resources and performance measurement/monitoring are furthered by the work that Eastern Health has done throughout this fiscal year. Identifying human resources indicators to monitor and measure allows the organization to develop and implement strategies to address issues.

Establishing baselines and monitoring various sustainability indicators helps the organization determine whether strategies implemented are as effective as anticipated. In 2012-13, Eastern Health launched operational improvement initiatives to be implemented over a two-year period to save $43 million and reduce 550 full-time equivalents (FTEs) through attrition. The organization also initiated a clinical utilization review.

In addition to these strategies, Eastern Health has introduced process improvement tools throughout the organization in order to identify and create efficiencies. For example, the Lean philosophy looks at processes and identifies how things can be done more efficiently by focusing on continuous improvement. A number of projects using the Lean philosophy are ongoing, including at the Major's Path site where blood collection wait times have decreased.

In terms of human resources, Eastern Health is a member of the Excellence Canada Healthy Workplace Program. In March 2013, Eastern Health completed Level II certification. The criteria for this Level II focused on a wide range of healthy workplace planning and programming and is evidence of the effort that has gone into creating a positive workplace culture. The Excellence Canada Healthy Workplace Program provides a national framework to assist Eastern Health to advance its programs and strategies in this area and in keeping with industry best practices. A healthy workplace contributes to higher engagement, safer workplaces and reduced absenteeism. These have a direct impact on the organization's ability to maintain service delivery and financial sustainability.

As part of the organization's commitment to sustainability, difficult-to-recruit classifications are monitored and a number of initiatives have been implemented. These include financial incentives, salary differentials, sign-on bonuses, bursaries, and salary continuance, as per the provincial government market adjustment policy.

Building on the progress made in 2012-13, Eastern Health has documented the following objective, measures and indicators for 2013-14:

2013-14 Objective, Measures and Indicators

Objective: By March 31, 2014, Eastern Health will have demonstrated efficiencies in identified programs.

Measure: Demonstrated efficiencies

Indicators:

- Continued benchmarking and consultation to identify ongoing opportunities for improving efficiencies throughout Eastern Health.
- Decreased budget variance.
- Decreased HR vacancy rate in selected areas.

4.4. Population Health

Population health describes the overall health of a community rather than of an individual. This approach focuses on a wide range of factors within and outside of the health care system that can influence health. These factors are known as the "determinants of health" and include such things as housing, education, literacy, social support networks, employment and income and healthy child development. The population health approach involves individuals, communities, schools, workplaces, and all levels of government.

Strategic investments to promote and protect health, prevent ill health and injury and reduce inequities have the potential to have a measurable impact on the health of the population served by Eastern Health.

The population served by Eastern Health has high rates of chronic disease, colo-rectal cancer and cardiovascular disease. It is important to know the health status of the population so that resources can be focused on prevention and intervention.

In 2011-12, Eastern Health focused on increasing opportunities for stakeholder consultation and collaboration. In 2012-13, Eastern Health continued to work with government and community partners to focus on Population Health, one of the provincial government's Strategic Directions.

The three-year goal and 2012-13 objective, measure and indicators are outlined in the tables that follow.

Goal: By March 31, 2014, Eastern Health will have implemented strategies using a population health approach to support better health outcomes for individuals and communities.
2012-13 Objective: By March 31, 2013, Eastern Health will have expanded population based initiatives to address healthy living.
Measure: Expanded population based initiatives.

Planned for 2012-13	Actual Performance for 2012-13[10]
Expanded population based initiatives to address healthy living, which include:	
Developed a Community Engagement Framework	Community engagement is the process of working collaboratively and interactively with communities to address issues affecting their well-being. Eastern Health has developed a Community Engagement Framework that uses the International Association of Public Participation *Spectrum of Public Participation.* This spectrum identifies five components: inform, consult, involve, collaborate and empower. Making changes to population health requires significant work with community partners. This Framework outlines a model to guide that engagement.

10 Appendix I provides definitions of the quantifiable indicators and provides clarity around what the indicator means and why we measure it.

Implemented the Health Promotion Plan to include a focus on: • Healthy eating (including breastfeeding) • Tobacco-free living • Physical activity	*Working in Health Promoting Ways: Where we Live, Work, Learn and Play*, the organization's Health Promotion Plan, has been developed and implementation has begun. This Plan outlines the context for health promotion and prevention, principles of practice and the priority areas for action up to 2017. There are 10 priority areas for action which includes healthy eating (such as breastfeeding), tobacco-free living and physical activity. In 2012-13, implementation has included the establishment of various committees for each of the priority areas for action. Examples of how the implementation of the plan was realized include: • *B4UR Pregnant Project-Phase 1* (Promoting Healthy Child Development) • *Take Care Down There Phase II-* Sexual Health Project – to be launched September 2013 (Promoting Sexual Health and Wellbeing) • Evaluation of the 20 Hour Baby Friendly Initiatives (BFI) (Promoting Healthy Eating-Breastfeeding) • *Working with Schools: A Position Statement and Practice Framework for Eastern Health* (Promoting Healthy Schools).
Begun implementation of the Eastern Health Healthy Food Policy	As part of Eastern Health's commitment to operational efficiencies, retail food services have been outsourced to a nationally recognized leader in that sector. Given this change, the implementation of the Healthy Food Policy has been delayed. A policy has been drafted, however, discussion with the retail vendor must occur prior to finalization and implementation.
Implemented healthy living activities in partnership with the member organizations of the Eastern Regional Wellness Coalition and the Wellness Coalition Avalon East	Eastern Health implemented healthy living activities in partnership with the member organizations of the Eastern Regional Wellness Coalition (ERWC) and the Wellness Coalition Avalon East (WCAE) in a number of ways. Some activities included: • Partnered with both Wellness Coalitions to deliver seven *Choosing Healthy Food and Beverage* Workshops in St. Johns, CBS, Pouch Cove, Clarenville, Carbonear, Marystown, and Bonavista. A workshop for Placentia was rescheduled due to weather and will take place May 2013. • WCAE participated in the launch of the Chronic Disease Prevention and Management strategy in July 2012, supporting fun activities with children and adults. • ERWC hosted its 7th annual Networking day "Taking Care of Me & My Community". A Mental Health Promotion Consultant with Eastern Health was involved in the day as a guest speaker.

