Together we can

Annual Performance Report
2013 - 2014

Eastern Health

ANNUAL PERFORMANCE REPORT

2013 - 2014

Eastern Health

Table of Contents

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 2013-14. This report marks the third and final year of Eastern Health's Strategic Plan, *Together We Can,* for the planning period of 2011-14.

During this time, the organization has focused on four priority areas: quality and safety, access, sustainability and population health. The Strategic Plan outlined specific goals, objectives and indicators associated with each of these priorities. Through this Annual Performance Report, Eastern Health provides the progress made toward our goals and highlights areas where improvement is required.

As always, I am proud of Eastern Health and the many individuals and groups that comprise this organization. The Annual Performance Report is one way in which we publicly demonstrate our level of commitment toward realizing our vision of *Healthy People, Healthy Communities*.

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 (Current Board members as of March 2014)
Top row: Michael J. O'Keefe - Chair, William Abbott, Robert Andrews, Barbara Cribb, Cindy Goff
Bottom row: Bill McCann, Sister Sheila O'Dea, Leslie O'Reilly, Shirley Rose, Frank Ryan

1. Overview

The Eastern Regional Health Authority (Eastern Health) is the largest integrated health authority in Newfoundland and Labrador, serving a population of 306,259 (Census 2011). The organization provides the full continuum of health and community services, including public health, long-term care, community services and hospital care[1].

In addition to regional programs and services, Eastern Health is responsible for provincial tertiary-level health services through both its academic health care facilities and provincial programs, such as rehabilitation and children's and women's health. Eastern Health also partners with numerous organizations – most notably Memorial University of Newfoundland and the College of the North Atlantic – to educate future health professionals, conduct research, advance knowledge, and improve patient, client and resident care. It is also notable that as of the 2012-13 fiscal year, Eastern Health took over responsibility for the Newfoundland and Labrador Public Health Laboratory.

For the fiscal year 2013-14 Eastern Health had a budget of approximately $1.3 billion, 12,771 employees, and 630 physicians (248 of which are salaried). The organization also benefitted from approximately 1,588 volunteers[2] who provided 69,853 hours[3] of volunteer work all over the region[4]. Volunteer activities range from on-one-one interactions to large group events with partner agencies.

Eastern Health benefits from the significant efforts of six foundations: Burin Peninsula Health Care Foundation, Discovery Health Care Foundation, Dr. H. Bliss Murphy Cancer Care Foundation, Health Care Foundation, Janeway Children's Hospital Foundation and Trinity Conception Placentia Health Foundation. Volunteer boards of directors govern these foundations as they raise funds for various facilities, equipment and services.

In addition, auxiliaries are associated with most of Eastern Health's acute care and long-term facilities. These volunteer groups provide numerous direct services such as coordinating volunteer services and raising funds through such means as gift shops. In 2013-14, the auxiliaries donated funds toward such initiatives as student scholarships, television rentals for long-term patients, Music Therapy, as well as the purchase of new medical equipment.

1 During the 2011-12 fiscal year, a number of child, youth and family services programs and services transferred from Eastern Health's responsibility to the new Child Youth and Family Services department of the Provincial Government.

2 This is the average number of volunteers who provided service to Eastern Health on a quarterly basis (6352 volunteers/4 quarters = 1588 volunteers). This is the best indicator of the number of volunteers as it accounts for re-occurring volunteers.

3 This number reflects the total number of hours contributed by the 6,352 (re-occurring and new) volunteers.

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

Overview

1.1. The Region

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

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

1.2. Vision

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

1.3. Mission

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

Figure 1: Communities with Eastern Health Sites

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 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 patients, clients, residents and their families. These programs and services improve the health and well-being of individuals and communities through the entire continuum of health and at all stages of life. Eastern Health has four main lines of business:

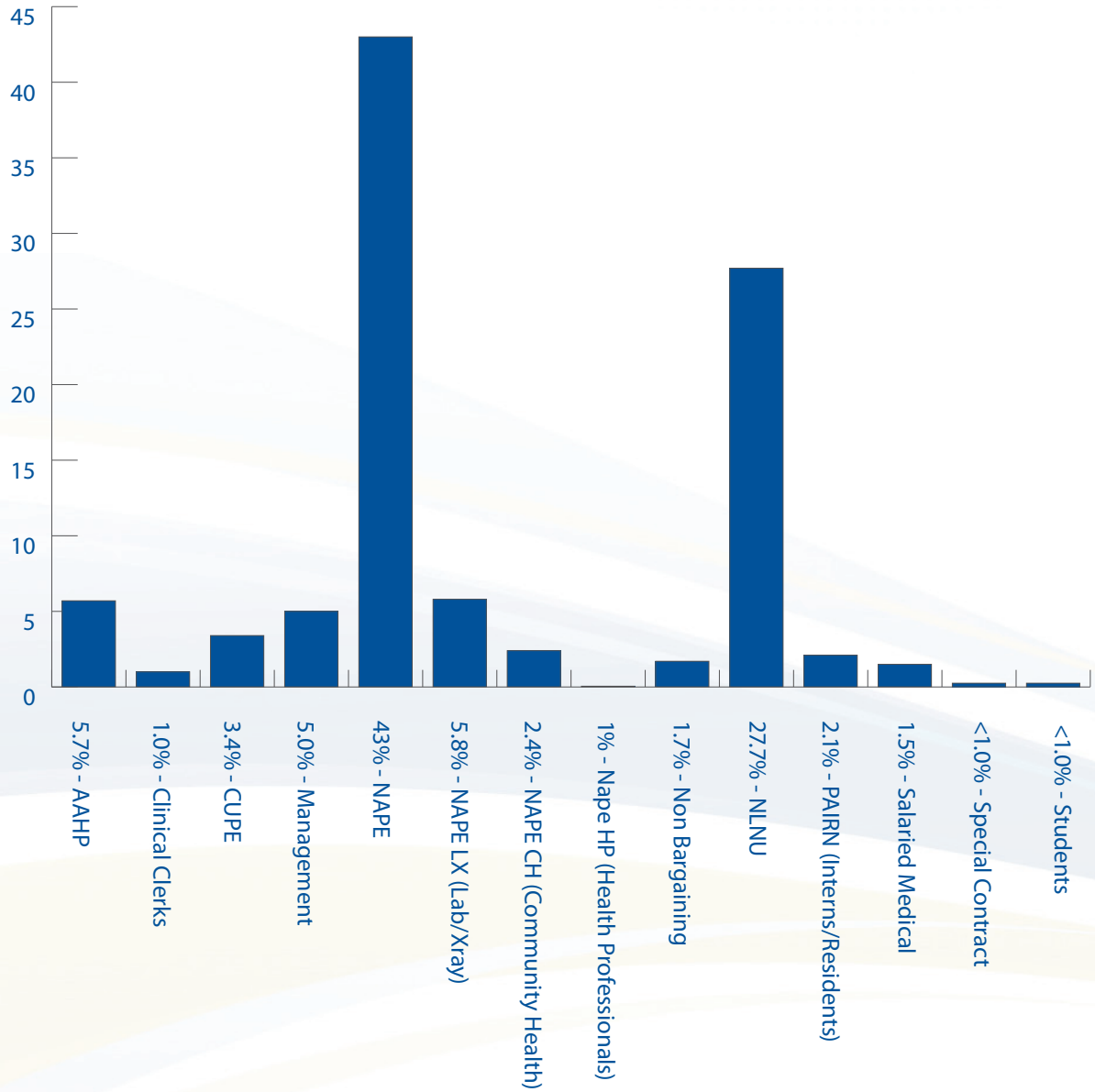
1) Promote Health and Well-being;
2) Provide Supportive Care;
3) Treat Illness and Injury;
4) Advance Knowledge

