Together we can

Annual Performance Report
2011-2012

Eastern Health

ANNUAL PERFORMANCE REPORT

2011 - 2012

Eastern Health

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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 2011-12.

Since its inception in 2005, Eastern Health has been evolving as an organization. Eastern Health has made tremendous strides toward the vision of *Healthy People, Healthy Communities* and we look forward to working towards our new mission statement: "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."

During 2011-12 Eastern Health developed a number of performance measures to help guide our work outlined in our Strategic Plan, *Together We Can*. Our focus on four priority areas of **quality and safety, access, sustainability** and **population health** underscores our commitment to achieving long-term outcomes and measuring progress along the way.

Indeed, this past year Eastern Health has strengthened our commitment to continuous improvement. We are continually developing innovative practices and learning opportunities. We challenge ourselves to re-think how we work with our partners and the people we serve on a daily basis. Moreover, we strive to increase our sense of pride in our dedicated employees, physicians, students and volunteers.

I am proud of Eastern Health and the many individuals who contribute to our overall success. I am confident that we will build on our successes and continue to strive for excellence as we help improve the health of our population over the long term.

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, Mr. Bill Abbott, Mr. William C. Boyd, Dr. Alice Collins, Mr. Frank Davis, Mr. Ed Drover
Bottom row: Mr. Earl Elliott, Sister Charlotte Fitzpatrick (resigned December 2011), Ms. Cindy Goff, Ms. Barbara Roebothan (resigned December 2011), Ms. Shirley Rose, Mr. John Walsh (resigned February 2012)

1. Overview

As the largest integrated health authority in Newfoundland and Labrador, Eastern Health serves a regional population of approximately 293,795 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 healthcare facilities and provincial programs such as organ procurement and air ambulance. 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 2011-12 the organization had a budget of approximately $1.35 billion, 12,989 employees and over 720 members of medical staff (approximately 200 of whom are employees). Eastern Health benefitted from approximately 1,500 volunteers who provided more than 85,000 hours of volunteer work.

Eastern Health also enjoys relationships with many service groups and community partners throughout the region, such as schools, post-secondary institutions, churches and voluntary/non-profit agencies as well as private sector organizations.

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 include: 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. Traditionally, the settlement patterns of this area have been tied to the fishing industry, which results in many small communities scattered along the coastline of these three peninsulas. The area also includes the provincial capital, St. John's, and the province's largest metropolitan area, the St. John's CMA (Statistics Canada Census Metropolitan Area). 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:

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

Arising from its new Strategic Plan 2011-14, *Together We Can*, Eastern Health has a new mission statement which will provide direction to the organization until 2017:

"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."

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**
   Implement measures that promote and protect population health and help prevent disease and injury.

2. **Provide Supportive Care**
   Offer residential care options, community-based support and continuing care, home support and nursing home care for individuals.

3. **Treat Illness and Injury**
   Investigate, treat, rehabilitate and care for individuals with illness or injury.

4. **Advance Knowledge**
   Expand knowledge through research, education and knowledge mobilization.

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 in Appendix I.

1.6. Number of Employees

Eastern Health has 12,989 employees[1]. Figure 1 shows the percentage of Eastern Health employees based on gender.

Figure 1: Eastern Health Employees by Gender

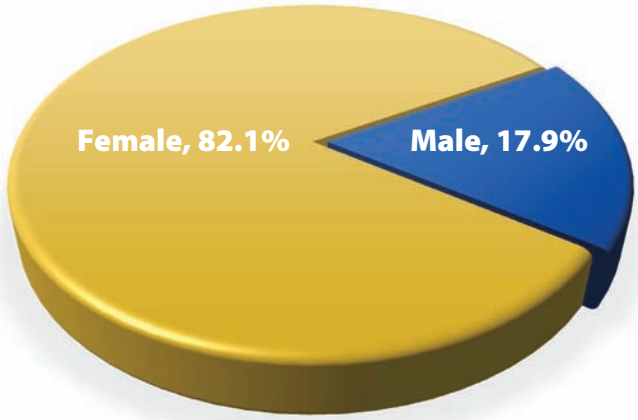
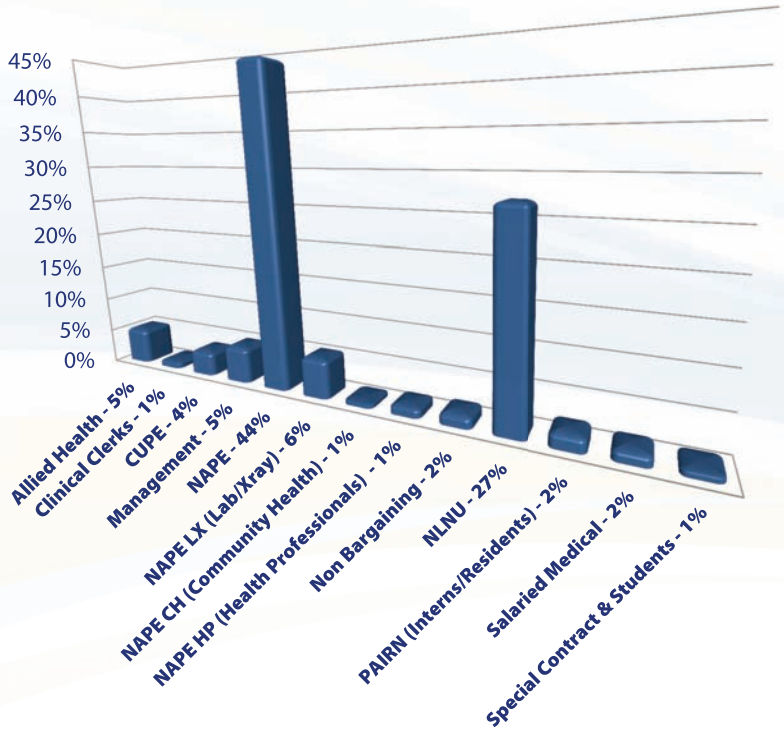


Figure 2 shows Eastern Health employees by classification.

Figure 2: Eastern Health Employees by Classification



[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 9, 2012. Total percentage equals 101% due to rounding.

1.7. Responsibility of Authority

The Regional Health Authorities Act (2006) outlines the responsibility of health authorities as the following:

Responsibility of Authority

(1) An authority is responsible for the delivery and administration of health and community services in its health region in accordance with this Act and the regulations.

(2) Notwithstanding subsection (1), an authority may provide health and community services designated by the minister on an inter-regional or province-wide basis where authorized to do so by the minister under section 4.

(3) In carrying out its responsibilities, an authority shall:

(a) promote and protect the health and well-being of its region and develop and implement measures for the prevention of disease and injury and the advancement of health and well-being;

(b) assess health and community services needs in its region on an ongoing basis;

(c) develop objectives and priorities for the provision of health and community services which meet the needs of its region and which are consistent with provincial objectives and priorities;

(d) manage and allocate resources, including funds provided by the government for health and community services, in accordance with this Act;

(e) ensure that services are provided in a manner that coordinates and integrates health and community services;

(f) collaborate with other persons and organizations, including federal, provincial and municipal governments and agencies and other regional health authorities, to coordinate health and community services in the province and to achieve provincial objectives and priorities;

(g) collect and analyze health and community services information for use in the development and implementation of health and community services policies and programs for its region;

(h) provide information to the residents of the region respecting

- the services provided by the authority,
- how they may gain access to those services, and
- how they may communicate with the authority respecting the provision of those services by the authority;

(i) monitor and evaluate the delivery of health and community services and compliance with prescribed standards and provincial objectives and in accordance with guidelines that the minister may establish for the authority under paragraph 5 (1)(b); and

(j) comply with directions the minister may give.

1.8. 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.

1.9. Revenues and Expenditures

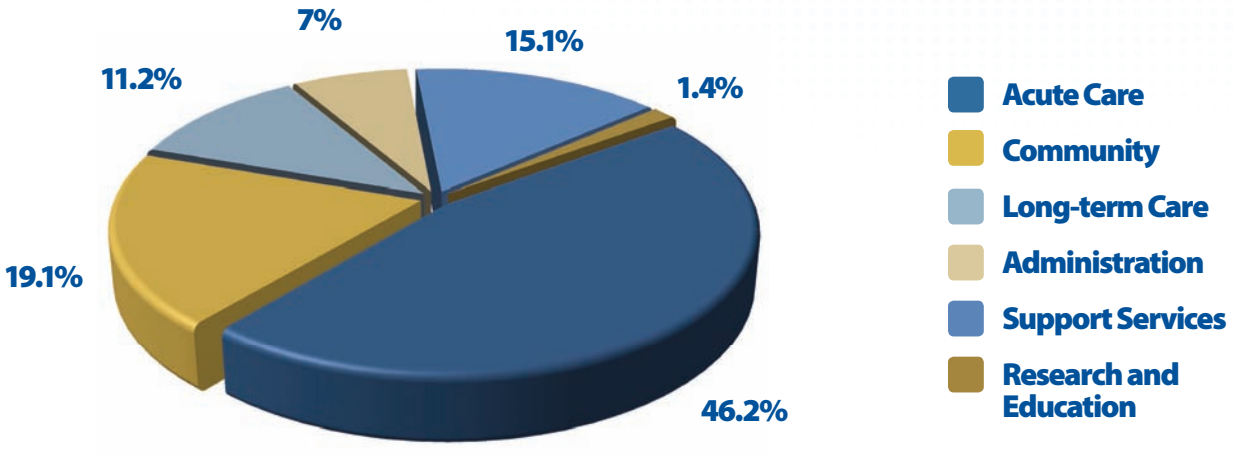
The Government of Newfoundland and Labrador's Budget 2011 announced new initiatives designed to expand current programs and introduce new provincial initiatives. Investments were made to enhance access and reduce wait times, strengthen long-term care and community supports, enhance mental health and addictions services and strengthen health care infrastructure. Investments to support areas such as the medical transportation assistance program, physician leadership, a home support review, implementation of the *Act Respecting the Protection of Adults* and medical/dental student bursary programs have also been made.

Budget 2011 provided additional funding of $47.9 million to address current service level adjustments as well as initiatives unique to Eastern Health including salary-related increases, inflation/utilization increases and home support increases and growth.

Financially, Eastern Health finished the period ending March 31, 2012 in a balanced financial position after availing of additional funding of $12.5 million and accessing $4.8 million of deferred revenues.

Figure 3 provides Eastern Health's expenditures by sector for 2011-12.

Figure 3: Expenditure by Sector

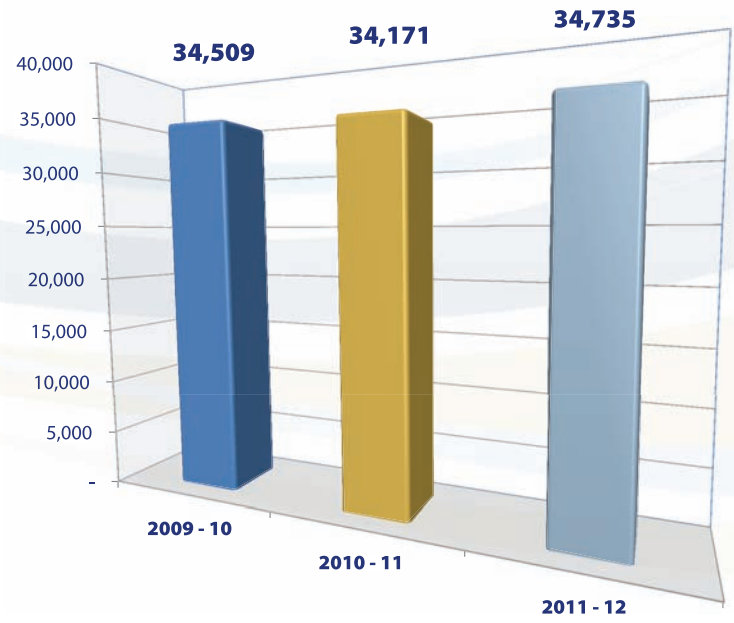


1.10. Other Key Performance Indicators

Eastern Health tracks numerous key performance indicators, including those outlined in the organization's strategic plan and in departmental operational plans.

Figure 4 shows that acute care admissions were 34,735 for 2011-12, which were consistent with the previous two years.

Figure 4: Acute Care Admissions



Overview

Figure 5 indicates that acute care inpatient days in 2011-12 totalled 299,203. This was also consistent with the previous two years.

The volume comparisons chart in Figure 6 shows some of the areas where Eastern Health has experienced service delivery volume changes for the year ending March 31, 2012, versus the year ending March 31, 2011. The largest increases are seen in ultrasound and dialysis services based on increased capacity. The decrease in nuclear medicine volumes is due to staffing challenges coupled with an increased demand for more resource-intensive scanning.

Figure 5: Acute Care Inpatient Days

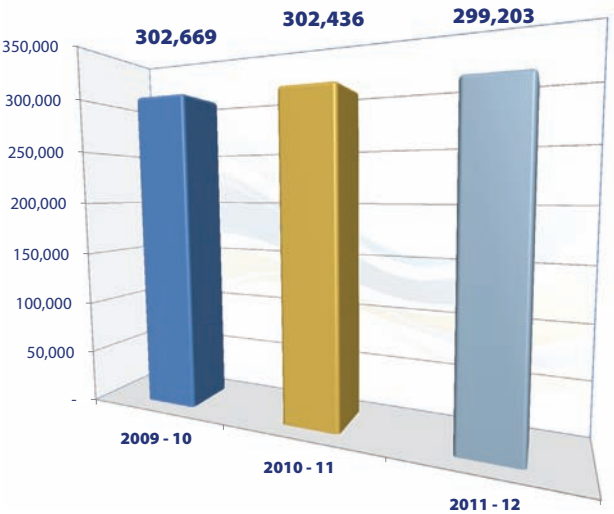
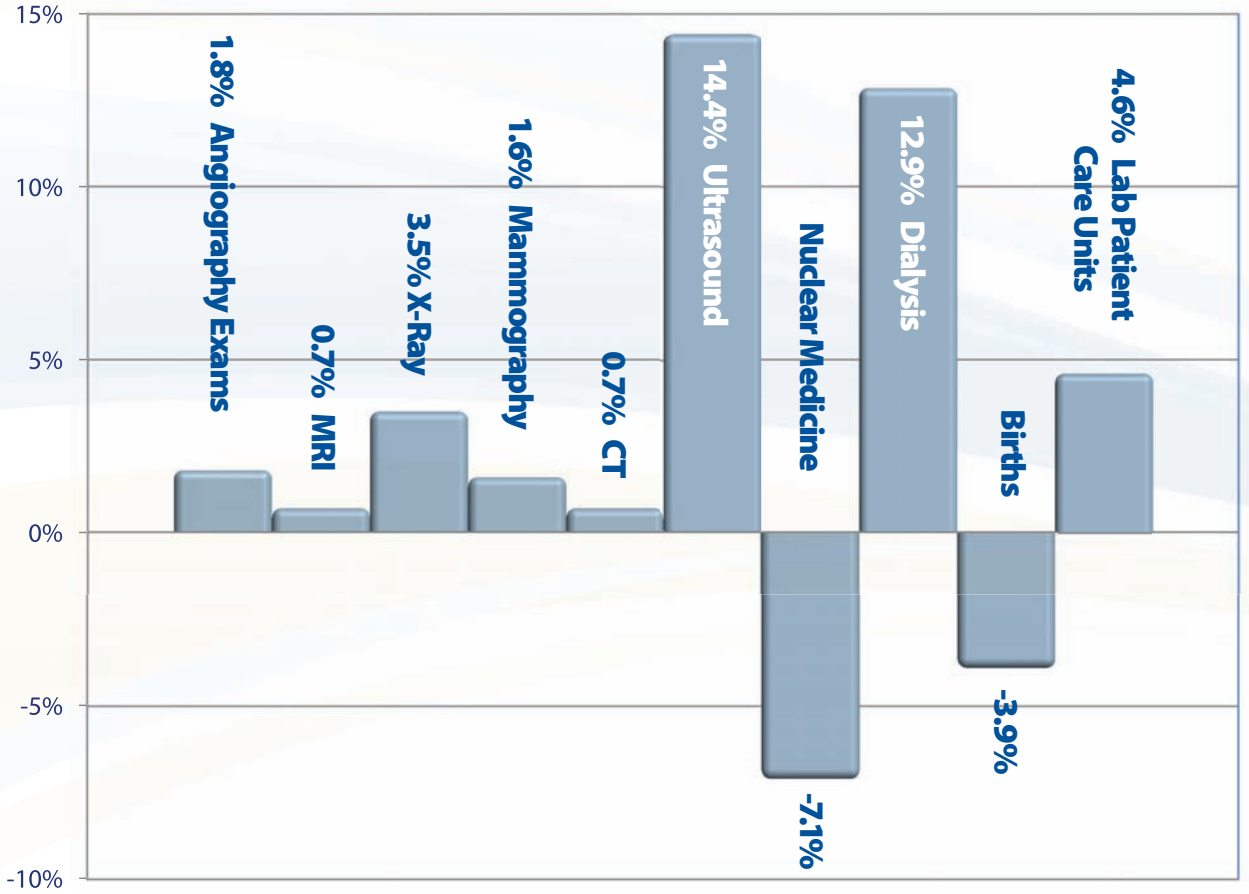


Figure 6: Volume Comparisons Chart



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 7, there was an increase of 6% (95,642 more encounters) in the acute care sites in 2011-12 than in the previous year. This increase can be attributed to the fact that many services are shifting to an ambulatory setting rather than an inpatient setting. In addition, there has been an increase in demand for ambulatory treatments such as intravenous medication infusions and blood transfusions.