Implemented the Newfoundland and Labrador provincial colorectal screening program	The Provincial Colon Cancer Screening Program is administered by Eastern Health. An advisory committee consisting of representatives of the provincial government, the regional health authorities, the Canadian Cancer Society, researchers and medical specialists oversees the program. The program was launched in July 2012 in the western region. It will be expanded to the central region, followed by the eastern region.
Monitored selected areas of population health, which include:	
Rate of physical activity	Rate of respondents aged 12 or older in the Eastern Health region who report physical activity during leisure time (moderately active or active) from the 2009 Canadian Community Health Survey: **45.2 per cent.** For the 2011 Canadian Community Health Survey it is **49.0 per cent.**
Rate of breastfeeding initiation	Percentage of breastfeeding initiation February 2012: **63.64 per cent.** For February 2013, it is **60.38 per cent.**
Baseline rate of breastfeeding duration	Percentage of breastfeeding duration (percentage of infants breastfed at 6 months) 1st Quarter 2012-13: **29.55 per cent**
Baseline rate of participation (by age) for screening for colorectal cancer	The Provincial Colon Cancer Screening Program is administered by Eastern Health and is overseen by an advisory committee. The program was launched in July 2012 in the western region. This population-based screening program for individuals aged 50-74 is available to residents served by Western Health. As of November 30, 2012, the program has mailed 905 home kits to participants with 510 returned giving a response rate of about 57 per cent. Since its launch, response from the public has been positive with 64 per cent of requests for screening kits being returned for analysis. Since the program has not yet been launched in the eastern region, a baseline rate for that area is not yet available.
Rate of seasonal influenza immunization rate in seniors, children, and Eastern Health staff, as per National Action Committee on Immunization's annual recommendations	In 2011-12, the seasonal influenza immunization rate for seniors aged 65+ as per the National Committee on Immunization recommendation: **41.90 per cent.** For 2012-13, it is **46.27 per cent.** In 2011-12, seasonal influenza immunization rate for children: **16.00 per cent** of children 6-23 months were immunized. For 2012-13, it is **20.38 per cent.** Seasonal Influenza Immunization rate – target population of Eastern Health staff (2011-12): **32.4 per cent** of Eastern Health staff were immunized. For 2012-13, it is **35.30 per cent.**

Discussion of Results

Making changes to the health of a population is a long-term commitment. It requires the participation of community partners and many levels of government. The progress noted above indicates that Eastern Health has engaged with its community in a number of capacities. The development of a Community Engagement Framework is an indication of Eastern Health's commitment to working with the community. This dedication to population health will continue as the organization, by working with many other groups, attempts to influence the health of the population it serves.

Health status reports show that the province of Newfoundland and Labrador has high rates of some chronic diseases, such as diabetes and colorectal cancer. Through the Chronic Disease Prevention and Management Strategy, chronic disease self-management workshops have been offered throughout the region as a way to begin implementing the strategy and to empower people to manage their disease.

The Provincial Colon Cancer Screening Program, which is administered by Eastern Health, was launched in western region in July 2012 and will be expanded to the central region, followed by the eastern region. An Advisory Committee is overseeing this program.

This work supports the provincial government's Strategic Direction of *Population Health*. Focusing on implementing a health promotion plan and implementing healthy living activities helps to further the focus area of healthy aging and healthy eating/physical activity. Similarly, focusing on rates of physical activity and breastfeeding helps the organization to understand areas of improvement required in order to contribute to the wellness of the population.

Building on the progress made in 2012-13, Eastern Health has documented the following objective, measures and indicators for 2013-14.

2013-14 Objective, Measures and Indicators

Objective: By March 31, 2014, Eastern Health will have contributed to improved programs and service delivery toward reducing inequities in the population.

Measure: Contributed to improved programs and service delivery

Indicators:

Contributed to improved programs and service delivery towards reducing inequities in the population, as demonstrated by the following:

- Increased opportunities to address identified barriers in selected programs.
- Improved opportunities to identify and reach vulnerable populations.
- Begun implementation of a Community Engagement Framework.
- Further implemented the Health Promotion Plan to include a focus on:
- Healthy eating (including breastfeeding);
- Tobacco-free living;
- Physical Activity.

Monitored selected areas of population health, which include:

- Rate of physical activity;
- Rate of breastfeeding initiation;
- Rate of breastfeeding duration;
- Rate of participation (by age) for screening for colorectal cancer.
- Rate of seasonal influenza immunization rate in seniors, children, and Eastern Health staff, as per *National Action Committee on Immunization's* annual recommendations.

5. Opportunities and Challenges Ahead

As the largest integrated health authority in Newfoundland and Labrador, providing regional and provincial services, Eastern Health faces opportunities and challenges on a provincial and regional level. The organization is committed to identify the challenges and to work with internal and external stakeholders to meet these challenges and to take advantage of the many opportunities that present themselves.

Over the past two years, Eastern Health has embarked on a commitment to create efficiencies within the system. Process mapping and using the Lean philosophy are being embraced to provide efficient processes for both patients and staff. Already, evidence of improvements are being seen, including reductions in a number of wait times, as outlined in the Report on Performance and Highlights sections of this Annual Performance Report. Eastern Health is also seeing results from its operational improvement initiatives, including a clinical utilization review.

The backbone of any health care organization is a culture of quality and safety. Eastern Health has embraced a number of national initiatives - such as *Safer Healthcare Now!* and *MORE OB*® program – to enhance safety. Through the development of a Safety Network, Eastern Health will continue to recognize the interdependence of patient and workforce safety to implement system-wide initiatives that will strengthen its safety culture.

Eastern Health will further build on a culture of quality and safety by participating in the Accreditation Canada survey that will take place in September 2013. This survey, based on comparison to recognized national and international standards of excellence, is an opportunity to assess and improve services. Accreditation teams have been working hard to ensure the organization achieves national benchmarks.

Demographics show a changing population. The population of the Eastern Health region represents almost 60 per cent of the province's population and it is anticipated that this will increase over the next several years. Accordingly, programs within Eastern Health face increasing demand for services, potentially impacting wait times. An opportunity to continue to support healthy aging and to invest in health promotion and prevention programs is outlined in the organization's Health Promotion Plan *Working in Health Promoting Ways: Where We Live, Work, Learn and Play.* Through this plan, Eastern Health will help to enable individuals and populations to increase control over and improve their health as we work towards our vision of *Healthy People, Healthy Communities.*

Based on the findings of the Eastern Health community health needs assessments, the importance of community engagement is recognized by the organization and provides an opportunity to improve services based on community feedback. The geographic area which Eastern Health serves is both large and diverse, presenting a challenge to target resources where they are most effective. However, community engagement offers a real opportunity to involve citizens in policy and decision making and to develop collaborative partnerships to improve the health and well-being of individuals and communities. Eastern Health's new Community Engagement Framework outlines the organization's direction in this area.

Financial sustainability will continue to be a focus for the organization. Eastern Health launched operational improvement initiatives to be implemented over a two-year period to save $43 million and to reduce 550 full-time equivalents (FTEs) through attrition. During 2012-13, the organization realized savings of nearly $20 million and reduced full-time equivalents (FTEs) by 180.1. This work will continue into 2013-14.

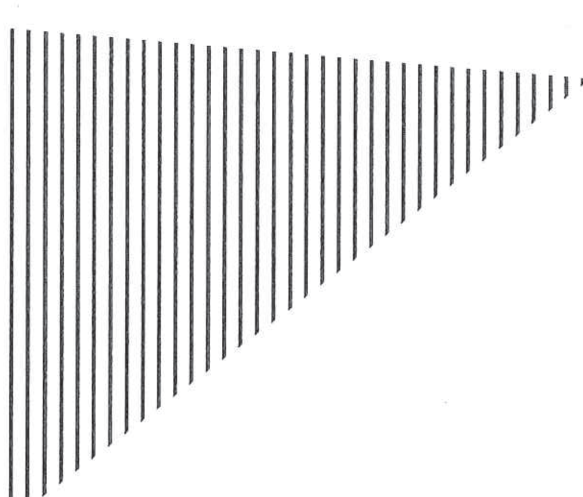
Improving employee engagement continues to be a challenge for the organization. Eastern Health recognizes the power of working with engaged staff and is committed to taking the opportunity to work with programs and departments, and in consultation with staff, to develop an overall plan for improved engagement.