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

1.6. Employees

Eastern Health has 12,771 employees[5], approximately 82% of whom are female. Figure 2 shows Eastern Health employees by classification.[6]

Figure 2: Eastern Health Employees by Classification



5 The number of employees provides a general "snapshot", as there are fluctuations throughout the year (e.g., during summer hiring). This number is provided as of March 31, 2014.

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

1.7. Provincial Mandate

In addition to its regional mandate (see Appendix I), Eastern Health has unique provincial responsibilities for tertiary level institutional services including:

- Cancer Care
- Cardiac and Critical Care
- Children's 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 distinct 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 Health Ethics Network Newfoundland and Labrador (PHENNL)
- Provincial Insulin Pump Program (up to age 25 years)
- Provincial Kidney Program
- Provincial Organ Procurement Program
- Provincial Pediatric Advice and Poison Control Lines
- Provincial Pediatric Enteral Feeding Program
- Provincial Perinatal Program
- Provincial Public Health Laboratory
- Provincial Synagis® Program – Respiratory Syncytial Virus (RSV)
- Stem Cell Transplantation

Eastern Health also has education and research roles associated with its position within the academic health sciences community. Memorial University of Newfoundland is the main education and research partner.

1.8. Revenues and Expenditures

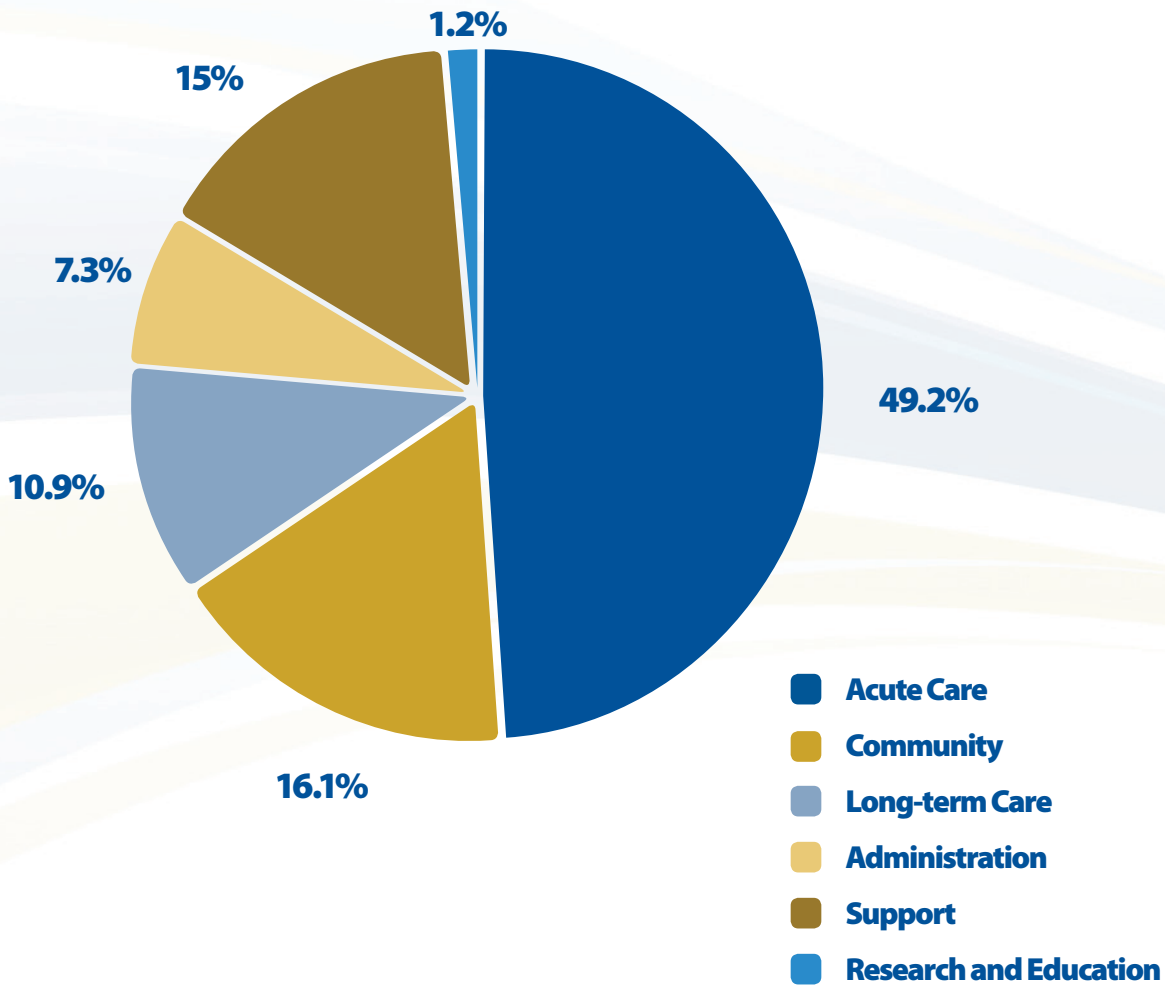
Eastern Health's budget for 2013-14 was approximately $1.3 billion. The Government of Newfoundland and Labrador's Budget 2013 included funding to increase access to health services and treatments, enhance long-term care and community supports, as well as continued investment in health care infrastructure improvements. This included provincial initiatives such as reducing Endoscopy wait lists and wait times, the Paid Family Caregiving Home Support Option, a Community Rapid Response Team as well as the Enhanced Care in Personal Care Homes pilot.