Figure 8 shows that long-term care resident days have increased by 12,947 (approximately 2.3%) over 2010-11.

Figure 7: Acute Care Ambulatory Encounters

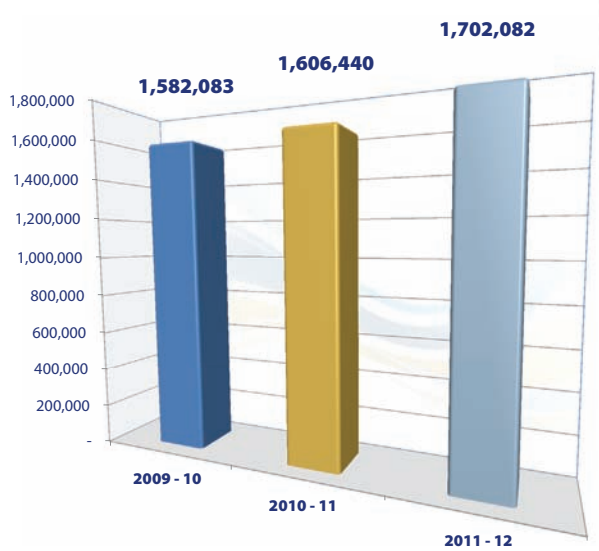
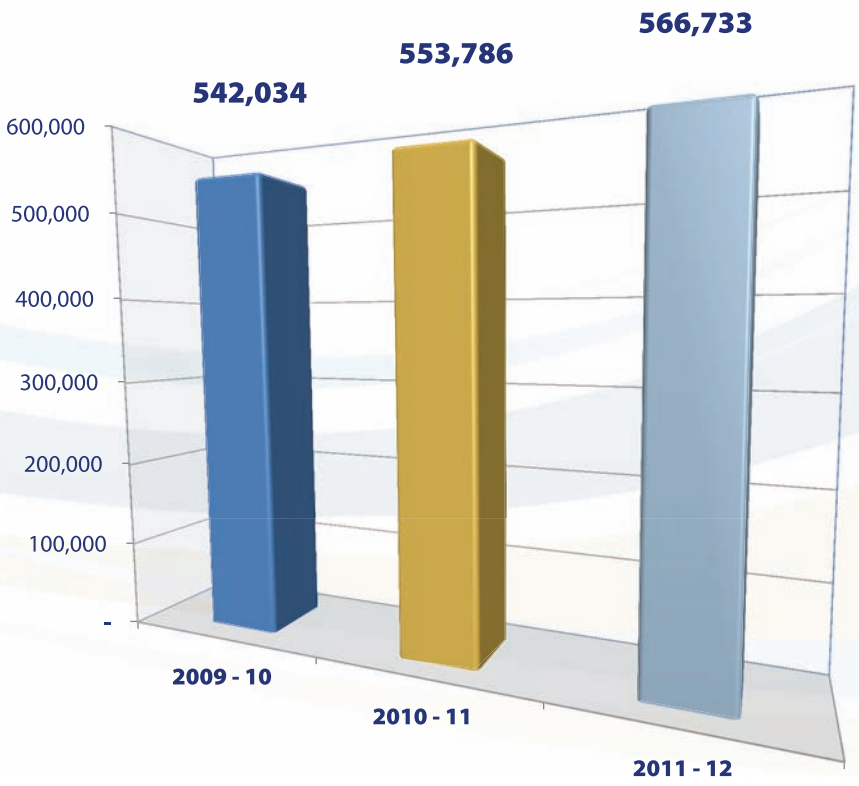


Figure 8: Long-term Care Resident Days



Overview

Figure 9 shows the number of community health service events from 2009-10 to 2011-12. [2]

Figure 9: Community Health Service Events

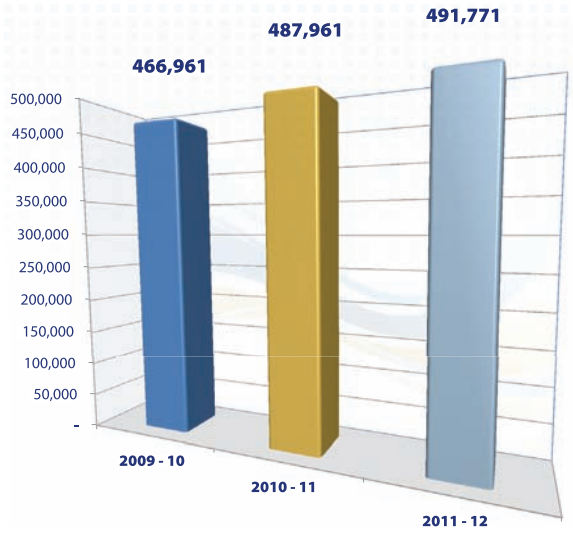


Figure 10 provides statistics regarding Eastern Health's hospitals, primary health care centres and long-term care resident days.

Figure 10: Statistics from a Three-Year Period

	2009-2010	2010-2011	2011-2012
Hospitals and Primary Health Care Centres			
Acute Care Inpatient Days	302,669	302,436	299,203
Emergency Room Visits	231,396	230,057	246,967
Surgical Daycare	46,025	47,182	47,771
Births	3,142	3,035	2,916
Ambulatory Encounters	1,582,083	1,606,440	1,702,082
Community Health Service Events			
Family Support Programs	169,908	172,035	187,690
Community Support Programs	206,169	212,237	207,195
Community Youth Corrections	6,233	5,835	4,885
Health Promotion and Protection	57,289	60,797	58,497
Mental Health and Addictions	27,362	40,867[3]	47,540
Long-term Care			
Long-term Care Resident Days	542,034	553,786	566,733

Bed numbers by each facility of Eastern Health are listed in Appendix II.

[2] 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 above, 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.

[3] An increase in Mental Health and Addictions numbers in 2010-11 reflect an increase in the number of services being entered into the Client Referral Management System.

2. Shared Commitments

Partnerships are of tremendous importance to Eastern Health and are inherent in the organization's vision and values. Partnerships are encouraged at various levels from direct program and service delivery to policy and advocacy. Such partnerships are the cornerstone of true collaboration for the purpose of providing multiple benefits to individuals and their communities.

Eastern Health continues to collaborate closely with officials from the Department of Health and Community Services on a variety of activities, ensuring alignment of the Strategic Directions provided by the Minister of Health and Community Services. Eastern Health also works with the provincial Department of Child, Youth and Family Services (CYFS) and has a memorandum of understanding outlining the relationship with respect to administrative and clinical issues.

Eastern Health continues to work closely with its many external partners, such as professional associations, regulatory boards, unions, schools, police, ambulance service providers and research affiliates. For example, 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 in support of its mandate of education and research. Eastern Health has permanent representation on the Board of Directors of 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's auxiliaries and many volunteers are dedicated to enhancing the quality of life for patients, clients, residents and their families. In addition to the efforts of approximately 2,000 individual volunteers, Eastern Health benefits from the commitment of numerous volunteer agencies and community partners, such as Lions Clubs, Kinsmen and various faith based groups.

Close connections continue between Eastern Health and the faith and fraternity-based owner boards for long-term care services in both St. John's 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.

The organization 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 that population.

During the 2011-12 fiscal year, Eastern Health worked with many of the partners already referenced. Some examples of new or expanded partnerships include collaboration between the Mental Health and Addictions Program and Stella Burry Community Services to offer staff training, collaboration with numerous community-based agencies to oversee the U-Turn Drop In Centre in Carbonear (a support service for individuals recovering from addictions) and new partnerships with private sector groups throughout the region as part of the *Take Care Down There* sexual health promotion campaign.

3. Highlights and Accomplishments

This section of the report highlights some of the accomplishments achieved by Eastern Health during 2011-12. These highlights are presented according to the Strategic Directions provided 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

The focus areas of the Department of Health and Community Services' Strategic Direction *Population Health* are: *Aboriginal Health, Cancer Care, Communicable Disease, including sexually transmitted disease, chronic disease management, environmental health, health emergency management, smoking rates and protection from environmental smoke, maternal/newborn health, injury prevention, healthy eating/physical activity, healthy aging and wellness.*

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 bullets list some of the accomplishments Eastern Health has achieved in this area in 2011-12:

- Hired patient navigators (three situated in Eastern Health): oncology nurses who serve cancer patients within the Provincial Cancer Care Program, with 597 referrals received from April 2011 to February 29, 2012.
- Progressed toward implementation of the Newfoundland and Labrador Colon Cancer Screening Program, including forming an advisory committee to oversee the program.

- Developed an expansion to the Provincial Breast Screening Program and submitted to the Provincial Cancer Control Advisory Committee at the Department of Health and Community Services.
- Implemented a Community Chemotherapy Program in the St. John's area.
- Resumed reportable testing for estrogen and progesterone receptor (ER/PR) testing.
- Began implementation of a Chronic Disease Prevention and Management Strategy by initiating Chronic Disease Self-Management Workshops throughout the region.
- Continued to offer the *Making a Difference Breastfeeding Course* to nurses to increase rates of breastfeeding initiation and duration. A total of 158 nurses and nurse practitioners completed the 20 hour course.
- Completed an evaluation of Eastern Health's Breastfeeding Training Program.
- Standardized the Healthy Beginnings-Postnatal and Early Childhood Follow Up program resulting in all breastfeeding mothers being offered a home visit after their delivery.
- Launched the B4UR Pregnant Health Promotion Strategy and conducted an evaluation of the B4UR Pregnant preconception health information package distributed
- Partnered with the Eastern Regional Wellness Coalition and the Wellness Coalition-Avalon East to host *Wellness Under the Big Top*, a conference showcasing the community wellness initiatives in the Eastern region.
- Released *Determining the Big Picture: The Results of the Discovery Zone Community Health Needs Assessment* in April 2011.
- Conducted 603 telephone surveys, 30 key informant interviews, 26 focus groups and received 19 public submissions, for a total of 842 primary research participants in the Trinity-Conception Needs Assessment, which was released July 2012.
- Implemented the *Take Care Down There* sexual health promotion campaign.
- Awarded 14 Healthy Schools grants in the Eastern School District.
- Supported 23 Provincial Wellness Grant recipients.
- Received funding from the Public Health Agency of Canada to partner with the Eastern School District, Government of Newfoundland and Labrador and several other agencies to implement the Family Physical Activity Challenge in 11 schools.
- Awarded 22 grants totalling $20,525 through the Wellness Coalition-Avalon East; awarded 28 grants to community groups totalling $24,431 through the Eastern Regional Wellness Coalition.

Highlights and Accomplishments

Access to Priority Services

Within this Strategic Direction, the focus areas are: *access management, long-term care and community supports, mental health and addictions services, NLPDP-Pharmacare initiatives, pre-hospital emergency* and *rural health.* The following bullets list some of the accomplishments Eastern Health has achieved in these areas in 2011-12:

- Reduced the percentage of people who leave the Emergency Room without being seen by a physician from 11 per cent to 5.5 per cent at the Health Sciences Centre and from 9 per cent to 4.5 per cent at St. Clare's Mercy Hospital.
- Began renovations to the emergency department St. Clare's Mercy Hospital and completed renovations at the Health Sciences Centre emergency department to improve patient flow and help reduce wait times.
- Implemented an electronic bed cleaning tracking system at St. Clare's Mercy Hospital and the Health Sciences Centre, helping to improve patient flow.
- Implemented an electronic dispatch system for internal patient portering, resulting in response time improvement from 20 to 30 minutes to 8.8 minutes.
- Hired Nurse Practitioners for emergency rooms to decrease wait times for less acutely ill patients and opened fast track at the Health Sciences Centre.
- Reduced wait times for diagnostics services by adding technologists and expanding operating hours resulting in CT services median wait time reduction from 75 days in 2009-10 to 38 days in 2011-12 and ultrasound services from 133 days in 2009-10 to 53 days in 2011-12.
- Developed a new priority classification template for the MRI service to improve access and wait times.
- Recruited two anaesthesiologists, established a pre-admission clinic, which has resulted in decreased surgical cancellations due to lack of medical preparation and created a chronic pain service at the Carbonear General Hospital, which has improved access to interventional pain treatment.
- Opened a third cardiac catheterization room in January 2012, which will result in an increased capacity of approximately 33 per cent.
- Participated in the development of a National Organ Waitlist, through the Organ Procurement Program (OPEN).
- Developed a functional plan in preparation for a new PET/CT program.
- Reduced average wait times for an inpatient bed from 7.5 hours to 6.6 hours at the Health Sciences Centre since implementing the Over-Capacity Protocol.
- Reduced median wait times for highest priority orthopedic patients by 69 per cent and by 47 per cent for lower priority patients by implementing a central intake system for orthopedic patients.
- Reduced the number of cardiac surgery cancellations due to not having a critical care bed available, from 56 (2010-11) to 17 (2011-12) this was achieved through a number of initiatives including decreasing the number of surgeries scheduled per week based on analysis of cases completed in previous years and protecting five beds in the Cardiac Intensive Care Unit for cardiac surgery only.

- Reduced wait time for allergy testing at the Dermatology Centre from 13 months to 5.5 months by realigning workflow and reducing the number of no-shows.
- Increased surgical capacity of two operating suites within the Children's and Women's Health Program, resulting in the completion of almost 800 additional Orthopedic, Plastic and General Surgery procedures.
- Decreased the wait time for Wound Care Clinic from 8 months to 3.5 months by developing a referral form and triage criteria.
- Increased the number of total joint replacement surgeries by 220 by establishing a best practices working group to focus on improving pre-surgical preparation of patients and decreasing inpatient length of stay and adding additional operating room capacity at the Janeway.
- Received funding from the provincial government to purchase equipment in a number of areas which will have an impact on wait times, including nine replacement dialysis units, four laproscopes and an arthroscope at the Carbonear General Hospital.
- Increased dialysis capacity at the Burin Peninsula Health Care Centre by increasing operation from three days per week to six days per week with an expanded capacity of 24 patients.
- Implemented dialysis services within St. Clare's Mercy Hospital to improve access for inpatients.
- Participated in the Canadian Paediatric Surgical Wait Time Project (CPSWT): a National initiative to measure wait times for children in need of surgery in six targeted areas.
- Began a Central Intake process for inpatient rehabilitation program in order to assist with reducing wait times.
- Established working groups in the area of Occupational Therapy (Learning and Behaviour and Child Development) and Speech Language Pathology (Janeway) to focus on wait time strategies for these areas.
- Introduced Bariatric Surgery program to improve treatment options for morbidly obese clients.
- Implemented an eight-bed inpatient stroke care unit at St. Clare's Mercy Hospital.
- Reopened and achieved high utilization of four additional beds on Low Intensity Rehabilitation Unit in the L. A. Miller Centre (increasing from 16 to 20 beds).
- Expanded wait time management strategies in a number of areas, including Regional Endoscopic Services, Mental Health and Addictions Services and Emergency Departments.
- Commenced a telephone survey of individuals who are currently on the waitlist for endoscopic services to confirm validity of the waitlist.
- Participated in the planning for long-term care facilities and dementia bungalows in St. John's, Bonavista, Carbonear and Clarenville.
- Purchased 10 additional telehealth units to expand telepsychiatry in the Mental Health and Addictions Program.
- Reduced wait time for Traumatic Stress services by 80% through the introduction of a new group model.