Eastern Health will continue to strive to avail of the opportunities and address the challenges as it accomplishes its 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.*

Non-consolidated Financial Statements

Eastern Regional Health Authority – Operating Fund

March 31, 2013



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Eastern Regional Health Authority – Operating Fund

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STATEMENT OF MANAGEMENT RESPONSIBILITY

The accompanying non-consolidated financial statements of the **Eastern Regional Health Authority – Operating Fund** as at March 31, 2013 have been prepared by management in accordance with the Canadian public sector accounting standards and the integrity and objectivity of these statements are management's responsibility. Management is also responsible for all the notes to the financial statements and schedules.

In discharging its responsibilities for the integrity and fairness of the 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 external auditor, Ernst and Young LLP, Chartered Accountants, conducts an independent examination, in accordance with the Canadian generally accepted auditing standards, and expresses an opinion on the financial statements for the year ended March 31, 2013.

George Butt, CA
Vice President, Corporate Services

Chris O'Grady, 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 statement of financial position of the **Eastern Regional Health Authority – Operating Fund** as at March 31, 2013, and the non-consolidated statements of operations, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's responsibility for the 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, 2013 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,
July 4, 2013.

Chartered Accountants

Eastern Regional Health Authority – Operating Fund

NON-CONSOLIDATED STATEMENT OF OPERATIONS

Year ended March 31
[in thousands of dollars]

	Budget $	2013 $	2012 $
	[unaudited] *[note 19]*		
Revenue			
Provincial plan	1,149,258	**1,149,258**	1,202,911
Provincial plan capital grant	—	**23,497**	44,800
Other capital contributions	—	**6,713**	5,083
MCP	74,183	**74,483**	73,302
Inpatient	11,558	**10,779**	10,260
Resident	17,824	**18,560**	18,005
Outpatient	8,784	**9,091**	8,015
Other	39,232	**39,951**	42,569
	1,300,839	**1,332,332**	1,404,945
Expenses			
Patient and resident services	362,070	**362,744**	365,589
Client services	210,993	**210,918**	258,235
Diagnostic and therapeutic	180,690	**179,020**	175,989
Support	164,170	**164,273**	150,964
Ambulatory care	136,315	**142,729**	128,924
Administration	114,529	**113,861**	113,574
Medical services	97,742	**98,875**	105,373
Amortization of tangible capital assets	—	**31,813**	31,605
Research and education	17,762	**16,526**	18,227
Interest on long-term debt	10,204	**9,469**	9,594
Other	3,810	**8,031**	24,567
Employee future benefits			
Accrued severance pay	—	**6,840**	10,125
Accrued sick leave	—	**1,780**	2,831
Accrued vacation pay	—	**(678)**	979
	1,298,285	**1,346,201**	1,396,576
Annual (deficit) surplus	2,554	**(13,869)**	8,369
Accumulated deficit, beginning of year		**(62,496)**	(70,865)
Accumulated deficit, end of year		**(76,365)**	(62,496)

See accompanying notes

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NON-CONSOLIDATED STATEMENT OF CHANGES IN NET DEBT

Year ended March 31
[in thousands of dollars]

	Budget $ *[unaudited]* *[note 19]*	2013 $	2012 $
Annual (deficit) surplus	—	**(13,869)**	8,369
Changes in tangible capital assets			
Acquisition of tangible capital assets	—	**(30,210)**	(49,883)
Amortization of tangible capital assets	—	**31,813**	31,605
Increase (decrease) in net book value of tangible capital assets	—	**1,603**	(18,278)
Changes in other non-financial assets			
Net decrease in prepaid expenses	—	**2,218**	1,495
Net increase in supplies inventory	—	**(892)**	(1,673)
Increase (decrease) in other non-financial assets	—	**1,326**	(178)
Increase in net debt	—	**(10,940)**	(10,087)
Net debt, beginning of year	—	**(438,139)**	(428,052)
Net debt, end of year	—	**(449,079)**	(438,139)

See accompanying notes

NON-CONSOLIDATED STATEMENT OF FINANCIAL POSITION

As at
[in thousands of dollars]

	2013 $	2012 $
Financial assets		
Cash	**13,288**	6,406
Accounts receivable *[note 3]*	**31,924**	22,684
Due from government/other government entities *[note 4]*	**62,135**	67,924
Advance to General Hospital Hostel Association	**1,248**	1,374
Sinking fund investment *[note 10]*	**13,506**	12,063
	122,101	110,451
Liabilities		
Accounts payable and accrued liabilities *[note 6]*	**106,076**	107,917
Due to government/other government entities *[note 7]*	**23,087**	24,617
Accrued vacation pay	**47,454**	48,132
Employee future benefits		
Accrued sick leave *[note 16]*	**63,288**	61,508
Accrued severance pay *[note 15]*	**113,908**	107,068
Deferred revenue *[note 8]*		
Deferred capital grants	**65,984**	50,597
Deferred operating revenue	**12,910**	7,750
Long-term debt *[note 9]*	**138,473**	141,001
	571,180	548,590
Net debt	**(449,079)**	(438,139)
Non financial assets		
Tangible capital assets *[note 5]*	**353,264**	354,867
Supplies inventory	**15,397**	14,505
Prepaid expenses	**4,053**	6,271
	372,714	375,643
Accumulated deficit	**(76,365)**	(62,496)

Contingencies *[note 13]*
Contractual obligations *[note 14]*

See accompanying notes

Approved by the Board:

_______________ Director _______________ Director

Eastern Regional Health Authority – Operating Fund

NON-CONSOLIDATED STATEMENT OF CASH FLOWS

Year ended March 31
[in thousands of dollars]

	2013 $	2012 $
Operating transactions		
Annual (deficit) surplus	**(13,869)**	8,369
Adjustments for:		
Amortization of tangible capital assets	**31,813**	31,605
Capital grants provincial and other	**(30,210)**	(49,883)
Increase in accrued severance pay	**6,840**	10,125
Increase in accrued sick leave	**1,780**	2,831
Changes in non-cash assets and liabilities related to operations *[note 11]*	**14,373**	18,657
Cash provided by operating transactions	**10,727**	21,704
Capital transactions		
Construction and purchase of tangible capital assets	**(30,210)**	(49,883)
Capital asset contributions	**30,210**	49,883
Cash provided by capital transactions	**—**	—
Investing transactions		
Sinking fund payments	**(1,443)**	(1,393)
Cash used in investing transactions	**(1,443)**	(1,393)
Financing transactions		
Decrease in bank indebtedness	**—**	(11,614)
Repayment of long-term debt	**(2,528)**	(2,414)
Repayment of advance to General Hospital Hostel Association	**126**	123
Cash used in financing transactions	**(2,402)**	(13,905)
Net increase in cash during the year	**6,882**	6,406
Cash, beginning of year	**6,406**	—
Cash, end of year	**13,288**	6,406
Supplemental disclosure of cash flow information		
Interest paid	**9,469**	9,594

See accompanying notes

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[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.