The budget also targeted existing and projected growth in the Home Support Program and new drug therapies for Cancer Care and Haematology programs.

Eastern Health ended the fiscal year 2013-14 in a balanced financial position as a result of one-time stabilization funding of $27.4 million from the Provincial Government. Eastern Health continues to improve management practices and operational efficiencies, which have resulted in savings of approximately $27.0 million of the targeted $43.0 million during the 2011-14 planning cycle.

Figure 3 provides Eastern Health's expenditures by sector for 2013-14.

Figure 3: Expenditure by Sector



1.9. Other Key Performance Indicators

Eastern Health tracks numerous key performance indicators. The graphs that follow provide statistics from the three fiscal years of the 2011-14 planning cycle.[7]

Figure 4 shows that acute care admissions were 2.9% higher than the previous year.

Figure 4: Acute Care Admissions

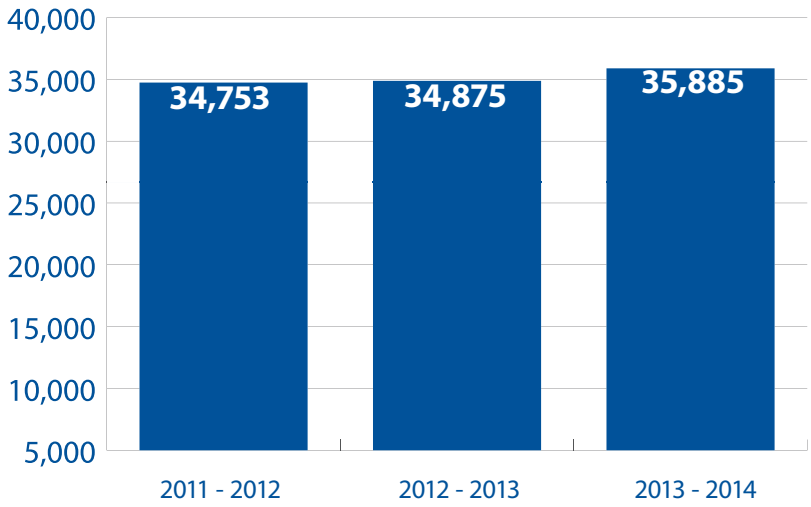
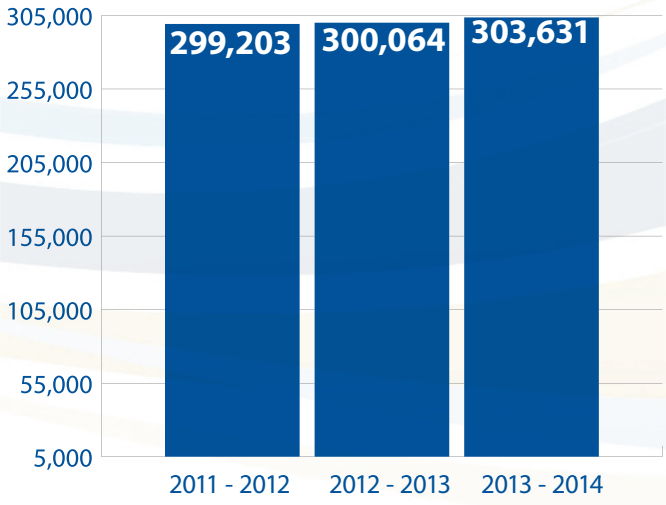


Figure 5 indicates that inpatient days were 1.19% higher than the previous year.

Figure 5: Acute Care Inpatient Days



7 During 2011-14, Eastern Health has been standardizing and automating the data provided in its Annual Performance Reports. The data set used is in compliance with the *Standards for Management Information Systems in Canadian Health Service Organizations* (MIS Standards), a set of national standards used across the health care system to collect and report financial and statistical data from health service organizations. There may be some variance from previously reported data.

Figure 6 shows the number of Emergency Room visits for the past three years, which have decreased by 3,687 from 2011-12 to 2013-14.

Figure 6: Emergency Room Visits

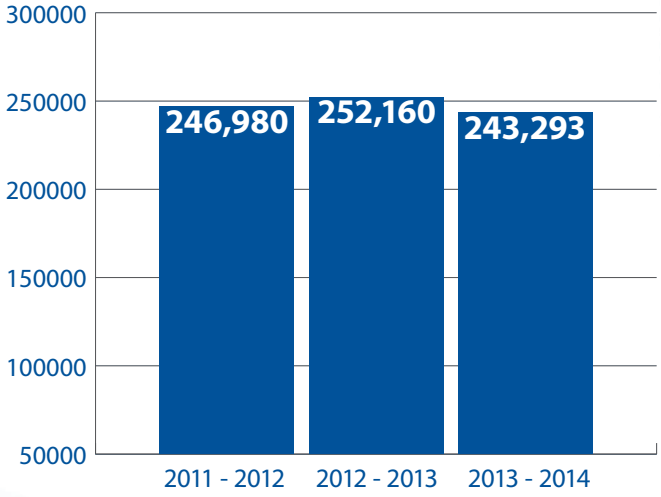


Figure 7 provides volume comparison to the previous year, which indicates both increases and decreases for some service areas. The MIS Standardized Diagnostic Imaging Workload Units (WLU) was revised effective April 1, 2013, which impacts year over year comparisons for some modalities.