Highlights and Accomplishments

- Began work on the beginning phases of a treatment centre for youth with complex mental health needs to accommodate up to 12 young people age 12 to 18 years.
- Completed a clinical chart audit and referral satisfaction survey to describe and assess the Mental Health & Addictions' Community Connections Program, including referral source, wait times, client diagnoses and goal/ treatment plan.
- Assisted the Community Connections groups of the Southeast Avalon area to conduct a focused needs assessment on mental health service needs.
- Initiated Primary Percutaneous Coronary Intervention (PCI) Program in the Cardiac/ Critical Care Program to facilitate timely access to balloon angioplasty.
- Operationalized Paramedicine and Medical Transport satellite stations in the St. John's–Mount Pearl area.
- Offered LEAP (Learning Essential Approaches to Palliative and End of Life Care) training.

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

The focus areas of this Strategic Direction are: *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 bullets list some of the accomplishments Eastern Health has achieved in these areas in 2011-12:

- Received accreditation from various organizations, including full accreditation from Accreditation Canada; a five-year accreditation status by the Commission on Dental Accreditation of Canada for the Dental Services Program; a four-year accreditation from Ontario Laboratory Accreditation (OLA) for five laboratory sites.
- Developed a new strategic plan for the organization with each program/department developing an operational plan in support of organizational priorities.
- Created and delivered a quarterly Organizational Scorecard in support of performance indicators identified in the 2011-14 strategic plan.
- Created a Key Performance Indicator (KPI) portal.
- Held Town Halls across the region to inform staff about the organization's priorities as outlined in the strategic plan.
- Developed an Allied Health Professional Practice Consultation framework to collect data regarding professional practice issues and initiatives.

- Continued to implement the Eastern Health Model of Acute Clinical Nursing Practice at St. Clare's, Burin and Carbonear acute care sites.
- Implemented the provincially mandated new job code strategy in the Payroll, Scheduling, Human Resources and Budgeting systems.
- Facilitated an internal review of all management classifications.
- Finalized and released a Statement of Rights and Responsibilities for Clients, Patients and Residents of Eastern Health, which outlines the rights of individuals when receiving care, as well as expectations on the part of health care professionals that individuals will fully participate in their treatment and care.
- Worked with Eastern Health's Child Youth and Family Services (CYFS) Transition Committee, Finance and Human Resources departments to ensure the efficient transition of the CYFS programs and services from Eastern Health's responsibility to the new Department of CYFS within the provincial government.
- Launched the Client Satisfaction/Experience of Care Survey Program.
- Implemented new Quality Case Review Guidelines.
- Offered a number of ethics education events on topics such as Advanced Health Care Directives and withdrawing/withholding artificial nutrition/hydration.
- Developed and implemented initiatives to support the *Personal Health Information Act* (PHIA), such as providing PHIA education sessions and enhancing the monitoring of privacy breaches.
- Acquired new scanning software and hardware for implementation in 2012-13 in support of bridging Electronic Health Record solution.
- Implemented first phase of voice recognition technology within city sites for transcription services.
- Advanced physicians' participation in e-signing of electronic reports, with 95 per cent set up.
- Offered seven-week training program for individuals wishing to volunteer in Pastoral Care and Ethics.
- Developed a detailed orientation manual on recall processes for Clerk IVs to help increase consistency amongst all staffing departments.
- Began drafting a Volunteer Resources Policy Statement.
- Initiated a Nurse Practitioner Council to share best practices and review standards of practice.
- Began enhancing the Provincial Cervical Cytology Registry, which is housed at Eastern Health, to improve the screening program, including implementation of a follow-up system that will ensure that women with abnormal Pap test results receive care in a timely manner.
- Implemented RapidArc, an advanced treatment option for prostate cancer patients requiring radiation therapy resulting in shorter, more comfortable radiation treatments.
- Began participation in an internationally recognized patient safety improvement program aimed at enhancing patient safety and quality care for maternal and newborn services, Managing Obstetrical Risk Efficiently (MOREOB).

Highlights and Accomplishments

- Conducted a survey and completed a report entitled "Levels of Perinatal Care in Newfoundland and Labrador" which highlights the scope of services/treatments provided by obstetrical facilities.
- Incorporated the International Dietetics and Nutrition Terminology into the electronic health record to standardize practice and language.
- Instituted the Universal Hearing Screening Program for newborns.
- Developed prioritization guidelines for occupational therapy and physiotherapy services in long-term care.
- Installed new analysers for routine lab testing allowing for standardized operating procedures and enabling comparative results across the region.
- Presented six Lighthouse Grants for Innovation to employees to support innovative projects and encourage new approaches to work.
- Made significant progress in policy development, including: Working Alone or in Isolation, Employee and Family Assistance Program, Safe Patient/Resident Handling, Duty to Accommodate and Management of Exposure to Hazardous Medications.
- Involved in over 100 clinical trials at any point in time through the Clinical Trials Research Group, with approximately 44 new clinical trials approved.
- Involved in reviewing and approving multiple grant proposals by the Health Research Ethics Authority (HREA) and the Research Proposal Approval Committee (RPAC). Approximately 153 new research projects were approved in 2011-12.
- Implemented telepathology to enable real-time discussion and consultation between pathologists across the region.
- Created an in-house service and support depot for wound care therapy surfaces for long-term care and wound care products for acute care, essentially reducing rental costs and resulting in substantial savings.
- Graduated, through the Centre for Nursing Studies, 111 BN Collaborative graduates, six BN Post-RN Nurse Practitioner graduates and 50 Practical Nurse graduates.
- Developed a Healthy Workplace Plan 2011-2014 and an Employee Health Profile.
- Launched and held Eastern Health's first annual Recognition Week in June 2011, which included the first CEO Awards of Excellence.
- Initiated the FISH! Philosophy to help create a healthy and productive work environment.
- Finalized and released the Employee Promise – *Together We Can.*
- Implemented first year activities under the Leadership Strategy 2011-14.
- Began Conflict Management Training, with 262 managers and 38 union and clinical leaders completing the training to date.
- Provided education opportunities to managers, including the LEADS program Leadership for Life! and a change management certification program.
- Revised General Orientation, including: development of an employee handbook, website for new employees, a corporate video, a CEO welcome video and branding.

- Developed 77 active affiliation agreements, which are agreements between post-secondary institutions and Eastern Health for student placements.
- Awarded 37 signing bonuses for difficult-to-fill health professional positions; awarded 35 bursaries to health professionals.
- Began an inaugural Psychology Internship Program with four pre-doctoral psychology interns selected to participate.
- Launched volunteer webpage to help expand volunteer recruitment and developed a volunteer handbook.
- Completed a comprehensive hand hygiene audit of healthcare workers in all health care facilities.
- Completed the Allied Health Mentoring for Leadership toolkit and pilot project.
- Developed timely and accurate surveillance reports for healthcare-associated infections.
- Began piloting a Safe Resident Handling Program to decrease workplace injuries at Agnes Pratt and Golden Heights Manor.
- Initiated discussions with the Department of Health and Community Services and Newfoundland and Labrador HealthLine to provide follow-up to patients who leave the emergency department without being seen and who have been triaged as urgent or emergent (for whom there may be some risk).
- Implemented PhaSeal (a closed system drug transfer device) for chemotherapy to minimize unintended exposure to the effects of chemotherapy drugs.
- Implemented a Falls Prevention and Management Program at 65 per cent of long-term care sites, surpassing the target of 50 per cent by March 2012.
- Initiated a Call Don't Fall program in the Coronary Care Unit at Health Sciences Centre which resulted in a decrease in fall rates of 78 per cent
- Implemented a program for community clients who are at risk of falling and implementing strategies to reduce or eliminate risk in the client's home setting.
- Continued to implement Safer Healthcare Now with chart audits in the Home and Community Care Program, resulting in 91 per cent compliance with accreditation standards for medication reconciliation.
- Trained all Pathology Lab staff in basic LEAN concepts and 5S workplace organization, through Lighthouse Grant funds.
- Launched the Quality Health Care Scholarships (based on a recommendation from the Cameron Inquiry) with two scholarships of $6,500 awarded.
- Provided mandatory safety education entitled "Clinical Safety: Everyone's Role."
- Delivered disclosure workshops.
- Achieved full implementation of the Client Safety Reporting System (CSRS); all programs and departments within the organization now have access to electronic reporting of occurrences.
- Continued deployment of CSRS occurrence reporting system to facilities in Central Health, Western Health and Labrador-Grenfell Health.

Highlights and Accomplishments

- Initiated the executive "Walk the Talk" program, which is designed to reinforce the importance of patient and employee safety.
- Achieved PRIME (Protection, Return to Work, Insurance Management for Employers/ Employees) compliance through the Workplace Health, Safety and Compensation Commission.
- Received accreditation for six Protection Services staff as Level I Profilers in the area of Targeted Violence. This is a service offered to assess threats of violence against staff, clients and/or stakeholders.
- Increased fire drill compliance in 2011 over the base year 2010 as follows: from 60% to 78% in Acute Care; from 49% to 52% in Long-term Care; from 20% to 27% in Community/ Administration.

Celebrate

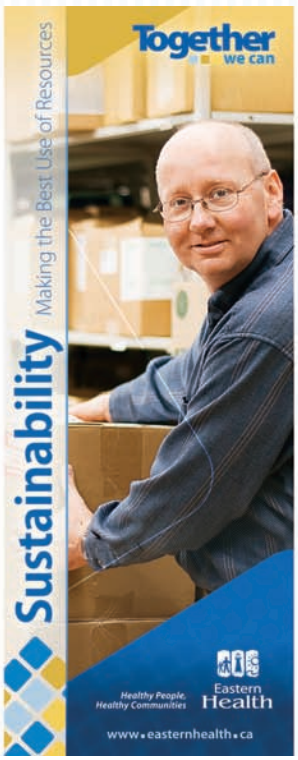
Throughout the 2011-12 year, Eastern Health has had much to celebrate. From anniversaries of facilities that have demonstrated a long tradition of providing excellence in health care, to our staff, physicians and volunteers who lead by example, the following points are some of the highlights over the past year.

- A number of anniversaries were celebrated this year: the Lion's Manor Nursing Home in Placentia celebrated 25 years; the Dr. A. A. Wilkinson Memorial Health Centre celebrated 75 years; the Dr. G. B. Cross Memorial Hospital celebrated 25 years of health care services in Clarenville; the Neonatal Transport Team celebrated 40 years of service in 2011.
- Dr. Andrew Furey and Dr. Art Rideout headed a group of 26 Eastern Health care professionals who travelled to Port-au-Prince, Haiti, in July 2011 to volunteer their time at the Bernard Mevs Hospital.
- Eastern Health announced the recipients of the organization's first CEO Awards of Excellence. Innovation – Gail Dicks-O'Keefe, Speech Language Pathologist, St. Clare's Mercy Hospital; Service Excellence – Jeffrey Andrews, Environmental Services Worker, Dr. L.A. Miller Centre; Leadership Excellence – Charmaine Lane, Division Manager, Medicine, St. Clare's Mercy Hospital; Mentoring – Karen Donovan, Occupational Health Nurse Coordinator, Health Sciences Centre; Safety – Rick Abbott, Regional Manager, Pharmacy Services, Dr. H. Bliss Murphy Cancer Centre; Community Capacity Building – Donna Ronan, Program Manager, Mental Health and Addictions, Janeway Family Centre. A seventh award was given to the Adult Orthopedic Surgery Team for demonstrating Team Excellence in their work at the Health Sciences Centre, St. Clare's Mercy Hospital and the Dr. L.A. Miller Centre.

- The 9th annual Allied Health Recognition Ceremonies, held in St. John's, Clarenville and Carbonear, recognized 250 preceptors, 24 authors of scholarly articles or presentations at national and international conferences and 14 professionals volunteering at the national association level. Five awards were given to allied health professionals nominated by their peers: Clinician of the Year: Gerrianne Devereaux, Dietitian; Leader of the Year: Michelle Alexander, Social Worker; Manager of the Year: Krista Wade, Occupational Therapist; New Clinician of the Year: April Doody, Physiotherapist and Preceptor of the Year: Elise Murphy-Dowden, Speech-Language Pathologist.
- Planning Department received the Primary Health Care Researcher Award 2011 from Memorial University of Newfoundland.
- Held Service and Retirement Awards Ceremonies: 573 employees were recognized for having reached a milestone of 25, 30, 35, 40 or 45 years of service and 321 employees retired in 2011.
- Awarded Eastern Health Scholarships to 19 staff members and 14 dependents of staff.
- Celebrated Volunteer Appreciation Week during April 2011, with recognition events held throughout the region.
- St. Clare's Mercy Hospital Auxiliary received $50,000 from the estate of a long-time Auxiliary supporter and purchased patient equipment.
- Merlee Steele-Rodway, Director of Medical Device Reprocessing Services, was recognized by the Canadian Standards Association (CSA) and the Standards Council of Canada (SCC) as an MDR expert. She was invited to attend International Standards Organization (ISO) standards reviews in April 2012.
- Helped to host the Emergency Medical Services (EMS) Chiefs of Canada National Conference, along with a National EMS Research Roundtable, in combination with Horizon 2011 and the Canadian Emergency Physicians Association annual convention.
- Two respiratory therapists, Marie Fitzpatrick and Dan Johnson, were the first in Newfoundland and Labrador to become certified as Hyperbaric Technologists.
- Eight Recreation Specialists achieved certification from the National Council of Therapeutic Recreation Certification: Wayne Bishop, Rebecca Maloney, Leanne Lewis, Anne Mack, Amy Greene, Charlene Edwards, Marsha Gaulton and Stacey Tucker.
- Deanne Wareham, Physiotherapist, was recognized as the Clinical Educator of the Year from the School of Physiotherapy at Dalhousie University.
- The Audiology Department was awarded the "Friends of the Canadian Hard of Hearing Association" at their AGM in 2011.
- Elizabeth Kennedy, Director of Clinical Efficiency, and Shawn Thomas, Director of Diagnostic Imaging, co-presented on the Patient Flow Study at the National Healthcare Efficiency Conference in Toronto (September 2011); Elizabeth also presented at the ARNNL AGM on the Evidence Informed Practice Committee (June 2011).
- Volunteers Marie Ryall, Herman Harris and Marina Harris received the prestigious Caring Canadian Award from the Governor General of Canada.
- Sponsored Earth Day Celebrations at all ARAMARK Healthcare sites.

Highlights and Accomplishments

- Celebrated Food & Environmental Services Recognition Week, February 2012.
- Corporate Communications received two awards for ***The Manager's Toolkit*** – one from the International Association of Business Communications (Newfoundland Chapter) and a national award from the Health Care Public Relations Association.
- Gynecology pharmacists poster accepted for Canadian Gyne-Oncology Meeting.
- Kristi Parmiter received the Leadership in Pharmacy award from Canadian Society of Hospital Pharmacists.
- Professional Practice Nursing Program held the 2nd Annual Nursing Gala Awards and the 6th Annual Nursing Education Symposium in May 2011. Award recipients were: Beginning Practitioner of the Year - Melissa Lambert; Nursing Practice of the Year - Christine Broders, Anita Forward, Barbara Albrechtsons, Susan Morgan, Kimberly Buckle and Alana Langdon; Nurse Educator of the Year - Gloria Earle; Nursing Leadership of the Year - Jackie Brockerville; Nurse Manager of the Year - Beth Snow; Nursing Director of the Year - Elaine Warren; Nurse Preceptor of the Year - Shirley Coombs; Advanced Nursing Practice of the Year - Barbara Earles.



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 the first year, 2011-12.

Appendix III provides definitions of the quantifiable indicators from each of the priority areas outlined in this section of the report: what each indicator means and why we measure it.

This section also includes the objectives and associated indicators for the next fiscal year, 2012-13.