Until October 2011, the Authority was responsible for child, youth and family related services. Effective October 31, 2011, a new department for child, youth and family services ["CYFS"] was formed by the Government of Newfoundland and Labrador [the "Government"], and the related operations were transferred from the Authority to the new CYFS department. For the year ended March 31, 2012, the non-consolidated financial statements of the Authority included the operations of CYFS for the seven-month period ended October 31, 2011.

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

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND ADOPTION OF ACCOUNTING STANDARDS RELATED TO FINANCIAL INSTRUMENTS

A. SIGNIFICANT ACCOUNTING POLICIES

Basis of accounting

The non-consolidated financial statements have been prepared in accordance with Canadian accepted accounting principles established by the Public Sector Accounting Standards Board ["PSAB"] of the Canadian Institute of Chartered Accountants ["CICA"]. The significant accounting policies used in the preparation of these non-consolidated financial statements are as follows:

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2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND ADOPTION OF ACCOUNTING STANDARDS RELATED TO FINANCIAL INSTRUMENTS [Cont'd]

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 12]. 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 been issued.

Revenue recognition

Provincial plan revenue without eligibility criteria and stipulations restricting their 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 as 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 expenditures, 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.

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NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND ADOPTION OF ACCOUNTING STANDARDS RELATED TO FINANCIAL INSTRUMENTS [Cont'd]

Expenses

Expenses are recorded on the accrual basis as they are incurred and measurable based on receipt of goods or services and 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 include cash on hand and balances with banks.

Inventory

Inventory is valued at the lower of cost and net realizable value, 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 financial statements as legal title is held by 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 financial statements of the Authority.

Contributed tangible capital assets are recorded at their estimated fair value at the date of contribution.

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

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2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND ADOPTION OF ACCOUNTING STANDARDS RELATED TO FINANCIAL INSTRUMENTS [Cont'd]

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.

Tangible:	
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 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.

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.

Accrued vacation pay

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

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NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND ADOPTION OF ACCOUNTING STANDARDS RELATED TO FINANCIAL INSTRUMENTS [Cont'd]

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 and the public sector. 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 recognized immediately through the non-consolidated statement of operations.

Accrued sick leave

Employees of Eastern Health are entitled to sick pay benefits that accumulate but do not vest. In accordance with PSA for post-employment benefits and compensated balances, 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 recognized immediately through the non-consolidated statement of operations.

Pension costs

Employees are members of the Public Service Pension Plan and the Government Money Purchase Plan [the "Plans"] administered by the Government. 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 $39,673,213 for the year ended March 31, 2013 [2012 – $40,724,565].

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.

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2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND ADOPTION OF ACCOUNTING STANDARDS RELATED TO FINANCIAL INSTRUMENTS [Cont'd]

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 cash equivalents 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 financial statements 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.

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NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES AND ADOPTION OF ACCOUNTING STANDARDS RELATED TO FINANCIAL INSTRUMENTS [Cont'd]

B. ADOPTION OF ACCOUNTING STANDARDS RELATED TO FINANCIAL INSTRUMENTS

On April 1, 2012, the Authority adopted *PS 3450 – Financial Instruments* ["PS 3450"] and *PS 1201 – Financial Statement Presentation.* The standards were adopted prospectively from the date of adoption. The new standards provide comprehensive requirements for the recognition, measurement, presentation and disclosure of financial instruments.

Under PS 3450, all financial instruments are included in the non-consolidated statement of financial position and are measured either at fair value or amortized cost based on the characteristics of the instrument and the Authority's accounting policy choices [see note 2A – Significant Accounting Policies and adoption of accounting standards related to financial instruments].

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[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:

	2013					
			Past due			
	Total	Current	1-30 days	31-60 days	61-90 days	Over 90 days
	$	$	$	$	$	$
Services to patients, residents and clients	14,570	1,025	2,765	2,878	1,609	6,293
Other	19,747	11,433	—	—	—	8,314
Gross receivables	34,317	12,458	2,765	2,878	1,609	14,607
Less impairment allowance	2,393	—	—	—	—	2,393
Accounts receivable	31,924	12,458	2,765	2,878	1,609	12,214

4. DUE FROM GOVERNMENT/OTHER GOVERNMENT ENTITIES

	2013	2012
	$	$
Government of Newfoundland and Labrador	**60,279**	54,330
Other government entities	**1,856**	13,594
	62,135	67,924

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5. TANGIBLE CAPITAL ASSETS

	Land and land improvements $	Buildings and improvements $	Equipment $	Equipment under capital leases $	Construction in progress $	Total $
2013						
Cost						
Opening balance	**2,810**	**351,727**	**441,116**	**15,445**	**48,221**	**859,319**
Additions	—	**10,650**	**18,464**	—	**1,096**	**30,210**
Disposals	—	—	**(110)**	—	—	**(110)**
Closing balance	**2,810**	**362,377**	**459,470**	**15,445**	**49,317**	**889,419**
Accumulated amortization						
Opening balance	**492**	**143,759**	**345,316**	**14,885**	—	**504,452**
Additions	—	**9,192**	**22,061**	**560**	—	**31,813**
Disposals	—	—	**(110)**	—	—	**(110)**
Closing balance	**492**	**152,951**	**367,267**	**15,445**	—	**536,155**
Net book value	**2,318**	**209,426**	**92,203**	—	**49,317**	**353,264**

	Land and land improvements $	Buildings and improvements $	Equipment $	Equipment under capital leases $	Construction in progress $	Total $
2012						
Cost						
Opening balance	2,810	341,232	409,515	15,445	41,374	810,376
Additions	—	10,495	32,541	—	6,847	49,883
Disposals	—	—	(940)	—	—	(940)
Closing balance	2,810	351,727	441,116	15,445	48,221	859,319
Accumulated amortization						
Opening balance	492	134,918	323,591	14,786	—	473,787
Additions	—	8,841	22,665	99	—	31,605
Disposals	—	—	(940)	—	—	(940)
Closing balance	492	143,759	345,316	14,885	—	504,452
Net book value	2,318	207,968	95,800	560	48,221	354,867

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

6. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

	2013 $	2012 $
Accounts payable and accrued liabilities	**59,146**	67,588
Salaries and wages payable	**42,435**	35,588
Employee/employer remittances	**4,495**	4,741
	106,076	107,917

7. DUE TO GOVERNMENT/OTHER GOVERNMENT ENTITIES

	2013 $	2012 $
Federal government	**11,007**	11,251
Government of Newfoundland and Labrador	**10,408**	7,387
Other government entities	**1,672**	5,979
	23,087	24,617

8. DEFERRED REVENUE

	2013 $	2012 $
Deferred capital grants [a]		
Balance at beginning of year	**50,597**	52,549
Receipts during year	**45,597**	47,931
Recognized in revenue during year	**(30,210)**	(49,883)
Balance at end of year	**65,984**	50,597
Deferred operating revenue [b]		
Balance at beginning of year	**7,750**	15,554
Receipts during year	**1,213,312**	1,245,195
Recognized in revenue during year	**(1,208,152)**	(1,252,999)
Balance at end of year	**12,910**	7,750

[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 and the liability is settled.