Figure 7: Volume Comparisons Chart

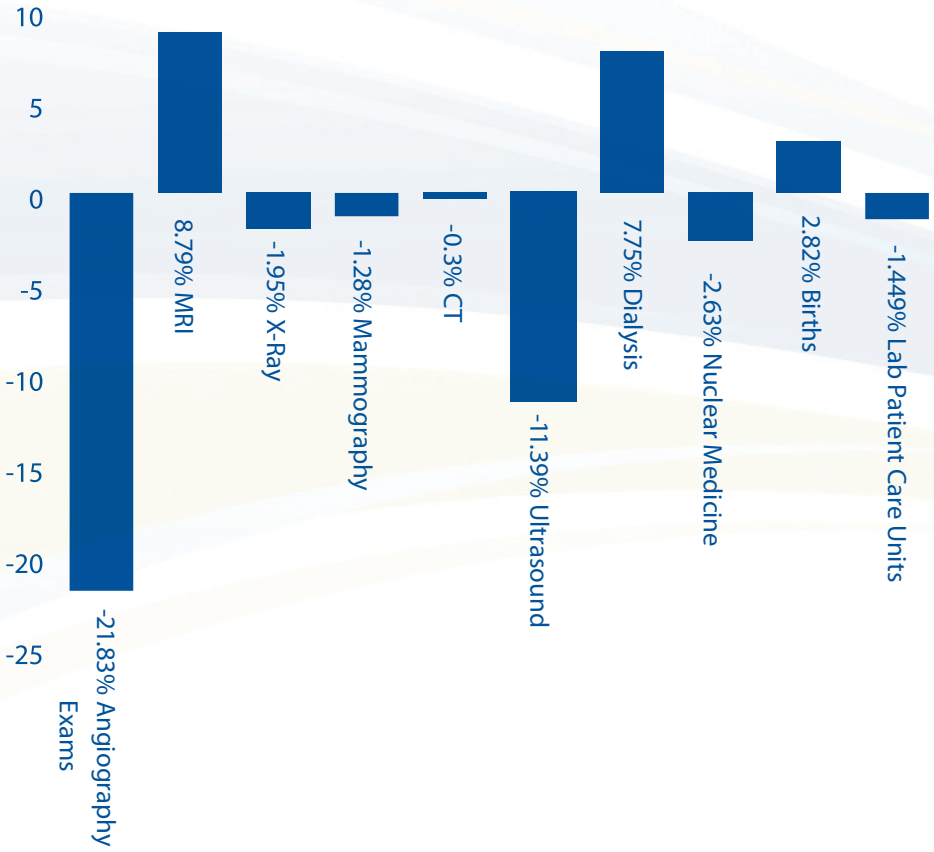


Figure 8 indicates that long-term care resident days have been increasing over the past three years (approximately 1 % each year). This is due to increased overall occupancy, greater efficiency in admission timeframes (days from vacancy to admission), and lower turnover rates (20% fewer admissions in last year).

Figure 8: Long-term Care Resident Days

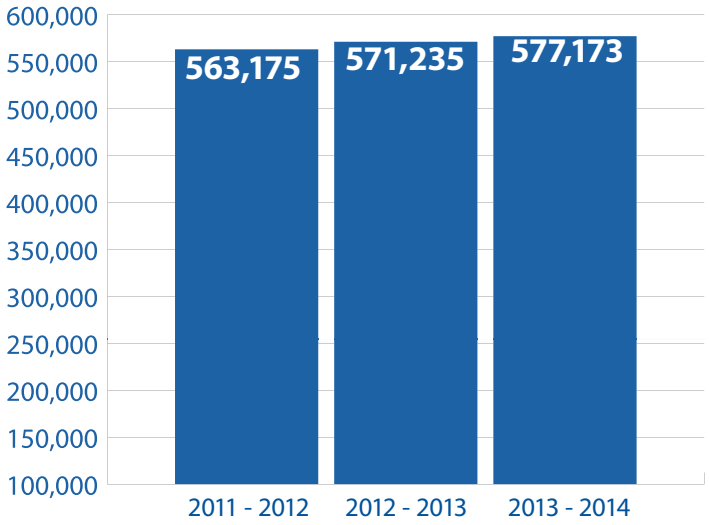
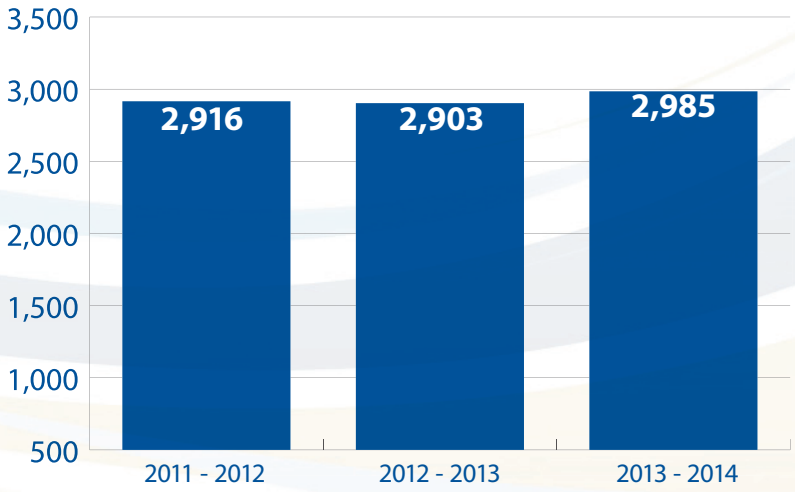


Figure 9 provides the number of live births at Eastern Health. The number has been very consistent over the past three years.