4.1. Quality and Safety

Eastern Health has renewed its commitment to quality and safety in its 2011-14 strategic plan. Quality and safety is a key priority of the entire Board of Trustees and the whole of the organization and significant time is devoted to quality and safety issues.

Research shows that organizations that report more occurrences generally have a strong culture of safety. Eastern Health encourages the reporting of occurrences and close calls to identity improvements.

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

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, clients, residents, employees, physicians, volunteers and students.

Objective: By March 31, 2012, Eastern Health will have refined its 2011-14 Safety Plan (clinical and occupational health and safety).

Measure: Refined 2011-14 Safety Plan

Planned for 2011-12	Actual Performance for 2011-12[4]
Refined the Quality Framework to address the clinical components of the Safety Plan	During 2011-12 Eastern Health refined its Quality Framework to address the clinical components of the Safety Plan in the following ways: • Reviewed the 2007 version of the Quality and Risk Management Framework and identified new directions. A number of groups were consulted during the process (i.e. Clinical Issues Committee, Select Clinical Directors, Accreditation Teams, Regional Quality Councils and the Executive Team). The document has undergone revisions and feedback is ongoing. • Identified indicators for the Quality Council scorecard. • Completed and approved the Quality Case Review Guidelines, which provide a framework for the quality review process.
Refined the Occupational Health and Safety Framework of the Safety Plan	The Occupational Health and Safety Framework of the Safety Plan was refined during 2011-12, as indicated below: • Collaborated with the other safety partners within the organization to have an integrated approach to client and employee safety. • Introduced an internal safety auditing tool, which has been piloted in selected areas (i.e., Environmental Services). • Worked with internal departments to incorporate OH&S indicators (organizational, program and departmental levels) into COGNOS, a business intelligence tool. • Explored potential information technology solutions to integrate reporting of employee incidents into the electronic occurrence reporting system. • Initiated a more proactive consultation from programs when dealing with design of new facilities and/or redesign of new work areas.

[4] Appendix III provides definitions of the quantifiable indicators and provides clarity around what the indicator means and why we measure it.

Further established selected baseline measures, which include:	Established selected baseline measures. These include:
Baseline measures of reporting of adverse events, occurrences and close calls	A definition of "Occurrence" is in Appendix III. Eastern Health's electronic Client Safety Reporting System (CSRS) was fully implemented in October 2011, which means the first true "baseline" for reporting will be the 2012-2013 fiscal year. In 2011-12, 17,731 occurrences were reported and investigated. Of these, 11 per cent (1,887) were close calls, in other words they did not reach the client; 75 per cent (13,287) of occurrences did not result in harm to the client; 14 per cent (2,557) of occurrences resulted in harm to the client, 95 per cent of which (2,434) were minor and temporary in nature.
Baseline measure of 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** 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**
Baseline measure of Alternate Level of Care days as a percentage of total patient days	Alternate Level of Care (ALC) days as a per cent of total adult patient days (Medicine and Surgery only, Health Sciences Centre and St. Clare's Mercy Hospital, (2011-12): **12.03 days**
Baseline measure of MRSA infection	Rate of MRSA infections in long-term care (2011-12): **0.89** 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.
Baseline measure of hand hygiene compliance	Rate of hand hygiene compliance (Spring 2011 Audit): **52.60% of observations practised appropriate hand hygiene.** Audits of hand hygiene compliance occur during a particular period of time. In 2011, the Infection Prevention and Control Program conducted 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.

Baseline measures of *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 & St. Clare's Mercy Hospital (2011-12): **0.52** infections per 1,000 central line days (3 infections) Percentage of Acute Myocardial Infarction (AMI) Perfect Care for Carbonear Hospital (2011-12): **69.64 per cent** Percentage of Acute Myocardial Infarction (AMI) Perfect Care rate for HSC (2011-12): **87.3 per cent** Surgical Site Infection rate per 100 procedures for C Sections at Health Sciences Centre (2011-12): **6.93** 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 Ventilator Associated 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
Baseline measure of implementation of medication reconciliation across the region	Percentage of Medication Reconciliation implementation (Acute Care Inpatient Units, as of March 2012): **78.57 per cent**
Baseline measure of 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**
Baseline measure of Workers' Compensation hours per Full Time Equivalent position (FTE)	Workers' Compensation hours per FTE (4th Quarter 2011-12): **12.07 hours**
Baseline measure of lost time incident rate	Employee lost time incident rate (4th Quarter 2011-12): **1.54**
Baseline measure of median duration of Workers' Compensation claims	The median duration of Workers' Compensation claims is not available for 2011-12. This indicator has previously been measured as an average; however work is underway to calculate the median duration to better reflect the duration of claims.

Discussion of Results

Eastern Health is striving to provide a healthy work environment and is committed to implementing programs and initiatives that support safety and building a safety culture. Significant work has been ongoing to fully implement the Clinical Safety Reporting System (CSRS) and there have been numerous education sessions for employees in the area of safety. The "Good Catch Award" is an excellent example of an incentive program to help build a culture of safety by increasing the number of close calls reported. This award has a goal to promote the reporting of close calls in CSRS. As part of the philosophy of being a proactive culture of safety, employees will recognize and report close calls before they become adverse events affecting our patients. Each month, a "Good Catch" is identified and recognition is provided to the people involved.

Establishing baseline measures of indicators such as hand hygiene measures and lost time incident rate will help Eastern Health monitor and evaluate its safety culture into the future.

Eastern Health's strategic priority of Quality and Safety aligns with government's strategic direction of accountability and stability of health and community services.

Building on the progress made in 2011-12, Eastern Health has documented the following objective, measures and indicators for 2012-13.

2012-13 Objective, Measures and Indicators

Objective: By March 31, 2013, Eastern Health will have monitored its Safety Plan and further established professional peer review.

Measures: Safety Plan monitored and professional peer review further established.

Indicators: 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)
- Monitored readmission to selected services
- Monitored Alternate Level of Care days as a percentage of total patient days
- Monitored rate of MRSA infection
- Monitored hand hygiene compliance
- Monitored *Safer Healthcare Now!* performance measures selected by the organization
- Monitored implementation of medication reconciliation across the region
- Monitored medication reconciliation compliance in sites where implemented
- Monitored Workers' Compensation hours per Full Time Equivalent position (FTE)
- Monitored lost time incident rate
- Established baseline measure of median duration of Worker's Compensation claims

Further established professional peer review, as demonstrated by the following:

- Promoted multi-disciplinary Mortality and Morbidity Rounds across services
- Developed biannual performance appraisal tools for all medical staff
- Developed quality assurance initiatives within the Diagnostic Imaging Program

4.2. Access

Access to clinical health services has been identified as a significant issue throughout the organization. Wait times are challenging in a number of areas for many reasons.

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.

Numerous strategies have been undertaken to meet, exceed and/or maintain benchmarks, many of which are national. During this past year, work continued to develop strategies to reduce wait times in identified areas.

The overall three-year goal and 2011-12 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.

2011-12 Objective: By March 31, 2012, Eastern Health will have refined strategies to reduce wait times in identified areas and to increase efficiency in under-utilized areas.

Measure: Refined Strategies

Planned for 2011-12	Actual Performance for 2011-12[5]
Refined strategies to improve access and increase efficiency, with baseline measures to include:	Eastern Health refined strategies to improve access and increase efficiency. The following baseline measures have been identified:
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. The first data, which measures residents' median wait time in days for urgent long-term care placement (regional), will be available in the first quarter of 2012-13.
Baseline 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, Regional): **176.10 days**

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

Baseline wait time for specialists (non-urgent orthopedics, rheumatology, psychiatry)	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** Orthopedics Specialists Median Wait-Time-One (family physician request to initial specialist assessment) for priority 3 and 4 patients within target (March 2012): **182.00 days** Percentage of urgent priority I patients seen by Rheumatology Specialists within 30 days (4th Quarter 2011-12): **11.10 per cent** Psychiatry: The Mental Health & Addictions Program continues to work towards implementation of electronic wait time reports; however this process has taken longer than anticipated.
Baseline 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** Work is ongoing to develop additional wait time measures in this area. More work is required.
Baseline 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.
Baseline 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.
Baseline 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.
Baseline 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 anesthetic 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.

Baseline 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 2011-12, 100 per cent of cases were completed within this benchmark.
Baseline 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.
Baseline wait time for breast, bladder, colorectal, lung and prostate cancer surgeries	The 2011-12 data for cancer surgeries are provided below. The data is based on the methodology of including in its wait time calculations any emergency cancer surgery patients, but excluding inactive wait times for patients where delays have been identified. Percentage of Breast Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only, fiscal annual data for 2011-12): **79.1 per cent** Percentage of Bladder Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only, fiscal annual data for 2011-12): **57.7 per cent** Percentage of Colorectal Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only, fiscal annual data for 2011-12): **75.1 per cent** Percentage of Lung Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only, fiscal annual data for 2011-12): **56.5 per cent** Percentage of Prostate Cancer Surgeries completed within 42 days as per internal Eastern Health target (city only, fiscal annual data for 2011-12): **68.2 per cent**
Baseline 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** DI - Percentage of CTs completed within 30 days - Non Urgent (Regional, 2011-12): **59.93 per cent** DI - Percentage of Ultrasounds completed within 30 days - Non Urgent (excludes Obstetrics and echocardiograms) (Regional, 2011-12): **20.72 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** Average wait time in days for non-urgent Cardiac Echocardiograms (Cardiac Program only, 4th Quarter): **177.00 days**
Baseline rate of patients who left without being seen in the Emergency Room	Percentage of Emergency Department visits who left the Emergency Department without being seen by a physician (Regional, 2011-12): **4.40 per cent**

Discussion of Results

Access to health services is of significant public interest. Over the past few years, Eastern Health has invested in ensuring good collection of data to allow benchmarking of wait times and analysis to make change. There have been significant gains in decreasing wait times thanks to investments in human and capital resources as well as identifying efficiencies. Work will continue toward identifying access issues and developing new approaches to improve access.

The progress made in this area is in line with government's strategic direction: access to priority services.

Building on the progress made in 2011-12, Eastern Health has documented the following objective, measure and indicators for 2012-13.

2012-13 Objective, Measures and Indicators

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

Indicators: Implemented strategies to reduce wait time and increase efficiency as evidenced by the following measures:

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

4.3. Sustainability

Sustainability refers to making the best use of Eastern Health's resources – both fiscal and human. This means increasing the effective use of resources and to ensure that the practices we have in place today do not compromise Eastern Health's financial well-being in future. The need to ensure good stewardship around financial and human resources is a priority for the Board.

During 2011-12, Eastern Health identified a number of areas to increase efficiencies.

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

Goal: By March 31, 2014, Eastern Health will have strengthened its sustainability through the efficient utilization and monitoring of its fiscal and human resources.

2011-12 Objective: By March 31, 2012, Eastern Health will have identified where efficiencies can be improved to optimize patient, client and resident care.

Measure: Identified efficiencies

Planned for 2011-12	Actual Performance for 2011-12[6]
Identified opportunities for efficiencies through a benchmarking and consultation process	Eastern Health identified opportunities for efficiencies through benchmarking and consultation. Some examples include: • Began an operational improvements initiative through a benchmarking process, comparing our operations to those of similar organizations across the country, to identify efficiencies and improve performance. • Patient Flow Study – implementation of 67 per cent of recommendations have resulted in a number of efficiencies, including decreasing the number of cardiac surgery cancellations due to unavailability of critical care beds. • No show rates in Diagnostic Imaging – monitoring and auditing of no show rates have resulted in patients being contacted by telephone in an attempt to identify causes. • Worked with the Department of Health and Community Services to improve wait times in emergency departments resulting in a reduction in the number of patients who left the ER without being seen at the Health Sciences Centre and St. Clare's Mercy Hospital. • Used the LEAN philosophy in a number of areas to identity process improvement resulting in increased efficiencies, including in Central Bookings of Diagnostic Imaging. • Skill Mix Model - Research Department working with the Long-term Care Program to evaluate its skill-mix model.

[6] Appendix III provides definitions of the quantifiable indicators and provides clarity around what the indicator means and why we measure it.

	• Reduced average wait times for an inpatient bed from 7.5 hours to 6.6 hours at the Health Sciences Centre since implementing the Over-Capacity Protocol. • Increased the number of patients who have been admitted to orthopedics and plastic surgery from 882 to 1,098 in orthopedics, and from 102 to 377 in plastic surgery (from 2010-11 to 2011-12) due to dedicated operating room trauma time at the Health Sciences Centre. • Introduced procurement card use, resulting in savings in human and financial resources plus improvement in payment time to vendors. • Medical Device Reprocessing Services (MDRS), Materiels and Biomedical Support and Perioperative programs collaborated to initiate the Supply Chain Project. This will decrease costs and wastage of supplies, increase space and improve workflow to provide a more efficient and effective support service. • MDRS awarded a Request for Proposals for Modernization of Medical Device Reprocessing equipment, which involves a two-year project to improve efficiency and decrease the amount of overtime due to equipment malfunctions. • MDRS collaborated with Materiels and Biomedical Support to track and trend repairs on equipment, which will reduce repair costs and identify equipment that is at the end of its life. • An assessment of a new electronic dispatch system for internal patient portering in April 2012 found the average response times decreased from 20-30 minutes to 8.8 minutes and the turnaround times dropped from 45 minutes to 22 minutes on average.
Developed baseline measures, which include:	Developed baseline measures:
Budget variance across the region	Budget Variance (March 2012): **(0.77 per cent)** **$17.3 million**
Baseline 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** HR vacancy rate in Nursing (posted external; does not include Casuals; 3rd Quarter 2011-12): **1.31** HR vacancy rate in Nursing (posted internal; does not include Casuals; 3rd Quarter 2011-12): **2.90**

Report on Performance - Sustainability

Discussion of Results

The progress made within this program area supports government's strategic direction of improved accountability and stability in the delivery of health and community services. Eastern Health has analyzed various services and program areas and developed strategies to address any inefficiencies. Through an increased emphasis on evaluation and evidence, the organization is able to make and monitor improvements. As strategies are employed throughout program areas, the learnings can be shared to make improvements elsewhere in the organization. This approach to sustainability is consistent with Eastern Health's values of fairness and excellence.

Building on the progress made in 2011-12, Eastern Health has documented the following objective, measures and indicators for 2012-13.

2012-13 Objective, Measures and Indicators

Objective: By March 31, 2013, Eastern Health will have implemented strategies to improve and monitor efficiency in identified programs.

Measure: Strategies Implemented

Indicators: Implemented strategies to improve and monitor efficiencies.

Monitored efficiency as evidenced by:

- Decreased budget variance across the region
- 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.

In 2011-12, 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 2011-12 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.

2011-12 Objective: By March 31, 2012, Eastern Health will have begun implementing Chronic Disease Prevention and Management and Cancer Control Strategies.

Measure: Begun implementation of strategies

Planned for 2011-12	Actual Performance for 2011-12[7]
Increased opportunities for stakeholder consultation	Eastern Health increased opportunities for stakeholder consultation. Some examples are: • Conducted 603 telephone surveys, 30 key informant interviews, 26 focus groups and received 19 public submissions totaling 842 participants to get input into the community health needs of the Trinity-Conception area. • Participated in consultations and information sessions to increase knowledge of cancer services as part of a Provincial Cancer Care Quality Committee. • Held stakeholder consultations to support development of Eastern Health's Chronic Disease Prevention and Management Strategy.

[7] Appendix III provides definitions of the quantifiable indicators and provides clarity around what the indicator means and why we measure it.