[b] Deferred operating revenue represents 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.

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NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

9. LONG-TERM DEBT

	2013 $	2012 $
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 maturing in May 2014, payable in monthly instalments of principal and interest of $101,670.	**1,380**	2,480
Newfoundland and Labrador Housing Corporation, 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 $1,851,664.	**1,525**	1,699
Royal Bank of Canada (Veterans Pavilion), 4.18% loan, unsecured, maturing in April 2013, payable in blended monthly instalments of $55,670.	**55**	706
Canadian Imperial Bank of Commerce loan, unsecured, bearing interest at prime lending rate less 0.625 basis points, maturing in 2016, repayable in monthly instalments of $21,200 plus interest.	**866**	1,121
Newfoundland and Labrador Housing Corporation 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 $864,014.	**864**	886
Bank of Montreal, 4.96% term loan, unsecured, amortized to December 2014, repayable in blended monthly instalments of principal and interest of $7,070.	**67**	146
Newfoundland and Labrador Housing Corporation 2.40% mortgage, amortized to July 1, 2020, repayable in blended monthly instalments of $1,022, secured by property with a net book value of $53,098.	**82**	93
Canada Mortgage and Housing Corporation mortgages on land and buildings with a net book value of $4,619,334 – 8%, on Blue Crest Home; repayable in blended monthly instalments of $7,777, maturing in November 2025.	**748**	781
10.5% on Golden Heights Manor, repayable in blended monthly installments of $7,549, maturing in August 2027.	**681**	701
2.65% on Golden Heights Manor, repayable in blended monthly installments of $20,482, maturing in June 2023.	**2,205**	2,388
	138,473	141,001

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NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

9. LONG-TERM DEBT [Cont'd]

Annual principal repayments to maturity are as follows:

	$
2014	2,005
2015	945
2016	752
2017	621
2018	539
Thereafter	133,611
	138,473

10. SINKING FUND

A sinking fund investment, established for the partial retirement of the debenture *[note 9]*, is held in trust by the Government. The balance as at March 31, 2013 included interest earned in the amount of $4,536,000 [2012 – $3,841,000].

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 debenture sinking fund payments are guaranteed by the Government.

11. CHANGES IN NON-CASH ASSETS AND LIABILITIES RELATED TO OPERATIONS

	2013 $	2012 $
Accounts receivable	**(9,240)**	(1,012)
Supplies inventory	**(892)**	(1,673)
Prepaid expenses	**2,218**	1,495
Accounts payable and accrued liabilities	**(1,841)**	1,288
Due from/to government/other government entities	**4,259**	27,336
Accrued vacation pay	**(678)**	979
Deferred capital grants	**15,387**	(1,952)
Deferred operating revenue	**5,160**	(7,804)
	14,373	18,657

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

12. 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, 2013, the balance of funds held in trust for residents of long-term care facilities was $3,989,210 [March 31, 2012 – $4,250,000]. These trust funds consist of a monthly comfort allowance provided to residents who qualify for subsidization of their boarding and lodging fees.

13. CONTINGENCIES

A number of 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.

14. CONTRACTUAL OBLIGATIONS

The Authority has entered into a number of operating leases and multiple year 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 disclosure below relates to the unperformed portion of the contracts:

	2014 $	2015 $	2016 $	2017 $	2018 $	Thereafter $
Future operating lease payments	12,603	12,119	11,891	10,750	8,308	70,017
Managed print services	2,506	2,506	2,506	—	—	—
Vehicles	303	303	302	199	40	—
	15,412	14,928	14,699	10,949	8,348	70,017

15. ACCRUED SEVERANCE PAY

The Authority provides a severance payment to employees upon retirement, resignation or termination without cause. In 2013, cash payments to retirees for the Authority's unfunded employee future benefits amounted to approximately $7,331,000 [2012 – $7,872,000]. The actuarial valuation for both the accrued severance pay and accrued sick leave was performed effective April 1, 2010, and an extrapolation of that valuation has been performed to March 31, 2012 and March 31, 2013.

	2013 $	2012 $
Accrued benefit obligation, beginning of year	**107,068**	96,943
Benefits expense		
Current service cost	**7,696**	6,741
Interest cost	**4,129**	4,481
Actuarial loss	**2,346**	6,775
	121,239	114,940
Benefits paid	**(7,331)**	(7,872)
Accrued benefit obligation, end of year	**113,908**	107,068

The significant actuarial assumptions used in measuring the accrued severance pay and benefits expenses are as follows:

	2013 $	2012 $
Discount rate – obligation	**3.60**	3.85
Discount rate – benefit expense	**3.60**	3.85
Rate of compensation increase	**4.00**	4.00

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

16. ACCRUED SICK LEAVE

	2013 $	2012 $
Accrued benefit obligation, beginning of year	**61,508**	58,677
Benefits expense		
Current service cost	**6,411**	6,329
Interest cost	**2,340**	2,669
Actuarial loss	**898**	2,741
	71,157	70,416
Benefits paid	**(7,869)**	(8,908)
Accrued benefit obligation, end of year	**63,288**	61,508

The significant actuarial assumptions used in measuring the accrued sick leave and benefits expenses are as follows:

	2013 $	2012 $
Discount rate – obligation	**3.60**	3.85
Discount rate – benefit expense	**3.60**	3.85
Rate of compensation increase	**4.00**	4.00

17. RELATED PARTY TRANSACTIONS

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

	2013 $	2012 $
Grants from the Province	**1,165,320**	1,247,711
Transfers from other government entities	**95,266**	85,222
Transfers to other government entities	**(89,962)**	(99,913)
	1,170,624	1,233,020

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

18. FINANCIAL INSTRUMENTS AND RISK MANAGEMENT

Financial risk factors

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. 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 source of risk exposure and how each is managed is outlined below:

Credit risk

Credit risk is the risk of loss associated with counterparty's inability to fulfill 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"] total $64,000,000. As at March 31, 2013, the Authority had $64,000,000 in funds available on the Facility [March 31, 2012 – $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 the Province, assuming these can be obtained.

19. BUDGET

The Authority prepares an initial budget for a fiscal period that is approved by the Board of Trustees and 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 unaudited budget amounts as presented in the non-consolidated statement of operations [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.