Figure 9: Live Births



2. Shared Commitments

The vision and values of Eastern Health implicitly recognize the importance of partnerships to the mutual benefit of the organization and the individuals and communities it serves. The organization is committed to strengthening partnerships in carrying out its mission of improving programs and services as well as contributing to the overall health of the population.

Eastern Health aligns its priorities with the Provincial Government's Strategic Directions by working closely with officials from the Department of Health and Community Services (DOHCS). Eastern Health also has a close working relationship with the provincial Department of Child, Youth and Family Services via a memorandum of understanding (MOU) that outlines the working relationship between the two entities and enables continued collaboration.

Eastern Health has numerous partners in a wide variety of areas, including unions, professional associations, regulatory boards, school districts, emergency response agencies, and research affiliates. Eastern Health works with over 40 educational institutions and organizations to help educate future health providers and has a particularly strong affiliation with Memorial University of Newfoundland in its mandate of education and research. The organization also has close links with the Newfoundland and Labrador Centre for Applied Health Research (NLCAHR), the Newfoundland and Labrador Centre for Health Information (NLCHI) and the Health Research Ethics Authority.

Approximately 1,588 volunteers are dedicated to enhancing the quality of life for Eastern Health's patients, clients, residents and their families. These volunteers include the auxiliaries and foundations associated with various health and long-term care sites throughout the region. In addition to this level of volunteer commitment, Eastern Health values its relationships with numerous voluntary, community-based agencies all through the region, such as the Red Cross, St. John Ambulance, Canadian Blood Services and various musical groups and faith-based organizations.

Throughout 2013-14 there were many examples of Eastern Health's work with its external partners – both existing and new – that supported strategic priorities as well as components of Eastern Health's operational and work plans. Activities range from being very program-specific (e.g. working with Baby-Friendly Newfoundland and Labrador and the Town of Portugal Cove-St. Philip's to host an educational session for grandmothers about the benefits of breastfeeding) to broader, multi-partner initiatives. For example, in keeping with one of the Provincial Government's Population Health initiatives, the *Journey in the Big Land* enhances cancer care for the Labrador Inuit, Innu and members of the NunatuKavut Community Council in conjunction with Eastern Health, Labrador-Grenfell Health and Aboriginal partners. In addition, many of Eastern Health's programs continue to work with stakeholder and consumer groups such as the Canadian Mental Health Association, the Newfoundland and Labrador AIDS Committee, Choices for Youth and Stella's Circle.

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

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

3. Highlights and Accomplishments

This section highlights some of the many accomplishments achieved by Eastern Health throughout 2013-14 and are presented according to the three Strategic Directions of Provincial Government as communicated by the Minister of Health and Community Services: *Population Health*; *Access to Priority Services; and, Accountability and Stability in the Delivery of Health and Community Services.*

These highlights and accomplishments were achieved through Eastern Health's operational plans as well as work plans within various programs across the organization. They also reflect Eastern Health's values of respect, integrity, fairness, connectedness and excellence.

It is also important to note that since Eastern Health took over responsibility for the Public Health Laboratory during the 2012-13 fiscal year, this section includes accomplishments from that program. In addition to the highlights listed, the Report on Performance section of this report outlines progress related to each of Eastern Health's strategic priorities.

Population Health

The following highlights and accomplishments demonstrate Eastern Health's commitment to Provincial Government's Strategic Direction of *Population Health*, with particular focus on Aboriginal Health, Communicable Disease, Environmental Health, Health Emergency Management, Smoking Rates and Protection from Environmental Smoke, and Wellness.

- Eastern Health partnered with Labrador-Grenfell Health and Aboriginal partners to develop *Journey in the Big Land*, a program to enhance cancer care for the Labrador Inuit, Innu and members of the NunatuKavut Community.
- The Public Health Program coordinated the region's response to a high demand for influenza vaccines during January-March 2014.
- Electronic access to Communicable Disease Control information was implemented for Public Health Nurses, including development of immunization status reports by way of an electronic workbook.
- Organized a consultation on seasonal influenza vaccination to examine the ethical considerations regarding policy and direction on mandatory seasonal influenza vaccination for health care workers.
- The Public Health Laboratory saw a higher than average demand for influenza and respiratory virus testing (i.e. approximately 1.6 times the yearly average of 1520) but was able to meet this increased demand for services through restricting testing to critical and acute care services, outbreaks and other cases as warranted.
- Infection Prevention and Control (IPC), in collaboration with Decision Support, developed an alert system and supporting reports to improve utilization of IPC staff and support quality monitoring and reporting of infection-related data.
- Launched the *Take Care Down There* Phase II campaign, which targets people 18-30 years of age to increase awareness of risky sexual behaviours and safer sex choices.
- Opened a new Secondary Data Centre to provide Disaster Recovery and Business Continuance.
- Paramedicine and Medical Transport organized a new *Heroes Give Back* blood donor clinic in partnership with Canadian Blood Services during National Emergency Medical Services (EMS) Week 2013.
- Health Promotion completed an environmental scan of programs and services and data related to smoking and pregnant women. This scan

identified the need for a targeted approach to address issues of low income and low education and plans are being developed for such an approach.

- Launched Phase II of the *B4UR Pregnant* project, which includes targeted messaging around eating healthy, physical activity and the risks associated with smoking during pregnancy.

Access to Priority Services

Highlights and accomplishments listed below demonstrate Eastern Health's commitment to Provincial Government's Strategic Direction of *Access to Priority Services,* with particular focus on pharmacare initiatives, pre-hospital/emergency and rural health.