Increased collaboration with government and community partners	Eastern Health increased collaboration with government and community partners. Some examples are: • The Board of Trustees held a meeting with community groups in October 2011 to discuss partnerships and working together and began planning a similar session scheduled for June 2012. • The Provincial Colon Cancer Screening Program, administered by Eastern Health, struck an advisory committee consisting of representatives of the provincial government, the regional health authorities, the Canadian Cancer Society, researchers and medical specialists. • Collaborated with The Works through Memorial University of Newfoundland to offer a pilot exercise program for cancer patients. • Partnered with a number of organizations who provide support to clients, such as the Prostate Cancer Support Group, Young Adult Cancer Canada and the Consumers Health Awareness Network Newfoundland and Labrador (CHANNAL). • Hosted a Regional Wellness Conference with the Wellness Coalitions representing over 40 community groups. • Developed new partnerships in the Paramedicine Program involving allied health clinical ride-outs (air and ground) with two nursing schools, the medical school, family medicine emergency residents and pharmacy. • Strengthened various partnerships within the private sector. For instance, Canadian Tire donated two mountain bikes for the launch of the paramedic bike patrol at major events during the summer and 11 taxi companies participated in the *Take Care Down There* campaign. • Implemented the volunteer Therapy Dog Program at the Veterans Pavilion. • Collaborated with the Eastern School District on a number of Health Promotion activities, such as the *Living Healthy News*, Healthy Schools Grants, Eastern Active Schools, Living Healthy Resources and Curriculum Support. • Collaborated with the Department of Health and Community Services in the development of the provincial booklet *Healthy Eating for your Toddler*. • Facilitated three Helping Women Quit workshops for Community Health Nurses and Family Resource Centres (FRCs) in partnership with Addictions Services Eastern Health and the Provincial Smokers' Helpline. • Partnered with the Eastern School District, Government of Newfoundland and Labrador and several other agencies to implement the Family Physical Activity Challenge in 11 schools. The overall goal of the project is to use an existing program, Active Schools, to engage families and communities so children and youth are receiving consistent health messages where they work, live and play.

Increased opportunities to address barriers	Eastern Health increased opportunities to address barriers. Some examples are: • The Children and Women's Health Program identified barriers to services and has begun to address them. For example, the program has initiated a Central Intake process for the Development and Rehabilitation Service to ensure consistency in how people access that service. • The Community Supports Program has identified barriers/gaps related to its services. Arising from this, an Autism Working Group has been initiated. • The Community Supports Program implemented a Regional On-Call System to respond to emergency issues arising after hours. Guidelines and processes have been developed and cross orientation delivered for staff and managers. A Regional On-Call Committee has been developed to monitor the system and resolve issues. • The Surgical Patient and Family Education Program was revised and guidelines for developing written patient education materials updated. This has resulted in development/revisions of 62 patient education handouts and five were translated to French. Patient satisfaction surveys indicated that between 90-100 per cent of patients agreed that the pamphlets were effective and helped prepare them for their surgical experience.
Improved opportunities to identify and reach vulnerable populations	Eastern Health improved opportunities to identify and reach vulnerable populations during 2011-12. Through operational planning with each program area within Eastern Health, vulnerable populations were identified and action plans developed to reach these individuals and groups wherever possible based on identified needs, particularly within the priority focus area of Population Health. Formal consultations and assessments, such as the community health needs assessments and the development of the Chronic Disease Prevention and Management Strategy, helped to identify needs and gaps within communities. Eastern Health has also worked closely with existing and new community partners to identify and meet needs, such as working with the Consumers' Health Awareness Network Newfoundland and Labrador (CHANNAL) to expand peer support throughout the region. Some examples of how Eastern Health has identified and, in turn, reached vulnerable populations include the following: • Within the Rehabilitation Program, a Caregiver Education Group and a Spinal Cord Injury Education Group were initiated.

	• A regional Grief and Bereavement Information and Support Program, with trained facilitators, has begun and education sessions about bereavement are on-going; a Regional Advisory Bereavement Network has also been established. • Partnered with the Department of Health and Community Services and community groups to support the U-Turn Addictions Drop-In Centre for the Trinity-Conception area. • Partnered with the Salvation Army to open the Primary Health Care Clinic at the New Hope Community Centre in downtown St. John's to make health services more accessible and responsive to a vulnerable population. • The Community Supports Program increased its provincial standard compliancy to 77 per cent for Standardized/General Service Plans for individuals with intellectual disabilities. • Community Supports Program implemented and developed the Alternate Family Care (AFC) Network, connecting AFC caregivers, improving program communication and supporting caregivers. • Community Supports Program Urban maintained its focus on General Service Plans as a priority for all individuals with intellectual disabilities. Compliance has risen from 44 per cent in 2010-11 to 90 per cent during 2011-12. • A Falls Prevention program was implemented for community clients within the Home and Community Care program. • Enabled the participation of some marginalized individuals and groups through focus groups and key informant interviews throughout the Community Health Needs Assessments. • Through a pilot project, provided intensive case management to individuals who live in the urban area, are over age 50, have at least one chronic disease and utilized the Emergency Department (ED) more than 5 times in the last year for non-urgent reasons. • Through the HIV clinic, developed an education strategy for public, caregivers and individuals with HIV. • Initiated peer-led Chronic Disease Self-Management Workshops throughout the region.

Identified baseline measures of selected areas of population health, which include:	Eastern Health has selected a number of areas of population health to monitor, which include the following baseline measures for 2011-12:
Baseline 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): **45.2**
Baseline rate of breastfeeding initiation	Percentage of breastfeeding initiation (February 2012): **63.64 per cent** Percentage of breastfeeding initiation (Exclusive, birth to hospital discharge; February 2012): **33.77 per cent**
Baseline rate of breastfeeding duration	Manual data collection of breastfeeding duration is underway for 2011-12 but is taking longer than anticipated.
Baseline rate of participation (by age) for screening for colorectal cancer	All aspects of the program have been finalized. An Advisory Committee is overseeing the program and planning thus far includes: • Developed the patient pathway. • Developed educational and promotional material. • Purchased the Immunohistochemical Screening test kit. • Completed a validation study to ensure test quality and accuracy. • Purchased and began implementing an information system. • Hired a Follow-up Coordinator and advertised for a Medical Director. Baseline rate not yet available as screening has not yet begun.
Baseline rate of seasonal influenza immunization rate in targeted populations (i.e., high risk due to chronic disease, seniors aged 65+, children aged 6 months - 5 years and Eastern Health staff)	Seasonal influenza immunization rate - target population of high risk due to chronic disease: There were 13,955 individuals with chronic health conditions immunized with influenza vaccine in the Eastern Health region during 2011-2012. Of those immunized 2,025 were 2-18 years of age and 11,930 were 19-59 years of age. There is no source available to extract denominator data for this group; therefore Eastern Health is unable to determine the percentage of this group immunized. Seasonal influenza immunization rate for seniors – In 2011-12, the National Advisory Committee on Immunization (NACI) recommended seniors aged 60 and over to be immunized; **41 per cent** of the 60+ age group was immunized. Seasonal influenza immunization rate for children - In 2011-12, the National Advisory Committee on Immunization (NACI) recommended children aged 6-23 months to be immunized; **16 per cent** of this age group was immunized. Seasonal Influenza Immunization rate – target population of Eastern Health staff (reported yearly, 2011-12): **32.4**

Report on Performance - Population Health

Discussion of Results

Making changes to the health of a population involves a long-term commitment. It requires the participation of many levels of government and community partners. The progress noted above indicates that Eastern Health has engaged with its community in a number of capacities. 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.

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.

Population health will also be influenced by Cancer Control Strategies. The Provincial Breast Screening Program expansion has been developed and submitted to the Provincial Cancer Control Advisory Committee at the Department of Health and Community Services. The Provincial Colon Cancer Screening Program has struck an Advisory Committee to oversee this program and planning has progressed. The patient pathway has been developed and the screening test kit has been purchased. A validation study to ensure test quality and accuracy was completed in late February and an information system has been purchased, which is currently being implemented.

This work supports the provincial government's strategic direction of population health.

Building on the progress made in 2011-12, Eastern Health has documented the following objective, measures and indicators for 2012-13.

2012-13 Objective, Measures and Indicators

Objective: By March 31, 2013, Eastern Health will have expanded population based initiatives to address healthy living.

Measure: Expanded population based initiatives

Indicators: Expanded population based initiatives to address healthy living, which include:

- Developed a Community Engagement Framework
- Implemented the Health Promotion Plan to include a focus on:
  - Healthy eating (including breastfeeding)
  - Tobacco-free living
  - Physical activity
- Begun implementation of the Eastern Health Healthy Food Policy
- Implemented healthy living activities in partnership with the member organizations of the Eastern Regional Wellness Coalition and the Wellness Coalition Avalon East
- Implemented the Newfoundland and Labrador provincial colorectal screening program
- Monitored selected areas of population health, which include:
  - Rate of physical activity
  - Rate of breastfeeding initiation
  - Baseline rate of breastfeeding duration
  - Baseline 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

The health sector involves many exciting opportunities and, at the same time, remarkable challenges. Eastern Health is constantly learning and adapting to take advantage of the opportunities and overcome the challenges.

Eastern Health's greatest opportunities involve building on strengths and successes. Eastern Health is poised to be a leader in its field through strong partnerships, commitment to continuous improvement and the tremendous dedication of our employees, physicians and volunteers. Eastern Health is a learning organization that is working continuously to achieve all of our priorities and to demonstrate our progress.

At the same time, Eastern Health is affected by many challenges within the organization, region, province and beyond. There are many competing demands on resources and Eastern Health is constantly balancing the need to focus on prevention and long-term planning with the need for treatment of current illnesses and injuries.

Demographics continue to present challenges, both in terms of workforce planning and in terms of service demands within our communities. As the preliminary release of Census 2011 data indicates, there are a number of areas experiencing population growth in the region that result in increasing demands for services. At the same time, Eastern Health must find innovative ways to meet needs in numerous communities where the population continues to decline – particularly for our most vulnerable clients. These demographics will also have an impact on labour supply for years to come.

Eastern Health began an operational improvements initiative through a benchmarking process during the 2010-11 fiscal year. This process compared Eastern Health's operations to those of similar organizations across the country, to identify efficiencies and improve performance. Efficiencies identified will be implemented in the next two years.

Eastern Health acknowledges the challenges associated with renewing a sense of pride in the workplace and reinforcing the notion of "living the values of Eastern Health." We must continue to celebrate our successes and recognize all of the positive work that takes place throughout our organization on a daily basis – from the smallest gestures to the grandest accomplishments.

Eastern Health will continue to strive to avail of the opportunities and address the challenges as we accomplish our 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.*

6. Audited Financial Statements

Non-Consolidated Financial Statements

Eastern Regional Health Authority – Operating Fund
March 31, 2012

ERNST & YOUNG

Eastern Regional Health Authority – Operating Fund

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March 31, 2012

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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, 2012, 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, 2012 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.

Comparative information

Without modifying our opinion, we draw attention to note 3 to the non-consolidated financial statements, which describes that the **Eastern Regional Health Authority - Operating Fund** adopted Canadian public sector accounting standards on April 1, 2011 with a transition date of April 1, 2010. These standards were applied retroactively by management to the comparative information in these non-consolidated financial statements, including the non-consolidated statements of financial position as at March 31, 2011 and April 1, 2010, and the non-consolidated statements of operations, changes in net debt and cash flows for the year ended March 31, 2011, and related disclosures. We were not engaged to report on the restated comparative information, and as such, it is unaudited.

Basis of presentation and restriction 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.

Other matter

The non-consolidated financial statements as at March 31, 2011 and for the year then ended, prepared in accordance with Canadian generally accepted accounting principles as promulgated in Part V of the Canadian Institute of Chartered Accountants Handbook, were audited by other auditors who expressed an unqualified opinion on those financial statements in their report dated July 13, 2011.

Ernst & Young LLP

St. John's, Canada,
July 18, 2012

Chartered Accountants

Eastern Regional Health Authority - Operating Fund

NON-CONSOLIDATED STATEMENT OF OPERATIONS

Year ended March 31
[in thousands of dollars]

	Budget	2012	2011
	$	$	$
	[unaudited - note 22]		*[unaudited]*
Revenue			
Provincial plan	1,202,911	**1,202,911**	1,175,250
Provincial plan capital grant	—	**44,800**	52,173
Other capital contributions	—	**5,083**	2,198
MCP	72,835	**73,302**	67,567
Inpatient	12,184	**10,260**	9,058
Resident	18,201	**18,005**	17,714
Outpatient	10,078	**8,015**	8,733
Other	40,446	**42,569**	36,266
	1,356,655	**1,404,945**	1,368,959
Expenditures			
Patient and resident services	365,641	**365,589**	351,763
Client services	253,337	**258,235**	274,202
Diagnostic and therapeutic	174,879	**175,989**	162,476
Support	150,968	**150,964**	145,794
Ambulatory care	125,400	**128,924**	116,670
Administration	114,428	**113,574**	109,165
Medical services	104,971	**105,373**	93,726
Other	35,997	**24,567**	29,636
Research and education	18,278	**18,227**	17,738
Amortization of tangible capital assets	—	**31,605**	27,767
Accrued severance pay	—	**10,125**	8,373
Accrued sick leave	—	**2,831**	1,996
Accrued vacation pay	—	**979**	3,270
Interest on long-term debt	10,387	**9,594**	9,715
	1,354,286	**1,396,576**	1,352,291
Annual surplus	2,369	**8,369**	16,668
Accumulated deficit, beginning of year		**(70,865)**	(87,533)
Accumulated deficit, end of year		**(62,496)**	(70,865)

See accompanying notes

NON-CONSOLIDATED STATEMENT OF CHANGES IN NET DEBT

Year ended March 31
[in thousands of dollars]

	Budget	2012	2011
	$	$	$
	[unaudited]		*[unaudited]*
Annual surplus	—	**8,369**	16,668
Changes in tangible capital assets			
Acquisition of tangible capital assets	—	**(49,883)**	(54,371)
Amortization of tangible capital assets	—	**31,605**	27,767
Increase in net book value of tangible capital assets	—	**(18,278)**	(26,604)
Changes in other non-financial assets			
Net change in prepaid expenses - (increase) decrease	—	**1,495**	(2,121)
Net change in supplies inventory - (increase) decrease	—	**(1,673)**	122
Amortization of deferred charges	—	—	84
Increase in other non-financial assets	—	**(178)**	(1,915)
Increase in net debt	—	**(10,087)**	(11,851)
Net debt, beginning of year	—	**(428,052)**	(416,201)
Net debt, end of year	—	**(438,139)**	(428,052)

See accompanying notes

NON-CONSOLIDATED STATEMENT OF FINANCIAL POSITION

As at
[in thousands of dollars]

	March 31, 2012 $	March 31, 2011 $	April 1, 2010 $
		[unaudited]	*[unaudited]*
Financial Assets			
Cash	**6,406**	—	—
Accounts receivable *[note 4]*	**22,684**	21,672	22,538
Due from government/other government entities *[note 5]*	**67,924**	94,410	74,690
Advance to General Hospital Hostel Association	**1,374**	1,497	1,617
Sinking fund investment *[note 12]*	**12,063**	10,670	9,333
	110,451	128,249	108,178
Liabilities			
Bank indebtedness *[note 7]*	—	11,614	1,047
Accounts payable and accrued liabilities *[note 8]*	**107,917**	106,629	97,533
Due to government/other government entities *[note 9]*	**24,617**	23,767	18,289
Employee future benefits			
Accrued sick leave *[note 18]*	**61,508**	58,677	56,681
Accrued severance pay *[note 17]*	**107,068**	96,943	88,570
Accrued vacation pay	**48,132**	47,153	43,883
Deferred revenue *[note 10]*			
Deferred capital grants	**50,597**	52,549	50,353
Deferred operating revenue	**7,750**	15,554	22,242
Long-term debt *[note 11]*	**141,001**	143,415	145,781
	548,590	556,301	524,379
Net debt	**(438,139)**	(428,052)	(416,201)
Non financial assets			
Deferred charges	—	—	84
Tangible capital assets *[note 6]*	**354,867**	336,589	309,985
Supplies inventory	**14,505**	12,832	12,954
Prepaid expenses	**6,271**	7,766	5,645
	375,643	357,187	328,668
Accumulated deficit	**(62,496)**	(70,865)	(87,533)

Contingencies *[note 15]*
Contractual obligations *[note 16]*

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]

	2012 $	2011 $
		[unaudited]
Operating transactions		
Annual surplus	**8,369**	16,668
Adjustments for:		
Amortization of tangible capital assets	**31,605**	27,767
Capital grants provincial and other	**(49,883)**	(54,371)
Increase in accrued severance pay	**10,125**	8,373
Increase in accrued sick leave	**2,831**	1,996
Amortization of deferred charges	**—**	84
Changes in non-cash assets and liabilities related to operations *[note 13]*	**18,657**	(7,501)
Cash provided by (used in) operating transactions	**21,704**	(6,984)
Capital transactions		
Construction and purchase of tangible capital assets	**(49,883)**	(54,371)
Capital asset contributions	**49,883**	54,371
Cash provided by capital transactions	**—**	—
Investing transactions		
Sinking fund payments	**(1,393)**	(1,336)
Cash used in investing transactions	**(1,393)**	(1,336)
Financing transactions		
Increase (decrease) in bank indebtedness	**(11,614)**	10,567
Repayment of long-term debt	**(2,414)**	(2,367)
Repayment of advance to General Hospital Hostel Association	**123**	120
Cash provided by (used in) financing transactions	**(13,905)**	8,320
Net increase in cash	**6,406**	—
Cash, beginning of year	**—**	—
Cash, end of year	**6,406**	—
Supplementary disclosure of cash flow information		
Interest paid	**9,594**	10,461

See accompanying notes

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[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, and the related operations were transferred from the Authority to the new CYFS department. The non-consolidated financial statements of the Authority include 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

Basis of accounting

The Authority considers itself to be an Other Government Organization ["OGO"]. Accordingly, these non-consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards ["PSA"] as promulgated by the Canadian Institute of Chartered Accountants ["CICA"]. Previously, the Authority's financial statements were prepared in accordance with Part V of the CICA Handbook ["Pre-changeover Accounting Standards" or "Previous GAAP"].