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NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2013
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

19. BUDGET [Cont'd]

The following presents a reconciliation of budgeted revenue for the year ended March 31, 2013:

	2013 $ *[unaudited]*
Original budgeted revenue	**1,276,798**
Adjustments during the year for service and program changes, net	**24,041**
Revised original budget	**1,300,839**

SUPPLEMENTARY SCHEDULES

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NON-CONSOLIDATED SCHEDULE OF EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2013	2012
	$	$
	[unaudited]	*[unaudited]*
Patient and resident services		
Acute care	**201,416**	202,228
Long-term care	**140,339**	141,999
Other patient and resident services	**20,989**	21,362
	362,744	365,589
Client services		
Community support programs	**165,650**	162,620
Family support programs	**9,971**	11,171
Health promotion and protection	**15,033**	15,709
Mental health and addictions	**20,264**	14,579
	210,918	204,079
Diagnostic and therapeutic		
Other diagnostic and therapeutic	**80,489**	78,528
Clinical laboratory	**50,159**	51,712
Diagnostic imaging	**48,372**	45,515
	179,020	175,755
Support		
Facilities management	**64,897**	52,120
Food services	**30,137**	30,392
Other support	**30,444**	29,619
Housekeeping	**29,189**	29,285
Laundry and linen	**9,606**	9,548
	164,273	150,964
Ambulatory care		
Outpatient clinics	**78,726**	77,882
Emergency	**31,966**	29,691
Dialysis	**16,761**	16,790
Other ambulatory	**15,276**	4,561
	142,729	128,924

NON-CONSOLIDATED SCHEDULE OF EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2013 $ *[unaudited]*	2012 $ *[unaudited]*
Administration		
Other administrative	**38,687**	38,162
Materials management	**18,693**	20,299
Systems support	**16,270**	15,216
Human resources	**14,395**	13,645
Executive offices	**14,509**	15,190
Finance and budgeting	**10,867**	10,556
Emergency preparedness	**440**	335
	113,861	113,403
Medical services		
Physician services	**76,304**	81,815
Interns and residents	**22,571**	23,558
	98,875	105,373
Other		
Undistributed	**8,031**	24,567
Research and education		
Education	**13,933**	15,298
Research	**2,593**	2,929
	16,526	18,227
Interest on long-term debt		
Interest on long-term debt	**9,469**	9,594
Total shareable expenses	**1,306,446**	1,296,475

NON-CONSOLIDATED SCHEDULE OF EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[With a comparative for the seven-month period ended October 31, 2011]
[in thousands of dollars]

	2013 $ *[unaudited]*	2012 $ *[unaudited]*
Client services		
Family support programs	—	50,209
Health promotion and protection	—	1,404
Mental health and addictions	—	149
Community youth corrections	—	2,394
	—	54,156
Diagnostic and therapeutic		
Other diagnostic and therapeutic	—	234
Administration		
Other administrative	—	171
	—	54,561

NON-CONSOLIDATED SCHEDULE OF REVENUE AND EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2013 $ *[unaudited]*	2012 $ *[unaudited]*
Revenue		
Provincial plan	**1,149,258**	1,149,204
MCP	**74,483**	73,302
Inpatient	**10,779**	10,260
Resident	**18,560**	18,005
Outpatient	**9,091**	8,015
Other	**39,256**	40,869
	1,301,427	1,299,655
Expenditures		
Compensation		
Salaries	**699,302**	693,565
Employee benefits	**113,166**	112,065
	812,468	805,630
Supplies		
Other	**225,975**	230,672
Medical and surgical	**61,261**	58,402
Drugs	**49,175**	45,923
Plant operations and maintenance	**20,700**	21,171
	357,111	356,168
Direct client costs		
Community support	**121,409**	119,627
Family support	**4,331**	4,247
Mental health and addictions	**1,658**	1,209
	127,398	125,083
Lease and long-term debt		
Long-term debt – interest	**9,469**	9,594
Long-term debt – principal	**3,276**	3,162
	12,745	12,756
	1,309,722	1,299,637
(Deficiency) surplus for government reporting	**(8,295)**	18
Long-term debt – principal	**3,276**	3,162
(Deficiency) surplus before non-shareable items	**(5,019)**	3,180

NON-CONSOLIDATED SCHEDULE OF REVENUE AND EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2013 $ *[unaudited]*	**2012** $ *[unaudited]*
Adjustments for non-shareable items		
Provincial plan capital grant	**23,497**	44,800
Other capital contributions	**6,713**	5,083
Amortization of tangible capital assets	**(31,813)**	(31,605)
Interest on sinking fund	**695**	647
Accrued vacation pay	**678**	(979)
Accrued sick leave	**(1,780)**	(2,831)
Accrued severance pay	**(6,840)**	(13,133)
	(8,850)	1,982
(Deficiency) surplus as per statement of operations	**(13,869)**	5,162

Eastern Regional Health Authority – Operating Fund Schedule 2B - CYFS

NON-CONSOLIDATED SCHEDULE OF REVENUE AND EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[With a comparative for the seven-month period ended October 31, 2011]
[in thousands of dollars]

	2013 $ *[unaudited]*	2012 $ *[unaudited]*
Revenue		
Provincial plan	—	53,707
Other	—	1,053
	—	54,760
Expenditures		
Compensation		
Salaries	—	15,362
Employee benefits	—	2,269
	—	17,631
Supplies		
Other	—	7
Direct client costs		
Family support	—	34,080
Mental health and addictions	—	8
Health promotion	—	1,404
Community youth corrections	—	1,431
	—	36,923
	—	54,561
Surplus for government reporting	—	199
Surplus before non-shareable items	—	199
Adjustments for non-shareable items		
Accrued severance pay	—	3,008
Surplus of revenue over expenses	—	3,207

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

Year ended March 31
[in thousands of dollars]

	2013 $ *[unaudited]*	2012 $ *[unaudited]*
Revenue		
Provincial plan	**42,434**	37,189
Deferred grants – previous year	**50,597**	52,549
Foundations and auxiliaries	**6,515**	3,893
Transfer from operations	**179**	5,437
Transfer to operations	**(3,223)**	—
Transfer to other regions	**(506)**	222
Other	**198**	1,190
Deferred grant current year	**(65,984)**	(50,597)
	30,210	49,883
Expenses		
Equipment	**18,161**	32,541
Construction in progress	**1,096**	6,847
Buildings	**10,650**	10,495
Vehicles	**303**	—
	30,210	49,883
Surplus on capital transactions	—	—

NON-CONSOLIDATED SCHEDULE OF ACCUMULATED DEFICIT FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2013	2012
	$	$
	[unaudited]	*[unaudited]*
Assets		
Current assets		
Cash	**13,288**	6,406
Accounts receivable	**94,059**	90,608
Supplies inventory	**15,397**	14,505
Prepaid expenses	**4,053**	6,271
	126,797	117,790
Advance to General Hospital Hostel Association	**1,248**	1,374
	128,045	119,164
Liabilities		
Current liabilities		
Accounts payable and accrued liabilities	**129,163**	132,534
Deferred revenue – operating revenue	**12,910**	7,750
Deferred revenue – capital grants	**65,984**	50,597
	208,057	190,881
Accumulated deficit for government reporting	**(80,012)**	(71,717)

Appendix I – Definitions of Quantifiable Indicators from the Report on Performance Section

The following list of definitions explains the purpose behind the quantifiable 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: Quantifiable Indicators

Adverse events, occurrences and close calls: Occurrence: An undesired or unplanned event that is associated with the care or services provided to a client, and/or associated with risk to visitors, property or the organization; results from commission or omission; and includes close calls and problems in professional practice, products, procedures, and systems. This definition of occurrence includes both a close call (i.e., did not reach the client) and an adverse event (i.e., an occurrence that results in unintended harm to the client). While Eastern Health continues to encourage reporting of occurrences, the degree to which clients experience harm is a key indicator for clinical safety; to decrease the number of adverse events that result in harm while increasing the reporting of close calls.