- Developed and implemented an oral chemotherapy follow up clinic. This program provides assessment of patients receiving oral chemotherapy by an oncology pharmacist and is the first oncology pharmacy collaborative practice in the country.
- Completed renovations at the Emergency Department at St. Clare's.
- Established a process in collaboration with the NL Healthline to follow-up on patients who leave the Emergency Department without being seen.
- Improved public communication of Emergency Department processes and wait times (e.g. developed and distributed posters to provide patients/families with information).
- By means of the Remote Cardiac Device Monitoring Program, patients with implanted cardiac devices can now be monitored at home. This reduced the number of outpatient clinic visits for patients by up to 50%.
- Eastern Health is involved in a number of major capital projects across the region, including the new Community Health Centre north of Marystown, Western Bay Clinic, G.B. Cross East Wing Redevelopment, Carbonear Operating Room and various other repair and renovation projects.
- Supported by the Provincial Government, Long-term Care prepared for transition to new facilities in St. John's and Carbonear and Protective Community Residences (Dementia Care Bungalows) in Bonavista.
- Expanded the Janeway Lifestyles Program to the Burin Peninsula. This inter-disciplinary team works with families whose children have been identified as having risk factors for high cholesterol, high blood sugar, high blood pressure, liver disease, and weight concerns.
- Successfully redesigned family practice clinic operations to improve access within the Bonavista area. Wait times for family practice has been reduced dramatically to within one week.
- Implemented recommendations from the Trinity-Conception Community Health Needs Assessment, which includes holding a consultation with community physicians from Rural Avalon to discuss key issues such as recruitment and the use of technology, working with Memorial University's Faculty of Medicine to promote rural practice and exploring options for expanded Telehealth use.
- Further implemented a Volunteer Program for Palliative Care in Carbonear General Hospital.

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

The list below provides some of the accomplishments Eastern Health made during 2013-14 in support of Government's Strategic Direction of *Accountability and Stability in the Delivery of the Health and Community Services*. This includes a focus on clinical/administrative guidelines/program standards, evaluation of legislation, programs and services, health research, and information management and technology.

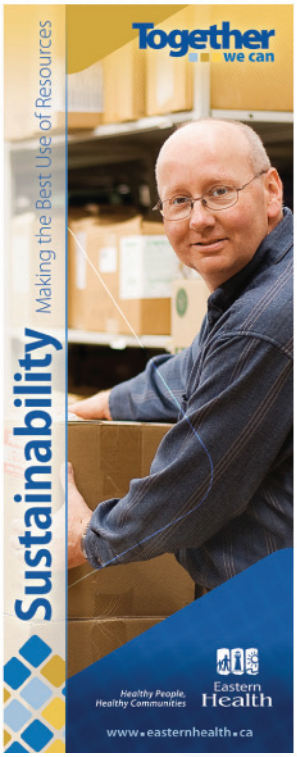
- The Orthopedic Central Intake model led Canada in measures to reduce wait times for total joint hip and knee surgery (as reported by Canadian Institute for Health Information). Plans are underway for the expansion of this model to Thoracic Surgery and Vascular Surgery.
- The success of the Urologist Recruitment Plan has resulted in the elimination of new referrals to out-of-province services as of January 2014.
- The Palliative Care program increased utilization of its beds as a result of improved communication and coordination of services. The 10-bed Palliative Care Unit at the Miller Centre saw an increase in bed utilization, which suggests that more patients are being given the choice of palliative care and that advance planning has taken place.
- The Children's and Women's Health program co-located Obstetrical and Gynaecological Units to the same floor at the Health Sciences Centre, which creates a more efficient and coordinated service.
- The Rehabilitation Day Services division formalized assessments and education processes for newly-diagnosed Amyotrophic Lateral Sclerosis (ALS) patients.
- The Rehabilitation Program established an Amputee Clinic for clients being considered for amputation, new amputees being considered for prosthetic fitting and new or current amputees with complex issues.
- The Rheumatology Program successfully implemented an interdisciplinary team to improve access and care for arthritic patients.
- The Medicine Program was recognized for process improvements by community physicians for improvements in access to pulmonary function testing. The program also sustained improvements achieved in access for patients with Movement Disorders and Thyroid Cancer.
- The Provincial Cervical Cancer Screening was consolidated under the leadership of Eastern Health's Cancer Care Program.
- Health Promotion coordinated the development of *Working with Schools: A Position Statement and Practice Framework for Eastern Health* to provide direction about how Eastern Health works with the education sector to maximize health and contribute to the achievement of learning outcomes.
- Participated in the planning committee for a healthy "built environment" workshop with municipal planners and health professionals, entitled *Working Together for Community Wellness*.
- Long-term care strengthened services to meet the needs of the aging population, such as expanding ventilator care services rurally within its Complex Care Service and implementing Enhanced Care Service for clients requiring a higher level of care (but not in need of Nursing Home placement).
- The Organ Donor Program successfully completed the accreditation process through Accreditation Canada. This was the first time that organ donation was part of the accreditation process as a separate program.