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[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 [Cont'd]

The significant accounting policies used in the preparation of these non-consolidated financial statements are as follows:

Basis of presentation

These non-consolidated financial statements reflect the assets, liabilities, revenue, and expenditures of the Operating Fund. Trusts administered by Eastern Health are not included in the non-consolidated statement of financial position. 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 revenues 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 when the liability is settled.

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

The Authority is funded by the Department for the total of its operating costs, after deduction of specified revenue and 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.

Expense recognition

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

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[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 [Cont'd]

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 and cash equivalents

Cash and cash equivalents include cash on hand and balances with banks, net of any overdrafts.

Inventory

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

Tangible capital assets

Capital assets are recorded at cost, although title to certain of these assets is held by the Government of Newfoundland and Labrador [the "Government"]. Contributed capital assets are recorded at their estimated fair value at the date of contribution. Minor equipment purchases are charged to operations in the year of acquisition.

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

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

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.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[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 [Cont'd]

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.

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.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[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 [Cont'd]

Accrued sick leave

Employees of Eastern Health are entitled to sick pay benefits which 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 and amounted to $40,724,565 for the year ended March 31, 2012 [2011 – $38,745,593].

Sinking funds

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

Contributed services

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

Financial instruments

Financial assets and liabilities are classified according to their characteristics and management's choices and intentions related thereto for the purpose of ongoing measurements. The fair value of a financial instrument is the estimated amount to be received or paid to terminate the instrument's agreement at the reporting date. Various market value data and other valuation techniques are used as appropriate to estimate the fair value of each type of financial instrument.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[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 [Cont'd]

Financial assets and liabilities are generally classified and measured as follows:

Asset/Liability	Classification	Measurement
Cash	Held for trading	Fair value
Accounts receivable	Loans and receivables	Amortized cost
Bank indebtedness	Other liabilities	Amortized cost
Accounts payable and accrued liabilities	Other liabilities	Amortized cost
Long-term debt	Other liabilities	Amortized cost

Use of estimates

The preparation of financial statements in conformity with PSA requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the non-consolidated financial statements, and the reported amounts of revenue and expenditures during the reporting period. Actual results could differ from these estimates.

3. TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS

Prior to the presentation of the March 31, 2012 non-consolidated financial statements, the Authority followed the recommendations of Pre-changeover Standards. In October 2009, the Public Sector Accounting Board ["PSAB"] finalized changes to accounting standards. As a result, for fiscal years ending on or after January 1, 2011, the Authority is required to reclassify itself in accordance with PSA standards. In accordance with recommendations of the Public Sector Accounting Handbook, the Authority determined that it is an OGO and PSA is the most appropriate framework for reporting purposes. The Authority adopted PSA for its fiscal year beginning April 1, 2011, with a transition date of April 1, 2010 [the "Transition Date"].

The impact of the conversion to PSA on the accumulated deficit at the Transition Date and on the comparative annual surplus for the year ended March 31, 2011 is presented in the reconciliations below. These accounting changes have been applied retroactively with restatement of prior periods.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

3. TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS

Exceptions to retroactive application

The Authority ensured that the estimates reflected in the opening non-consolidated statement of financial position prepared in accordance with PSA were consistent with those in the non-consolidated statement of financial position as at the same date prepared under Previous GAAP adjusted, as needed, for any difference in accounting policy. Estimates required under PSA that were not required under Previous GAAP reflect the conditions that existed at the opening non-consolidated statement of financial position date prepared in accordance with PSA.

Exemptions applied

In accordance with Section PS 2125, *First-time Adoption by Government Organizations*, the Authority elected to apply the following exemptions:

Tangible capital asset impairment
As a result of applying this exemption, the Authority prospectively applied, as of the Transition Date, the impairment criteria and conditions for tangible capital assets set out in Section PS 3150, *Tangible Capital Assets*.

Retirement and post-employment benefits
As a result of applying this exemption, the Authority elected to recognize all cumulative actuarial gains and losses as at the Transition Date to PSA directly in accumulated deficit.

The Authority reviewed the first-time adoption standard and determined that none of the other exemptions were applicable.

Early adoption

Section PS 3410, *Government Transfers*, was amended by the PSAB in December 2010. The main changes pertain to recognition criteria for government transfers by the recipient. These amendments are effective for fiscal years beginning on or after April 1, 2012 and earlier adoption is encouraged. The Authority elected to early adopt the Section for the year ended March 31, 2012.

Section PS 3450, *Financial Instruments*, provides guidance for recognition, measurement and disclosure of financial instruments. The transitional provisions in the standard state that when a government organization applies this standard in the same period it adopts PSA for the first time, this standard cannot be applied retroactively. The Authority previously disclosed in its prior non-consolidated financial statements the various risks related to financial instruments as required by this standard. As a result, there was no significant impact to the Authority's non-consolidated financial statements upon early adoption of this standard.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

3. TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS [Cont'd]

The following tables present the reconciliation of account balances from Previous GAAP to PSA:

[i] Reconciliation of the April 1, 2010 non-consolidated statement of financial position:

	Footnotes	Previous GAAP $	Adjustments $	PSA Standards $
Financial Assets				
Accounts receivable	f	97,228	(74,690)	22,538
Due from government /other government entities	f	—	74,690	74,690
Advance to General Hospital Hostel Association		1,617	—	1,617
Trust funds	a	3,820	(3,820)	—
Sinking fund investment	b	—	9,333	9,333
		102,665	5,513	108,178
Liabilities				
Bank indebtedness		1,047	—	1,047
Accounts payable and accrued liabilities	f	115,822	(18,289)	97,533
Due to government /other government entities	f	—	18,289	18,289
Employee future benefits				
Accrued sick leave	e	—	56,681	56,681
Accrued severance pay	c, g	113,069	(24,499)	88,570
Accrued vacation pay		43,883	—	43,883
Deferred revenue				
Deferred capital contributions	d	123,209	(123,209)	—
Deferred capital grants		50,353	—	50,353
Deferred operating revenue		22,242	—	22,242
Trust funds	a	3,820	(3,820)	—
Long-term debt	b, c	136,448	9,333	145,781
		609,893	(85,514)	524,379
Net debt		(507,228)	91,027	(416,201)
Non financial assets				
Deferred charges		84	—	84
Tangible capital assets		309,985	—	309,985
Supplies inventory		12,954	—	12,954
Prepaid expenses		5,645	—	5,645
		328,668	—	328,668
Accumulated deficit	d, e, g	(178,560)	91,027	(87,533)

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

3. TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS [Cont'd]

[ii] Reconciliation of the March 31, 2011 non-consolidated statement of financial position:

	Footnotes	Previous GAAP $	Adjustments $	PSA Standards $
Financial Assets				
Accounts receivable	f	116,082	(94,410)	21,672
Due from government /other government entities	f	—	94,410	94,410
Advance to General Hospital Hostel Association		1,497	—	1,497
Trust funds	a	3,891	(3,891)	—
Sinking fund investment	b	—	10,670	10,670
		121,470	6,779	128,249
Liabilities				
Bank indebtedness		11,614	—	11,614
Accounts payable and accrued liabilities	f	130,396	(23,767)	106,629
Due to government /other government entities	f	—	23,767	23,767
Employee future benefits				
Accrued sick leave	e	—	58,677	58,677
Accrued severance pay	c, g	118,745	(21,802)	96,943
Accrued vacation pay		47,153	—	47,153
Deferred revenue				
Deferred capital contributions	d	159,619	(159,619)	—
Deferred capital grants		52,549	—	52,549
Deferred operating revenue		15,554	—	15,554
Trust funds	a	3,891	(3,891)	—
Long-term debt	b, c	132,745	10,670	143,415
		672,266	(115,965)	556,301
Net debt		(550,796)	122,744	(428,052)
Non financial assets				
Tangible capital assets		336,589	—	336,589
Supplies inventory		12,832	—	12,832
Prepaid expenses		7,766	—	7,766
		357,187	—	357,187
Accumulated deficit	d, e, g	(193,609)	122,744	(70,865)

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

3. TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS [Cont'd]

[iii] Resulting adjustments to annual surplus (deficit) for the year ended March 31, 2011:

	$
Annual deficit, March 31, 2011 – Previous GAAP	(15,049)
Reversal of amortization of deferred capital contributions *[d]*	(17,961)
Provincial plan capital grants *[d]*	54,371
Change to accrued severance pay *[g]*	(2,697)
Change to accrued sick leave *[e]*	(1,996)
Annual surplus, March 31, 2011 – PSA	16,668

Notes:

[a] Under Previous GAAP, the Authority recorded all trust funds that it administered on behalf of other government entities. Under PSA, trusts administrated by a government organization should be excluded from the government reporting entity statements and disclosed in a note to the financial statements, describing the trusts under administration. As a result, the Authority removed the trust fund amounts previously recorded at the Transition Date.

[b] Under Previous GAAP, the sinking fund investment was presented net of sinking fund debenture. Under Section PS 3230, *Long-term Debt*, external restrictions on assets such as sinking fund investments can be segregated and presented separately on the non-consolidated statement of financial position. As a result, the Authority reclassified the sinking fund investment and has presented it separately on the non-consolidated statement of financial position.

[c] Under Previous GAAP, the Authority presented a current portion of accrued severance pay and long-term debt on the non-consolidated statement of financial position. Under PSA, current assets and liabilities are not presented separately. As a result, the current portion classification was removed upon the Transition Date and the total associated obligations are presented within one line on the non-consolidated statement of financial position.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

3. TRANSITION TO PUBLIC SECTOR ACCOUNTING STANDARDS [Cont'd]

[d] Under Previous GAAP, government transfers received and used for the purchase of capital assets were deferred and amortized to operations at the same rate the related assets were amortized. Under Section PS 3410, *Government Transfers*, funds received from the government and used for the purchase of capital assets are recognized as revenue when no stipulations exist and the related liability has been settled. As a result, the Authority removed the balance of deferred capital contributions at the Transition Date of $123,209,000 which resulted in a decrease in deferred capital contributions and a corresponding decrease in the accumulated deficit.

[e] Each employee of the Authority is entitled to a number of days of sick leave per fiscal year. Earned but unused sick leave is accrued and deferred. Under Previous GAAP, the Authority was not required to recognize a liability in respect of sick leave to the extent that the incapacity to work arising from injury or illness had not occurred. Under Section PS 3255, *Post-employment Benefits, Compensated Absences and Termination Benefits*, sick pay benefits that accumulate but do not vest are considered obligations. As a result, the Authority recorded an employee future benefit obligation related to sick leave, which resulted in an increase in the accumulated deficit at the Transition Date and an increase to the related expense in the non-consolidated statement of operations for 2011 and 2012.

[f] Under Previous GAAP, the Authority presented amounts due from and to government and other government entities within the respective accounts receivable and accounts payable balances on the non-consolidated statement of financial position. Section PS 1200, *Financial Statement Presentation*, suggests that amounts due from and to government and other government entities should be presented separately on the non-consolidated statement of financial position. As a result, the Authority has reclassified these amounts and presented them separately.

[g] Under Previous GAAP, the Authority recognized accrued severance pay, calculated based upon years of service and current salary levels. Under Section PS 3250, *Retirement Benefits*, the accrued severance pay would be classified as a retirement benefit and would follow the accrued benefit method, which is used to attribute the cost of the retirement benefit to the period of employee service through an actuarial valuation. As a result, the Authority recorded a change to the value of the accrued severance pay, which decreased the accumulated deficit at the Transition Date.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

4. ACCOUNTS RECEIVABLE

	March 31, 2012 $	March 31, 2011 $ *[unaudited]*	April 1, 2010 $ *[unaudited]*
Services to patients, residents and clients	**5,360**	7,672	8,799
Other	**17,324**	14,000	13,739
	22,684	21,672	22,538

5. DUE FROM GOVERNMENT/OTHER GOVERNMENT ENTITIES

	March 31, 2012 $	March 31, 2011 $ *[unaudited]*	April 1, 2010 $ *[unaudited]*
Government of Newfoundland and Labrador	**54,330**	65,751	60,288
Other government entities	**13,594**	28,659	14,402
	67,924	94,410	74,690

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

6. TANGIBLE CAPITAL ASSETS

	Land and land improvements $	Buildings and improvements $	Equipment $	Equipment under capital leases $	Construction in progress $	Total $
March 31, 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**

	Land and land improvements $	Buildings and improvements $	Equipment $	Equipment under capital leases $	Construction in progress $	2011 Total $ *[unaudited]*	2010 Total $ *[unaudited]*
March 31, 2011							
Cost							
Opening balance	2,810	336,965	374,128	15,445	26,935	756,283	716,733
Additions	—	4,267	35,664	—	14,439	54,370	39,922
Disposals	—	—	(277)	—	—	(277)	(372)
Closing balance	2,810	341,232	409,515	15,445	41,374	810,376	756,283
Accumulated amortization							
Opening balance	474	127,694	303,512	14,618	—	446,298	421,417
Additions	18	7,224	20,356	168	—	27,766	24,881
Disposals	—	—	(277)	—	—	(277)	—
Closing balance	492	134,918	323,591	14,786	—	473,787	446,298
Net book value	2,318	206,314	85,924	659	41,374	336,589	309,985

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

7. BANK INDEBTEDNESS

The Authority has access to lines of credit totaling $64,000,000 in the form of revolving demand loans and/or bank overdrafts at its financial institution, which was unused as at March 31, 2012 [March 31, 2011 – $52,386,000; April 1, 2010 – $62,953,000]. The Authority's ability to borrow has been approved by the Province's Minister of Health and Community Services.

8. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

	March 31, 2012 $	March 31, 2011 $ *[unaudited]*	April 1, 2010 $ *[unaudited]*
Accounts payable and accrued liabilities	**67,588**	73,989	64,803
Salaries and wages payable	**35,588**	28,810	29,321
Employee/employer remittances	**4,741**	3,830	3,409
	107,917	106,629	97,533

9. DUE TO GOVERNMENT/OTHER GOVERNMENT ENTITIES

	March 31, 2012 $	March 31, 2011 $ *[unaudited]*	April 1, 2010 $ *[unaudited]*
Federal government	**11,251**	10,677	9,971
Provincial government	**7,387**	6,023	5,444
Other government entities	**5,979**	7,067	2,874
	24,617	23,767	18,289

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

10. DEFERRED REVENUE

	March 31, 2012 $	March 31, 2011 $ *[unaudited]*	April 1, 2010 $ *[unaudited]*
Deferred capital grants [a]			
Balance at beginning of year	**52,549**	50,353	33,944
Receipts during year	**47,931**	56,567	55,959
Recognized in revenue during year	**(49,883)**	(54,371)	(39,550)
Balance at end of year	**50,597**	52,549	50,353
Deferred operating revenue [b]			
Balance at beginning of year	**15,554**	22,242	32,898
Receipts during year	**1,245,195**	1,133,814	957,312
Recognized in revenue during year	**(1,252,999)**	(1,140,502)	(967,968)
Balance at end of year	**7,750**	15,554	22,242

[a] Deferred capital grants represent government transfers 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.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

11. LONG-TERM DEBT

	March 31, 2012 $	March 31, 2011 $	April 1, 2010 $
		[unaudited]	*[unaudited]*
Sinking fund debenture, Series HCCI, 6.9%, to mature June 15, 2040, interest payable semi-annually on June 15 and December 15 [the "Debenture"].	**130,000**	130,000	130,000
Royal Bank of Canada (Central Kitchen), 6.06% loan maturing May 2014, payable in monthly instalments of principal and interest of $101,670.	**2,480**	3,508	4,485
Newfoundland and Labrador Housing Corporation 2.75% mortgage, maturing December 2020, repayable in blended monthly instalments of $18,216, secured by land and building with a net book value of $1,829,646.	**1,699**	1,869	2,022
Royal Bank of Canada (Veterans Pavilion), 4.18% loan, unsecured, maturing April 2013, payable in blended monthly instalments of $55,670.	**706**	1,329	1,928
Canadian Imperial Bank of Commerce loan, unsecured, bearing interest at prime lending rate less 0.625 basis points, maturing 2016, repayable in monthly instalments of $21,200 plus interest.	**1,121**	1,375	1,630
Newfoundland and Labrador Housing Corporation 10% mortgage, maturing December 2028, repayable in blended monthly instalments of $8,955, secured by land and building with a net book value of $935,778.	**886**	906	924
Bank of Montreal 4.96% term loan, unsecured, amortized to December 2014, repayable in blended monthly instalments of principal and interest of $7,070.	**146**	224	296
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 $1,910,869.	**93**	102	112
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 November 2025.	**781**	811	840
10.5% on Golden Heights Manor, repayable in blended monthly instalments of $7,549, maturing August 2027.	**701**	719	734
2.65% on Golden Heights Manor, repayable in blended monthly instalments of $20,482, maturing June 2023.	**2,388**	2,572	2,740
Bank of Montreal, 3.82%, repaid during the prior period	–	–	70
	141,001	143,415	145,781

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

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

11. LONG-TERM DEBT [Cont'd]

Annual principal repayments to maturity are as follows:

	$
2013	2,528
2014	2,005
2015	945
2016	752
2017	621
Thereafter	134,150

12. SINKING FUND

A sinking fund investment, established for the partial retirement of the Debenture *[note 11]*, is held in trust by the Government. The balance at March 31, 2012 included interest earned in the amount of $3,841,000 [March 31, 2011 – $3,194,000; April 1, 2010 – $2,606,000].

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.

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

	2012 $	**2011** $ *[unaudited]*
Accounts receivable	**(1,012)**	866
Supplies inventory	**(1,673)**	122
Prepaid expenses	**1,495**	(2,121)
Accounts payable and accrued liabilities	**1,288**	9,096
Due from/to government/other government entities	**27,336**	(14,842)
Accrued vacation pay	**979**	3,270
Deferred capital grants	**(1,952)**	2,196
Deferred operating revenue	**(7,804)**	(6,088)
	18,657	(7,501)

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

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

14. 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. At March 31, 2012, the balance of funds held in trust for residents of long-term care facilities was $4,250,000 [March 31, 2011 – $3,891,000; April 1, 2010 – $3,821,000]. These trust funds consist of a monthly comfort allowance provided to residents who qualify for subsidization of their boarding and lodging fees.

15. 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.

16. 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:

	2013 $	2014 $	2015 $	2016 $	2017 $	Thereafter $
Future operating lease payments	12,623	1,217	11,782	11,555	10,437	71,575
Managed print services	2,435	2,435	2,435	2,435	2,435	—
Vehicles	194	194	70	7	—	—
	15,252	3,846	14,287	13,997	12,872	71,575

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

17. ACCRUED SEVERANCE PAY

The Authority provides a severance payment to employees upon retirement, resignation or termination without cause. In 2012, cash payments to retirees for the Authority's unfunded employee future benefits amounted to approximately $7,872,000 [2011 – $6,442,000]. 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, 2011 and March 31, 2012.

	2012 $	2011 $ *[unaudited]*
Accrued benefit obligation, beginning of year	**96,943**	88,570
Benefits expense		
Current service cost	**6,741**	6,098
Interest cost	**4,481**	4,596
Actuarial loss	**6,775**	4,121
	114,940	103,385
Benefits paid	**(7,872)**	(6,442)
Accrued benefit obligation, end of year	**107,068**	96,943

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

	2012 $	2011 $	2010 $
Discount rate – benefit cost	**3.85**	4.65	5.20
Rate of compensation increase	**4.00**	4.00	4.00

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

18. ACCRUED SICK LEAVE

	2012 $	2011 $ *[unaudited]*
Accrued benefit obligation, beginning of year	**58,677**	56,681
Benefits expense		
Current service cost	**6,329**	5,906
Interest cost	**2,669**	2,878
Actuarial loss	**2,741**	1,777
	70,416	67,242
Benefits paid	**(8,908)**	(8,565)
Accrued benefit obligation, end of year	**61,508**	58,677

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

	2012 $	2011 $	2010 $
Discount rate – benefit cost	**3.85**	4.65	5.20
Rate of compensation increase	**4.00**	4.00	4.00

19. RELATED PARTY TRANSACTIONS

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

	2012 $	2011 $ *[unaudited]*
Grants from the Province	**1,247,711**	1,227,423
Transfers from other government entities	**85,222**	78,828
Transfers to other government entities	**(99,913)**	(98,239)
	1,233,020	1,208,012

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

20. CAPITAL MANAGEMENT

The Authority's objective when managing capital is to ensure it maintains adequate capital to support its continued operations.

The Authority is not subject to externally imposed capital requirements.

21. 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, liquidity risk and market risk. The Authority's Board of Trustees has overall responsibility for the oversight of these risks and reviews the Authority's policies on an ongoing basis to ensure that these risks are appropriately managed. The source of risk exposure and how each is managed is outlined below:

Credit risk

Credit risk is the risk of loss associated with a counterparty's inability to fulfil its payment obligation.

The Authority's credit risk is primarily attributable to accounts receivable. Eastern Health has a collection policy and monitoring processes intended to mitigate potential credit losses. Management believes that the credit risk with respect to accounts receivable is not material.

Liquidity risk

Liquidity risk is the risk that the Authority will not be able to meet its financial obligations as they become due. The Authority has an authorized credit facility totaling $64,000,000, which is unused as at March 31, 2012. 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.

Market risk

Market risk is the risk that changes in market prices, such as interest rates, foreign exchange rates and price risk, will affect the Authority's operations or the value of its financial instruments. The Authority is not subject to foreign exchange risk or interest rate price risk.

Long-term debt principally bears interest at fixed rates. The Authority does not consider its cash flow exposure to be significant.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2012
[All amounts are in Canadian dollars, except amounts disclosed in tables which are presented in thousands of Canadian dollars]

21. FINANCIAL INSTRUMENTS AND RISK MANAGEMENT [Cont'd]

Fair value

The fair value of the Authority's short-term financial instruments approximates their carrying value due to the short-term maturity and normal credit terms of those instruments.

The carrying value of long-term debt is considered to approximate fair value.

22. 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 Budget do not include amounts relating to certain non-cash and other items including 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.

The Original Budget and Budget prepared by the Authority were not updated to reflect the transfer of CYFS' operations from the Authority to a separate department of the Government during 2012. Approximately $90,900,000 was included in the Original Budget which related to the CYFS budget. The transfer of CYFS is expected to result in a budget reduction of approximately $34,490,000 for the Authority.

The following presents a reconciliation of budgeted revenue for the year ended March 31, 2012:

	2012 $ *[unaudited]*
Original budgeted revenue	1,314,023
Adjustments during the year for service and program changes, net	25,332
Revised original budget	1,339,355
Stabilization funds approved by the Government	12,500
Deferred revenue recognized as approved by the Government	4,800
Final budget	1,356,655

SUPPLEMENTARY SCHEDULES

NON-CONSOLIDATED SCHEDULE OF EXPENDITURES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2012	2011
	$	$
	[unaudited]	*[unaudited]*
Patient and resident services		
Acute care	**202,228**	196,852
Long-term care	**141,999**	135,829
Other patient and resident services	**21,362**	19,082
	365,589	351,763
Client services		
Community support programs	**162,620**	148,361
Family support programs	**11,171**	9,893
Health promotion and protection	**15,709**	15,057
Mental health and addictions	**14,579**	12,012
	204,079	185,323
Diagnostic and therapeutic		
Other diagnostic and therapeutic	**78,528**	73,918
Clinical laboratory	**51,712**	46,385
Diagnostic imaging	**45,515**	41,797
	175,755	162,100
Support		
Facilities management	**52,120**	50,531
Food services	**30,392**	29,567
Other support	**29,619**	28,314
Housekeeping	**29,285**	28,069
Laundry and linen	**9,548**	9,313
	150,964	145,794
Ambulatory care		
Outpatient clinics	**77,882**	70,146
Emergency	**29,691**	27,061
Dialysis	**16,790**	14,804
Other ambulatory	**4,561**	4,659
	128,924	116,670

NON-CONSOLIDATED SCHEDULE OF EXPENDITURES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2012 $ *[unaudited]*	2011 $ *[unaudited]*
Administration		
Other administrative	**38,162**	35,970
Materials management	**20,299**	19,233
Systems support	**15,216**	14,620
Human resources	**13,645**	13,125
Executive offices	**15,190**	14,866
Finance and budgeting	**10,556**	10,353
Emergency preparedness	**335**	974
	113,403	109,141
Medical services		
Physician services	**81,815**	78,287
Interns and residents	**23,558**	15,439
	105,373	93,726
Other		
Undistributed	**24,567**	29,636
Research and education		
Education	**15,298**	14,898
Research	**2,929**	2,840
	18,227	17,738
Interest on long-term debt		
Interest on long-term debt	**9,594**	9,715
Total shareable expenditures	**1,296,475**	1,221,606

See accompanying notes

NON-CONSOLIDATED SCHEDULE OF EXPENDITURES FOR GOVERNMENT REPORTING

For the seven-month period ended October 31, 2011
[with comparative figures for the year ended March 31, 2011]
[in thousands of dollars]

	2012 $ *[unaudited]*	2011 $ *[unaudited]*
Client services		
Family support programs	**50,209**	82,554
Health promotion and protection	**1,404**	2,016
Mental health and addictions	**149**	55
Community youth corrections	**2,394**	4,254
	54,156	88,879
Diagnostic and therapeutic		
Other diagnostic and therapeutic	**234**	376
	234	376
Administration		
Other administrative	**171**	24
	171	24
Total shareable expenditures	**54,561**	89,279

See accompanying notes

NON-CONSOLIDATED SCHEDULE OF REVENUE AND EXPENDITURES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2012 $ *[unaudited]*	2011 $ *[unaudited]*
Revenue		
Provincial plan	**1,149,204**	1,085,892
MCP	**73,302**	67,567
Inpatient	**10,260**	9,058
Resident	**18,005**	17,714
Outpatient	**8,015**	8,733
Other	**40,869**	33,841
	1,299,655	1,222,805
Expenditures		
Compensation		
Salaries	**693,565**	655,038
Employee benefits	**112,065**	106,005
	805,630	761,043
Supplies		
Other	**230,672**	223,473
Medical and surgical	**58,402**	54,583
Drugs	**45,923**	41,460
Plant operations and maintenance	**21,171**	18,464
	356,168	337,980
Direct client costs		
Community support	**119,627**	108,184
Family support	**4,247**	4,436
Mental health and addictions	**1,209**	248
	125,083	112,868
Lease and long-term debt		
Long-term debt - interest	**9,594**	9,715
Long-term debt - principal	**3,162**	3,115
	12,756	12,830
	1,299,637	1,224,721
Surplus (deficiency) for government reporting	**18**	(1,916)
Long-term debt - principal	**3,162**	3,115
	3,162	3,115

NON-CONSOLIDATED SCHEDULE OF REVENUE AND EXPENDITURES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2012 $ *[unaudited]*	2011 $ *[unaudited]*
Surplus before non-shareable items	**3,180**	1,199
Adjustments for non-shareable items		
Provincial plan capital grant	**44,800**	52,092
Other capital contributions	**5,083**	2,198
Amortization of tangible capital assets	**(31,605)**	(27,699)
Interest on sinking fund	**647**	588
Accrued vacation pay	**(979)**	(3,270)
Accrued sick leave	**(2,831)**	(1,996)
Accrued severance pay	**(13,133)**	(8,070)
	1,982	13,843
Surplus of revenue over expenditures	**5,162**	15,042

See accompanying notes

NON-CONSOLIDATED SCHEDULE OF REVENUE AND EXPENDITURES FOR GOVERNMENT REPORTING

For the seven-month period ended October 31, 2011
[with comparative figures for the year ended March 31, 2011]
[in thousands of dollars]

	2012 $ *[unaudited]*	2011 $ *[unaudited]*
Revenue		
Provincial plan	**53,707**	89,358
Other	**1,053**	1,837
	54,760	91,195
Expenditures		
Compensation		
Salaries	**15,362**	23,722
Employee benefits	**2,269**	3,763
	17,631	27,485
Supplies		
Other	**7**	3
Direct client costs		
Family support	**34,080**	57,332
Mental health and addictions	**8**	4
Health promotion	**1,404**	2,016
Community youth corrections	**1,431**	2,439
	36,923	61,791
	54,561	89,279
Surplus for government reporting	**199**	1,916
Surplus before non-shareable items	**199**	1,916
Adjustments for non-shareable items		
Provincial plan capital grants	**—**	81
Amortization of tangible capital assets	**—**	(68)
Accrued severance pay	**3,008**	(303)
	3,008	(290)
Surplus of revenue over expenditures	**3,207**	1,626

See accompanying notes

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

Year ended March 31
[in thousands of dollars]

	2012	2011
	$	$
	[unaudited]	*[unaudited]*
Revenue		
Provincial plan	**37,189**	44,584
Deferred grants - previous year	**52,549**	50,353
Foundations and auxiliaries	**3,893**	3,789
Transfer from operations	**5,437**	8,161
Transfer to other regions	**222**	(572)
Other	**1,190**	605
Deferred grant current year	**(50,597)**	(52,549)
	49,883	54,371
Expenditures		
Equipment	**32,541**	34,908
Construction in progress	**6,847**	14,747
Buildings	**10,495**	4,267
Vehicles	**—**	449
	49,883	54,371
Surplus on capital transactions	**—**	—

See accompanying notes

NON-CONSOLIDATED SCHEDULE OF ACCUMULATED DEFICIT FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2012	2011
	$	$
	[unaudited]	*[unaudited]*
Assets		
Current assets		
Cash	**6,406**	—
Accounts receivable	**90,608**	116,082
Supplies inventory	**14,505**	12,832
Prepaid expenses	**6,271**	7,766
	117,790	136,680
Advance to General Hospital Hostel Association	**1,374**	1,497
	119,164	138,177
Liabilities		
Current liabilities		
Bank indebtedness	—	11,614
Accounts payable and accrued liabilities	**132,534**	130,396
Deferred revenue - operating revenue	**7,750**	15,554
Deferred revenue - capital grants	**50,597**	52,549
	190,881	210,113
Accumulated deficit for government reporting	**(71,717)**	(71,936)

See accompanying notes

7. Appendix I – Lines of Business

1. Promote Health and Well-Being

Eastern Health implements measures that promote and protect population health and help prevent disease and injury. The primary initiatives in this line of business include: Health Protection; Health Promotion; Disease and Injury Prevention; Health Surveillance and Population Health Assessment.

a. Health Protection

Health protection includes the regulatory framework, programs and services for the control of diseases and protection from public health threats. Health protection identifies, reduces and eliminates hazards and risk to the health of individuals and communities. Health protection is delivered within the context of current legislation, where applicable.