Percentage of Unscheduled Readmissions 8-28 days post discharge for Surgery as per cent of cases typical, Health Sciences Centre (HSC) and St. Clare's Mercy Hospital, (SCMH): A risk-adjusted rate of unplanned readmission following discharge for a specific surgical procedure. A case is counted as a readmission if it is for a relevant diagnosis and occurs within 8-28 days after the index episode of care. An episode of care refers to all continuous inpatient hospitalizations and same-day surgery visits. Readmission rates provide one measure of quality of care. Although readmission following surgery may involve factors outside the direct control of the hospital, high rates of readmission act as a signal to hospitals to look more carefully at their practices, including the risk of discharging patients too early and the relationship with community physicians and community-based care.

Percentage of Unscheduled Readmissions within 7 days of discharge for combined Medicine, Surgery and Mental Health program types for HSC, SCMH and Waterford - as per cent of cases (typical): A Risk-adjusted rate of unplanned readmission following discharge for a specific surgical procedure. A case is counted as a readmission if it is for a relevant diagnosis and occurs within seven days after the index episode of care. An episode of care refers to all continuous inpatient hospitalizations and same-day surgery visits. Readmission rates provide one measure of quality of care. Although readmission following surgery may involve factors outside the direct control of the hospital, high rates of readmission act as a signal to hospitals to look more carefully at their practices, including the risk of discharging patients too early and the relationship with community physicians and community-based care.

Alternate Level of Care (ALC) days as a per cent of total adult patient days (Medicine and Surgery only, HSC and SCMH): Alternate Level of Care (ALC) refers to patients in an acute care hospital who no longer require the intensity of resources and services provided by that facility. The impact of ALC is two-fold: 1) From the client perspective, it is important that the client be placed in a health care setting that meets their assessed needs. Clients have the right to receive the services that best match their needs in order to attain their highest level of wellness in a timely manner. 2) From the resource allocation perspective, it is important that the individual be placed in the most suitable setting to ensure resources are utilized appropriately to meet

client needs. Inappropriate utilization causes delays in accessing services, wait times, and unnecessary stress and strain on the individual/family, care- providers and the health care system.

Rate of MRSA LTC infections: The purpose of this indicator is to determine the incidence and trend of new Methicillin-Resistant Staphylococcus Aureus (MRSA) infections for long-term care as well as identify cases that are associated with healthcare delivery. MRSA has become a significant and growing public health concern as healthcare-associated infections are a major cause of excess illness and death. MRSA surveillance is considered a component of Infection Prevention and Control (IPAC) and the 2012 Accreditation Canada Standards has made surveillance a requirement.

Rate of Hand Hygiene Compliance - 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. The audit tool measures whether health care providers are washing their hands at the right times and in the right way.

Rate of New MRSA Acute Care, health care associated infections per 10,000 patient days (excluding Janeway):
This indicator measures the incidence and trend of new Methicillin-Resistant Staphylococcus aureus (MRSA) infections for acute care and helps identify cases that are associated with healthcare delivery. MRSA has become a significant and growing public health concern as healthcare-associated infections are a major cause of excess illness and death.

MRSA surveillance is considered a component of Infection Prevention and Control (IPAC) and the 2012 Accreditation Canada Standards has made surveillance a requirement.

Central line-associated blood stream infection rate per 1,000 central line days - Critical Care HSC & SCM: Central lines disrupt the integrity of the skin making infection possible. Prevention is based on sterility of access to the line site on insertion and maintenance. *Safer Healthcare Now* has identified interventions designed to reduce the incidence of central line infection (CLI) which should result in a decrease in length of stay and mortality attributed to blood stream infection.

Percentage of Acute Myocardial Infarction (AMI) Perfect Care rate: Health Canada has identified cardiovascular disease or heart diseases as the number one killer in Canada. It is also the most costly disease in Canada, putting the greatest burden on our national healthcare system. *Safer Healthcare Now* has identified evidence-based care components for improved care for AMI.

Surgical Site Infection rate per 100 procedures for C-Sections at HSC: Surveillance of all C-section procedures is done in order to detect and address any infection of the surgical incision. The rate of infection detected is compared to the number of C-sections performed on a monthly basis.

Surgical Site Infection rate per 100 procedures for Colorectal Surgery at HSC, SCMH, G.B. Cross, Carbonear and Burin: In 2005 the *Safer Healthcare Now Campaign* identified the importance of complying with best practice for patients undergoing colorectal surgery to reduce surgical site infections.

Ventilator Associated Pneumonia per 1,000 ICU ventilator days - Critical Care (Combined HSC and SCMH): Ventilator associated pneumonia (VAP) is a device-associated infection and is preventable. VAP is associated with increased length of stay and mortality.

Percentage of Medication Reconciliation implementation (Acute Care Inpatient Units): 42 acute care inpatient units, under Accreditation Canada criteria, are in the process of implementing MedRec on admission. This percentage is provided as a point in time.

Percentage of Medication Reconciliation compliance (Acute Care Inpatient Units):

This indicator identifies the audit results of the MedRec process as determined by Accreditation Canada criteria. 75 per cent of the charts audited. This is a regional report and the percentage is reported as a point in time.

Workers Compensation hours per Full Time Equivalent (FTE): This indicator measures the average hours utilized for worker's compensation for the employee population as a whole based on Full-Time Equivalent (FTE).

Employee lost time incident rate: This indicator measures the number of workers' compensation lost-time incidents over the average employee count (expressed as a percentage).

Median duration of Worker's Compensation claims: This indicator measures the median weeks for worker's compensation for all cases where employees are off. It is calculated by finding the mid-point of all active cases including those cases originating in current and previous years.

Access: Quantifiable Indicators

Wait time for access to long-term care beds: Timely access to long-term care beds is critical in the management of many of our Alternate Level of Care (ALC) patients in the acute care setting. This measure assists health care organizations in identifying potential challenges in managing patients who no longer need acute care services and are waiting to be discharged to a more appropriate setting.

Wait time for non-urgent primary mental health and addictions: This wait time is an average for primary mental health and addictions services (community-based counseling services) for Priority 3 patients (scheduled/elective). The wait time is measured from the date of referral to when the service starts.