Highlights and Accomplishments

- Central Laundry had 6,656,359 pounds of clean laundry shipped through its plant in Pleasantville. This involves 77 employees (full time and casuals) in a plant that runs six days per week for approximately 60 hours/week.
- Environmental Services partnered with the Multi Materials Stewardship Board (MMSB) to participate in the Electronic Products Recycling Program, recycling electronics (e-waste) via Evergreen Recycling. A battery recycling program was also begun.
- Began a new contract for the transportation, treatment and disposal of biomedical waste that will result in significant cost savings over a 10-year period.
- The Planning Department led the organization in the development of its 2014-17 Strategic Plan, including consultation with over 3,000 staff, managers, physicians, and volunteers across the region as well a number of community-based stakeholders.
- Developed Surgical Case Performance reports for city Operating Rooms. These reports support analysis and monitoring of their operations and process improvement initiatives.
- Occupational Health & Safety and Rehabilitation advanced program and policy development in a number of areas including release of the Violence Prevention, Response, and Support Policy.
- Developed a recovery management process review in an effort to reduce absenteeism and launched an Attendance Management Pilot Project in Rural Avalon Long-term Care. The organization also successfully completed the Workplace Health, Safety and Compensation Commission (WHSCC) 2012 PRIME Audits.
- Completed implementation of automated medication dispensing cabinets (Pyxis) on all inpatient nursing units at St. Clare's site. This has made access to medications for nursing more timely, has increased efficiency and provided a safer medication administration process for the patient.
- The Communications Department launched an organizational blog entitled *StoryLine*.
- Human Resources filled 3,200 positions during 2013-14 and strategies to decrease vacancy rates for some difficult-to-fill positions were proven successful (e.g. Psychology).
- A performance appraisal tool for managers and an accompanying guide and policy was developed and implemented during 2013.
- Medical Services instituted Standard Operating Procedures (SOPs) for all Medical Services activities, completed "360" performance evaluations for all physician leaders and successfully recruited a new Director of Medical Services.
- The Centre for Nursing Studies graduated 117 Bachelor of Nursing (BN) students and 38 Practical Nursing (PN) students. An additional 215 nurses were enrolled in Continuing Nursing Studies during 2013-14.
- Allied Health Professional Practice held Recognition Ceremonies in St. John's, Carbonear, Clarenville and Burin. Fifteen Allied Health staff received awards, 105 staff were recognized for professional accomplishments and contributions to their communities, and 274 staff were recognized for their work supervising students doing clinical placements.
- Nursing Professional Practice oversaw the 4th annual Awards Recognition Gala with approximately 200 nurses and guests in attendance. Eighty-four nurses were nominated for 16 awards and 94 Registered Nurses were recognized for pursuing their Canadian Nurses Association Specialty Certifications.
- Quality, Patient Safety and Risk Management, with senior leaders, held 65 "Walk-the-Talk" initiatives, to discuss safety issues with staff.

- Processed 100% of Access to Information requests within the legislated timelines.
- The Safe Patient Handling project reached full implementation phase on three pilot sites: Agnes Pratt, Golden Heights Manor and Hoyles-Escasoni. This program promotes resident and employee safety with patient/resident handling tasks while providing day to day care, and is part of a provincial project.
- Researchers from the Applied Health Research Division partnered with the Department of Health and Community Services on a review of provincial cancer screening programs and on an evaluation of the Injury Prevention Program pilot project, which is intended to reduce injuries among nursing staff in long-term care facilities.
- The Cancer Care Program implemented a new electronic health record (EHR) at the Dr. H. Bliss Murphy Cancer Centre, the ARIA® oncology information system, which integrates all aspects of oncology care.
- The Dialysis Program implemented Nephrocare®, a computerized documentation system. Eastern Health is the first care provider in Canada to achieve the interface of this system with its current electronic documentation system (Meditech).
- Health Information Services and Informatics worked with physicians using speech recognition software to dictate reports, enabling timely creation and distribution of reports and expanded scanning/digitizing of paper records in the city.
- Home and Community Care completed the Point of Care Documentation Pilot in which nurses working in various areas of Eastern Health were provided laptops to use during home visits.
- Eastern Health participated in a Provincial Data Quality Committee (PDQC) which involved a detailed review of all Management Information Systems (MIS) data quality issues.

4. Report on Performance



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 this planning period, the Board of Trustees identified four priority issues: Quality and Safety, Access, Sustainability, and Population Health.

Since 2013-14 marks the end of the planning period, this section of the report outlines both the overall progress for the three-year goals of each of the priority issues as well as the progress made towards achieving the final year's objectives (2013-14). Appendix II 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.

Eastern Health's 2011-14 Strategic Plan aligns with Government's three Strategic Directions: Population Health, Access to Priority Services, and Accountability and Stability of Health and Community Services. The various components of Eastern Health's Strategic Plan are supported through an Operational Plan as well as various work plans within individual program areas across the organization.

In keeping with the planning process, while this current Annual Performance Report was developed, Eastern Health was finalizing its next strategic plan for 2014-17. The updated plan was tabled in the House of Assembly on June 30, 2014 as per legislative requirements.

4.1. Quality and Safety

Quality and safety is a continual priority for Eastern Health. The foundation of any health organization is its commitment to quality and safety and Eastern Health has developed numerous indicators to demonstrate its progress over the last three years. In the 2011-12 Annual Performance Report Eastern Health established a number of baseline measures to which comparisons can be made for the subsequent fiscal years (2012-13 and 2013-14). Developing good data is essential to show evidence of improvement over time.

The overall three-year goal, measure, and objectives related to quality and safety are outlined in the table below:

3-Year Goal: By March 31, 2014, Eastern Health will have increased the safety and quality of its programs and services for the benefit of its patients, residents, clients, employees, physicians, volunteers and students.	
Measure: Increased quality and safety of programs and services	
2011-14 Goal Indicators as Outlined in the Strategic Plan	**2014 Summary Results**
Increased safety and quality of programs and services, as evidenced by:	Throughout the 2011-14 planning cycle, Eastern Health increased safety and quality of its programs and services, as evidenced by:
• Decreased rate of unscheduled readmission to selected services	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** • 2012-13: **3.48 per cent** • 2013-14: **3.04 per cent** 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** • 2012-13: **2.46 per cent** • 2013-14: **2.03 per cent** During 2011-14, both of these rates decreased. Eastern Health accomplished this through such means as reviewing information and identifying opportunities to decrease readmissions in specific patient populations. For example, the Medicine Leadership Team has developed a "standard of care map" to assist patients with Chronic Obstructive Pulmonary Disease (COPD) and the Mental Health and Addictions program is participating in a national indicator project that includes the comparison of readmission rates with other psychiatric hospitals across Canada.