The major categories of service include:

- Immunization
- Communicable disease surveillance and control
- Environmental Health Services (conducted in cooperation with Government Services Centre (GSC))
- All hazards emergency planning (AHEP)

b. Health Promotion

Health promotion is the process of enabling individuals, families and communities to increase control over and to improve their own health. Health promotion programs and services involve the work of many internal and external partners working together to focus on:

- Building healthy public policy (e.g., smoke free policies)
- Strengthening community action (e.g., Regional Wellness Coalitions)
- Creating Supportive Environments (e.g., safe walking routes within communities)
- Supporting development of personal skills (e.g., child and family health programs)
- Re-orienting health services to focus on prevention and early intervention (e.g., through partnerships with community agencies, engaging the public through the media)
- Re-orienting health services to focus on population health as well as individual health outcomes
- Health Service Delivery (e.g., Healthy Baby Clubs, Child Health Clinics)

c. Disease and Injury Prevention

Many illnesses can either be prevented or delayed and injuries can be avoided. Actions include programs and services that are focused on eradicating, eliminating or minimizing the impacts of disease and disability. Programs and services vary, depending on the incidence or potential for disease, illness or injury identified in particular areas of the region.

The major categories of service include, but are not limited to:

- Screening (e.g., child development screening, cervical screening)
- Falls prevention
- Chronic disease prevention and management

d. Health Surveillance

Health surveillance involves the systematic and ongoing collection, analysis and dissemination of public health data. Intended for early detection and control of outbreaks and identification of disease trends that cause illness, this assists our understanding of the impacts and efforts to improve health and reduce the impact of disease.

e. Population Health Assessment

Population health assessment identifies the factors that underlie good health and those that create risks. These assessments lead to better services and policies. Initiatives include community health needs assessments and health status reports.

2. Provide Supportive Care

Eastern Health offers residential care options, community-based support and continuing care, home support and nursing home care for individuals based on assessed needs. These services are provided in select locations and in some cases may be means-tested and/or criteria-based. There is occasionally a relationship with other government agencies for subsidized funding to supplement program funding.

a. Individual, Family and Community Supportive Services

These programs provide financial and supportive services and case management for individuals of all ages with assessed needs. The program focuses on supporting individuals, families and caregivers and promotes community inclusion, independence, safety and well-being. Services are limited and some may be based upon both a financial assessment and an individual's ability to pay for such services.

The main categories of services are included below:

- Alternate residential options, home support, medical supplies, and assessment and placement services for nursing homes, personal care homes, palliative care and behavioural supports.
- The *Neglected Adults Service* investigates and follows up on referrals of neglect as defined under the *Neglected Adults Act*.
- Day Support provides individuals who continue to live in the community with a day-based service that includes health, education, social and recreational activities within a supportive group setting.
- *Community Behavioural Services* is a behavioural support and training program offered to individuals with developmental challenges.
- *Direct Home Services* offers a family-centred, home-based, early intervention program for families of infants and preschool children who have delayed development.

b. Short-term Adult Residential Care

This program involves short respite stays for individuals. The services are offered in selected locations.

- *Respite care* enables caregivers to avail of respite for defined periods with potential for extension in specific circumstances.

c. Long-term Adult Residential Care

This long-term program provides residential nursing home care for individuals who require ongoing support due to their disability, frailty or chronic illness. This involves a single entry system where an individual's needs are assessed and matched with available placements, as appropriate.

The major categories of services involve the following:

- Eastern Health has a number of operating arrangements with its long-term care beds for people assessed as having high level needs. In certain areas of the region, beds are part of nursing homes while in other areas they are part of hospitals or medical clinics.

Appendix I – Lines of Business

- *Personal Care Homes* are operated by private owners but are licensed and monitored through Eastern Health. These homes provide care for residents assessed as having low level needs.
- Through *Alternative Family Care Placements*, Eastern Health approves caregiver homes and monitors and supports placements of individuals who require care.
- Eastern Health owns and manages a limited number of cottages in various areas of the region.

3. Treat Illness and Injury

The organization investigates, treats, rehabilitates and cares for individuals with illness or injury. The clinical intent of these services is to treat illness and injuries, relieve symptoms, reduce the severity of an illness or injury and educate patients. Additionally, we provide care at the beginning of life (newborn care) and at the end of life (palliative care).

Services are offered in a variety of locations throughout the region, depending on factors such as the level of care required (primary, secondary or tertiary), access to health professionals and access to appropriate facilities. Certain services are self-referred, while others require a referral from a health professional. The organization offers services through a variety of inpatient and outpatient settings.

The key aspects are outlined as follows:

- *Outreach Services* offer selected clinical services throughout the region and some parts of the province. These include outreach clinics for cancer care, mental health and specialized children's services (e.g., physiotherapy).
- Throughout the region, people have access to *Primary Health Care*. The main form of primary care is through fee-for-service physicians who operate their own offices independently of Eastern Health. In many other cases, physicians work within one of Eastern Health's facilities to provide primary care. There are also a growing number of primary health care projects in which physicians and other health professionals work in a coordinated manner to offer care.
- Through *Community Health Centres*, health professionals provide assessment and care in a medical clinic setting within certain areas of the region.
- *Regional Cancer Centres* are staffed by Eastern Health employees, and patients are visited by specialists of the Cancer Care Program who work closely with local physicians. These centres are located in Gander, Grand Falls and Corner Brook.
- *Regional Hospitals* throughout the Eastern Health catchment area provide both primary and secondary level care. The primary disciplines are ambulatory, emergency, diagnostic imaging, general surgery, gynecology, laboratory medicine, obstetrics and medicine. These services are provided by multidisciplinary teams of health professionals.
- *Tertiary Hospitals* are located in St. John's and provide primary, secondary and tertiary level services. These tertiary facilities are academic healthcare facilities that accept referrals and transfers from all parts of the province for both inpatient and outpatient services. The majority of these specialty services are provided in the footnote [8].

[8] Medical, Surgical and Radiation Oncology; Cardiac and Critical Care; Specialized Diagnostics – Laboratory Medicine, Imaging, Nuclear Medicine, Pathology; Children and Women's Health – Specialty Pediatrics, Gynecology, Obstetrics, Pediatric Critical Care, Perinatology Medicine – Allergy & Immunology, Emergency Medicine, Endocrinology & Metabolism, Family Medicine, Gastroenterology, General Internal Medicine, Geriatrics, Haematology, Nephrology, Pharmacy, Respirology, Rheumatology; Surgery – Anaesthesia and Perioperative Medicine, Cardiac Surgery, Dentistry, General Surgery, Neuro Surgery Ophthalmology, Orthopedics, Otolaryngology, Plastic Surgery, Thoracic Surgery, Urology, Vascular Surgery; Psychiatry - child/adolescent psychiatry, geriatric psychiatry, adult and general psychiatry, forensic psychiatry.

- Throughout the region, *Rehabilitation Centres* provide patient rehabilitation following an illness or injury. The Miller Centre and the Janeway Children's Hospital and Rehabilitation Centre provide specialized rehabilitation services.
- *Patient Transport* provides both ground and air transport of patients. These services are conducted by both pubic and private operators and include ambulance and client transport for medical services.
- *Mental Health and Addictions Services* are offered to those who are experiencing mental health problems, mental illness or difficulties with alcohol, drugs and/or gambling, or are affected by someone else's use. These services range from health promotion-based programs to diagnosis and treatment (both inpatient and outpatient) to follow-up services. There are strong links with community-based partners such as advocacy groups, self-help groups and/or employment and housing.
- *Home visits* are another mechanism for health professionals to deliver care within the community setting.

4. Advance Knowledge

Eastern Health is dedicated to advancing research, education and knowledge mobilization. With its many academic links, the organization plays a key role in ensuring that the next generation of health professionals has opportunities to gain relevant educational experience. Staff and physicians are encouraged to seek the best information and knowledge from multiple sources and to incorporate quality evidence into their practice. As well, the organization is committed to ensuring that the issues faced in daily practice bring about innovative research and learning.

Education and research are collaborative endeavours, and overall success depends upon partnerships with affiliated organizations, particularly Memorial University of Newfoundland. Eastern Health also has close ties with the College of the North Atlantic and has affiliation agreements with numerous other post secondary institutions across the country and further abroad to provide student placements within clinical settings. Additionally, Eastern Health has permanent representation on the Board of Directors of the Newfoundland and Labrador Centre for Applied Health Research (NLCAHR) and the Newfoundland and Labrador Centre for Health Information (NLCHI).

The main categories within this area are listed below:

- Education of the next generation of health care providers is offered through affiliation agreements with numerous educational institutions. These arrangements enable students to study and participate in fieldwork experiences. Eastern Health's primary educational partnerships are with Memorial University of Newfoundland and College of the North Atlantic, in addition to various universities, colleges and other educational institutions that educate many of our staff.
- The Patient Research Centre provides for the coordination and implementation of clinical trials. During 2010-11, the centre was actively involved in over 100 clinical trials in cardiology, child health, clinical epidemiology/nephrology, endocrinology, gastroenterology, hematology, neurology, respirology, rheumatology and women's health.
- The Centre for Nursing Studies (CNS) offers LPN, BN, Nurse Practitioner and various continuing education programs.
- Continuing Education is offered throughout Eastern Health in various formats. We also partner with other health boards and community agencies to offer training to health professionals and the general public.

Appendix II – Eastern Health's Facilities and Bed Numbers

8. Appendix II – Eastern Health's Facilities and Bed Numbers

Acute Care Facility Beds*

Facility	Acute Care	Bassinettes
Janeway Children's Health and Rehabilitation Centre	78	0
General Hospital	338	30
Dr. L.A. Miller Centre	72	0
St. Clare's Mercy Hospital	203	0
Waterford Hospital	82	0
Dr. Walter Templeman Health Centre	5	0
Carbonear General Hospital	70	8
Placentia Health Centre	10	0
Dr. G. B. Cross Memorial Hospital	43	9
Burin Peninsula Health Care Centre	42	9
Bonavista Community Health Care Centre	10	0
Total	**953**	**56**

A further breakdown of bed types in each facility is outlined below.

Breakdown by Bed Type*

Facility	Critical Care	Palliative	Rehab	Long-term Care
Janeway Children's Health and Rehabilitation Centre	29	0	0	0
General Hospital	32	0	0	0
Dr. L.A. Miller Centre	0	10	62	0
St. Clare's Mercy Hospital	16	0	0	0
Waterford Hospital	0	0	0	84
Dr. Walter Templeman Health Centre	0	0	0	0
Carbonear General Hospital	6	4	0	0
Placentia Health Centre	0	0	0	0
Dr. G. B. Cross Memorial Hospital	4	2	4	0
Burin Peninsula Health Care Centre	4	1	0	0
Bonavista Community Health Care Centre	0	0	0	0
Total	**81**	**17**	**66**	**84**

*Bed numbers provide a general snapshot as these numbers change throughout the year.

Long-term Care Beds

Facility	Long-term Care Beds	Resident Days
Agnes Pratt Home	134	46,615
Blue Crest Interfaith Nursing Home	61	21,415
Bonavista Health Centre	13	4,430
Chancellor Park	70	25,273
Dr. Albert O'Mahony Memorial Manor	44	15,547
Dr. Walter Templeman Health Centre	15	3,633
Golden Heights Manor	70	24,527
Harbour Lodge Nursing Home	105	32,282
Hoyles-Escasoni Complex	369	130,468
Interfaith Senior Citizens Home	53	14,342
Lions Manor Nursing Home	75	24,963
Masonic Park Nursing Home	40	14,251
Pentecostal Home Clarke's Beach	69	22,504
Saint Luke's Home	124	43,709
Salvation Army Glenbrook Lodge	106	37,650
St. Patrick's Mercy Home	210	73,071
U.S. Memorial Health Centre	40	14,282
Veteran's Pavilion	56	17,771
Total	**1,654**	**566,733**

Community Health Centres

Facility	Holding Beds[9]
Community Health Centres	
Dr. Wm. Newhook Community Health Centre	4
Dr. A. A. Wilkinson Health Centre	4
Grand Bank Community Health Centre	4
Total	**12**

[9] The term "holding beds" refers to those beds used for temporary care of patients waiting for transfer, consults or tests for longer than two hours.

9. Appendix III – 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

Reporting of adverse events, occurrences and close calls: "Occurrence" is a broad term, which includes risks associated with the care or services provided to a client as well as risks associated with visitors, property and the organization. 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 7 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 percent 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 freed up for those who need them, and not tied up by those who neither need them nor benefit from them. Inappropriate utilization causes delays in accessing services and wait times, and unnecessary stress and strain on the individual/family, care-providers and the healthcare 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 to 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. In 2011, the Infection Prevention and Control Program conducted 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.

Safer Healthcare Now - 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.

Safer Healthcare Now - Percentage of Acute Myocardial Infarction (AMI) Perfect Care rate for Carbonear: 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 seven evidence-based care components for improved care for AMI.

Safer Healthcare Now - Percentage of Acute Myocardial Infarction (AMI) Perfect Care rate for HSC: 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 seven evidence-based care components for improved care for AMI.

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

Safer Healthcare Now - 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.

Safer Healthcare Now - 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.

Safer Healthcare Now - 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 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 Workers' Compensation claims: The duration of Workers' Compensation claims has previously been measured as an average within Eastern Health; however, work is underway to calculate the median duration to better reflect the duration of claims.

Access: Quantifiable Indicators

Wait time for access to long-term care beds: Wait times for long-term care are a major factor impacting access for clients that can lead to functional decline, caregiver stress and access to acute care for other patients.

Wait time for non-urgent primary mental health and addictions: Data provided is an average of 23 of our adult and all-ages clinics across the region. Quarterly wait time reports are based on manual data collection.

Wait time for specialists (non-urgent) - Orthopedics: "Wait Time 1" 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 initially seen and assessed by the specialist. Wait Time 1 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 internal target.
- Priority 2 - Semi Urgent: sub-acute non-traumatic inflammatory rheumatic disorders. Referral will be redirected 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 First Ministers in 2005 with agreement that baseline measures would be based on 2006-07 data.

Percentage of Hip Replacements completed within 182 days (city only): Hip replacement surgery was identified as a priority area by First Ministers in 2005, with agreement that baseline measures would be based on 2006-07 data.

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 First Ministers in 2005, with agreement that baseline measures would be based on 2006-07 data.

Percentage of Cataract Surgeries completed for patients who are at high risk within 112 days (local anesthetic only, city only): In 2005, First Ministers identified sight restoration as one of the priority areas where funding would be directed toward making meaningful access improvements, with agreement that baseline measures would be based on 2006-07 data.

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 First Ministers in 2005, with agreement that baseline measures would be based on 2006-07 data.

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 of first cycle.

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

Cancer Surgeries: The data for cancer surgeries is for the 2011-12 year and is based on the methodology of including in its wait time calculations any emergency cancer surgery patients, but excluding inactive wait times for patients where delays have been identified.

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

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

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 EH.

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 and the benchmark is 30 days. 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. Patients with the highest level of acuity (e.g., Canadian Triage and Acuity Scale (CTAS) level 1-2) have no or minimal wait time to a physician and rarely leave without being seen.

Sustainability: Quantifiable Indicators

Year to Date (YTD) Budget Variance: This indicator examines the level of actual expenditure as compared to the available budget. The benchmark and target have been established at a balanced budget. Financially, we finished the 2011-12 fiscal period with a $17.3 million expenditure variance on total expenditures of $1.3 billion.

HR vacancy rate for Difficult to fill (actively recruiting for minimum two months, does not include Casuals): This indicator is measured by the number of external competitions (that have been active for over two months) divided by the total number of employees.

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.

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 (2009-10).

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.

Percentage of breastfeeding initiation, exclusive, birth to hospital discharge, refers to the percentage of mothers who exclusively breastfeed from birth to hospital discharge. Percentage of breastfeeding initiation refers to percentage of mothers who begin breastfeeding and supplement with formula.

Rate of participation (by age) for screening for colorectal cancer: The Newfoundland and Labrador Colorectal Screening Program was not implemented in the fiscal year 2011-2012, so measurement and reporting was not possible.

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. While the indicator is for seniors aged 65+, the National Advisory Committee on Immunization recommended that seniors aged 60+ be immunized for the 2011-12 year.

Seasonal Influenza Immunization rate-children (reported yearly): While the indicator is for children aged six months to five years, the National Advisory Committee on Immunization recommended that children aged 6-23 months be immunized for the 2011-12 year.

Seasonal Influenza Immunization rate – Eastern Health Staff (reported yearly): This rate measures the uptake of seasonal influenza vaccination for our health care workers. Immunization of health care 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).