Wait time for specialists (non-urgent) - Orthopedics: "Wait Time One" for non-urgent consultation with an Orthopedic Surgeon is measured from the date that a referral is sent from a family physician to a specialist to the date that the patient is seen and assessed by the specialist. Wait Time One constitutes a significant portion of a patient's total wait time for access to services and therefore is an important indicator of both the quality and acceptability of a service.

Wait time for specialists – Rheumatology: The following classification system has been approved by the Rheumatology Program based on an analysis of best practice throughout the country:

Priority 1 - Urgent: Acute non-traumatic inflammatory rheumatic disorders requiring prompt intervention. Should be seen within 1-4 weeks by Rheumatologist. Target is 95 per cent within benchmark

Priority 2 - Semi Urgent: Sub-acute non-traumatic inflammatory rheumatic disorders. Will be referred to Internal Medicine.

Priority 3 - Routine: Chronic non-inflammatory rheumatic disorders. Referral will be redirected to general practice.

Wait time for specialists (non-urgent) – Psychiatry: Wait time data within the Mental Health & Addictions program is currently collected manually. This information only provides an estimated wait time for various services.

Therapeutic outpatient, community-based services and community supports (non-urgent) - Audiology: Longest wait time in months to access Audiology as average of selected service sites: point in time data, includes Central Auditory Processing Disorders and ENG Baseline Testing.

Percentage of Knee Replacements completed within 182 days (city only): Knee replacement surgery was identified as a priority area by Federal First Ministers in 2004. The provincial government has mandated quarterly wait time reports for patients undergoing knee replacements to monitor timeliness of access to this service.

Percentage of Hip Replacements completed within 182 days (city only): Hip replacement surgery was identified as a priority area by Federal First Ministers in 2004. The provincial government has mandated quarterly wait time reports for patients undergoing knee replacements to monitor timeliness of access to this service.

Percentage of Hip Fracture surgeries completed within 48 hours (city only): Improving timely access for hip fracture repair is one of the priority areas identified by the Federal First Ministers in 2004. Wait times are measured from the time the patient comes into the Emergency Department to the time of surgery. The provincial government has mandated quarterly wait time reporting.

Percentage of Cataract Surgeries completed for patients who are at high risk within 112 days (local anesthetic only, city only): In 2004 Federal First Ministers identified sight restoration as one of the priority areas where funding would be directed toward making meaningful access improvements. The provincial government has mandated quarterly wait time reporting.

Percentage of Level III Coronary Artery Bypass Grafts (CABG) surgery completed within 182 days (city only): Coronary Artery Bypass surgery was identified as a priority area by Federal First Ministers in 2004. The provincial government has mandated quarterly wait time reports for patients who required Level 3 Bypass-Only surgery to monitor timeliness of access to this service.

Percentage of Cancer Treatments (radiation) started within 28 days from ready to treat date (all disease sites): Wait time for radiation therapy is monitored to ensure patients have timely access to treatment. The standard has been set for 28 days, which is measured from the time the patient is ready for treatment until the time of the first treatment.

Cancer Surgeries - It is not possible to compare 2012-13 wait times to previous reports as the reporting methodology has changed. While all patients are included in the volumes of cases completed, calculations for wait times no longer include patients who had inactive wait times. The impact on comparing previously reported wait times may vary according to surgery type, volume of emergency cases and volume of waitlist patients who had a period of inactive wait times.

DI - Percentage of MRIs completed within 30 days - Non Urgent - (city only). This indicator is an aggregate of all MRI wait times within Eastern Health.

DI - Percentage of CTs completed within 30 days - Non Urgent (Regional): This indicator is an aggregate of all CT wait times within Eastern Health.

DI - Percentage of Ultrasounds completed within 30 days - Non Urgent (excludes OBS and echocardiograms, Regional): This indicator is an aggregate of all ultrasound wait times within Eastern Health.

Percentage of non-urgent (Priority 2) Endoscopies completed within 60 days (City Only): This indicator is identifying the percentage of Priority 2 Endoscopy patients who received care within 60 days.

Percentage of Echocardiograms completed: Wait time is measured as number of days using 3rd Next Available Appointment. This data represents echocardiograms completed by the Cardiology Program only.

Percentage of Emergency Department visits who left the ED without being seen by physician (Regional): Research has indicated that the percentage of patients who leave without being seen (LWBS) is related to the waiting time to see the physician.

Sustainability: Quantifiable Indicators

Year to Date (YTD) Budget Variance: This indicator examines the level of actual expenditure as compared to the available budget.

HR vacancy rate for Difficult to fill (actively recruiting for minimum 2 months, does not include Casuals): This indicator includes vacancies in five professional areas that have historically been difficult to recruit: Clinical Pharmacist, Combined Lab and X-Ray Technologist, Clinical Psychologist, Prosthetist/Orthotist Clinician/Technician and Audiologist.

HR vacancy rate in Nursing (posted external, does not include Casuals): This indicator is measured by the number of external competitions (excluding casual) divided by the total number of registered nurses.

HR vacancy rate in Nursing (posted internal, does not include Casuals): This indicator is measured by the number of internal competitions (excluding casual) divided by the total number of registered nurses. Although some internal movement is preferable, having stability within this classification is also important.

Population Health: Quantifiable Indicators

Rate of physical activity: Rate of respondents aged 12 or older in the Eastern Health region who report physical activity during leisure time (moderately active or active) based on the latest data from the Canadian Community Health Survey (2011).

Percentage of Breastfeeding Initiation and Breastfeeding duration rate: Health Canada recommends that all healthy term infants be exclusively breastfed for the first six months of life, and then continue to breastfeed, with the addition of safe and appropriate complementary foods, for up to two years of age or beyond. This indicator reports on initiated breastfeeding and is not limited to exclusive or a duration. Target rates for duration have not been defined; however, the intent is to measure breastfeeding duration at various intervals from birth to 12 months, generally to coincide with the time of Child Health Clinic visits. The denominator used is the total number of live births for the period.

Rate of participation (by age) for screening for colorectal cancer: The NL colon cancer screening program launched in late July 2012 in Corner Brook. This self-referred screening program is available to residents of Western Health Region between the ages of 50-74 and are 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. As of November 30, 2012, the program has mailed 905 home kits to participants with 510 returned giving a response rate of about 57 per cent. The negative results rate is 84.7 per cent and the positive result rate is 14.5 per cent.

Seasonal Influenza Immunization rate - High risk due to chronic disease (reported yearly): Children and adults with chronic disease are considered at high risk for developing influenza related complications and are one of the recommended target groups.

Seasonal Influenza Immunization rate - seniors aged 65+ (reported yearly): Seniors have been identified as one of the groups at highest risk from influenza and recommended for immunization.

Seasonal Influenza Immunization rate- children (reported yearly): The National Advisory Committee on Immunization recommends children aged 6-23 months be immunized to reduce the morbidity and mortality associated with influenza.

Seasonal Influenza Immunization rate – Eastern Health Staff (reported yearly): This rate measures the uptake of seasonal influenza vaccination for our healthcare workers. Immunization of healthcare workers is strongly supported to reduce the transmission of influenza to our patients, residents and families as well as keep our workforce healthy when influenza is prominent (typically November to March).

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