• Decreased Alternate Level of Care days as a percentage of total patient days	Alternate Level of Care (ALC) days as a percent of total adult patient days (Medicine and Surgery only, Health Sciences Centre and St. Clare's Mercy Hospital): • 2011-12: **12.03 per cent** • 2012-13: **15.29 per cent** • 2013-14: **17.39 per cent** The ALC days as a percentage of total patient days did not improve overall between 2011 and 2014 due to a number of ongoing, complex issues that affect this indicator, such as high demands that outstrip capacity for some community services. Eastern Health continues significant work to address these issues and thereby reduce ALC days. Most notably, the organization has signed onto an initiative entitled Triple Aim through the Institute for Healthcare Improvement (IHI). This initiative includes improving documentation on ALC patients to better inform decision making and further enhance understanding of specific needs. In addition, implementation of a lean methodology entitled Real Time Demand Capacity (RTDC) has begun at HSC, which involves cross functional site teams that focus on demand and capacity as well as discharge planning. Further, Eastern Health's Executive Team and Senior Leadership completed a planning session in March 2014 that resulted in 16 patient flow recommendations for several programs and services, with each recommendation assigned Senior Leadership responsibility and deadlines. The 16 recommendations are a standing item of the St. Johns Local Medical Advisory Committee, with progress updates being provided regularly. In addition to these initiatives to address these challenges, it must be noted that the demand for and availability of long-term care beds also continues to affect ALC days within Eastern Health. Work to address the challenges associated with ALC will continue into Eastern Health's new Strategic Plan for 2014-17.
• Decreased rate of MRSA infection	Rate of MRSA infections in long-term care: • 2011-12: **0.89 infections per 10,000 patient/resident days** • 2012-13: **1.11 infections per 10,000 patient/resident days** • 2013:14: **0.75 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** • 2012-13: **5.41 infections per 10,000 patient/resident days** • 2013-14: **4.05 infections per 10,000 patient/resident days**

	The rate of MRSA infection decreased between 2011 and 2014. During this time Eastern Health put in place a number of practices to help decrease the rate. For example, a committee has developed a new Antibiotic Resistant Organisms (ARO) screening policy for all Eastern Health facilities. As well, Infection Prevention and Control is providing leadership in such areas as antibiotic stewardship (i.e. to avoid over-use of antibiotics) and staff and physician education on routine infection prevention practices.
• Increased rate of hand hygiene compliance	Rate of hand hygiene compliance: • Spring 2011 Audit: **52.6 per cent of observations practised appropriate hand hygiene** • Summer 2012 Audit: **49 per cent of observations practised appropriate hand hygiene** • Spring 2014 Audit: **45 per cent of observations practised appropriate hand hygiene** The rate of hand hygiene compliance did not increase between 2011 and 2014. This was due to a number of challenges, including continued need for staff education around particular procedures and audits. In other words, hand hygiene compliance audits occur during a particular period and the results measured (i.e. compliance rates) do not necessarily mean that health care workers do not wash their hands; rather, the audit tool measures whether health care providers are washing their hands at the right times and in the right ways for that particular period. As a result of Eastern Health's latest audit and identified challenges, the Infection Prevention and Control program developed a Regional Hand Hygiene Strategy focusing on initiatives at the local site/unit level. Implementation of the strategy has begun with the goal of improving compliance rates. For example, a detailed action plan has been drafted and a working group formed to roll out the strategy. As well, a self-auditing pilot project started in November of 2013 and results from Phase 1 of this pilot indicate a compliance rate of 62%. There are now three phases of the pilot project started, slated to be completed by April 2015. Hand Hygiene has been identified as a continued priority into the organization's Strategic Plan 2014-17.

- Improved *Safer Healthcare Now!*[8] performance measures selected by the organization

Eastern Health has put significant efforts into improving the *Safer Healthcare Now! (SHN)* performance measures that have been selected (outlined below).

Central line-associated blood stream infection rate per 1,000 central line days (Critical Care Health Sciences Centre and St. Clare's Mercy Hospital):

- 2011-12: **0.52 infections** per 1,000 central line days
- 2012-13: **1.2 infections** per 1,000 central line days
- 2013-14: **0.6 infections** per 1,000 central line days

This indicator did not improve as planned, as consistent achievement of this indicator was more complex than originally anticipated. Prevention of Central Line Associated Blood Stream Infections (CLI) is a SHN! initiative that involves an evidence-based "bundle" of interventions and compliance with all elements of the bundle is necessary to prevent infections and improve outcomes. When there is non-compliance with even one element of the bundle, the overall compliance rate falls. Eastern Health continues to educate clinicians and stress the importance of compliance to all components of the CLI bundle in a consistent and reliable manner and to focus on addressing the most significant practice gaps. Results for 2013-14 show improvement from 2012-13 but results are not as good as 2011-12. However, for all three years Eastern Health has performed better than the target of 1.30 for the Safer Healthcare Now! Initiative

Percentage of Acute Myocardial Infarction (AMI) Perfect Care:

- 2011-12 Carbonear Hospital: **69.64 per cent**
- 2011-12 Health Sciences Centre: **87.3 per cent**

Since the reporting of AMI Perfect Care in 2011-12, there has been a change in methodology making comparison from 2011-12 to 2012-13 and 2013-14 data impossible. New data is available as follows:

- 4th Quarter 2012-13 Carbonear Hospital: **69 per cent**
- 4th Quarter 2013-14 Carbonear Hospital: **51 per cent**
- June and September 2012 Health Sciences Centre: **94 per cent**
- June 2013 Health Science Centre**: 85 per cent**

This indicator did not improve as planned, as consistent achievement of this indicator was more complex than originally anticipated. Similar to the CLI indicator, AMI Perfect Care is a SHN! initiative that involves an evidence-based "bundle" of interventions and compliance with all elements of the bundle is necessary to improve patient outcomes. When there is non-compliance with even one element of the bundle, the overall compliance rate falls. Eastern Health continues to educate clinicians and stress the importance of compliance to all components of the CLI bundle

8 *Safer Healthcare Now!* is a patient safety initiative aimed at reducing preventable adverse events and deaths in Canadian hospitals (http://www.saferhealthcarenow.ca)

in a consistent and reliable manner, which includes reviewing data entry methods. It is also important to note that due to its overall success with this indicator the Health Sciences Centre has moved to a maintenance model of reporting for selected months only (i.e. less frequent reporting).

Surgical Site Infection rate per 100 procedures for C-Sections at Health Sciences Centre:

- 2011-12: **6.93 infections** per 100 procedures
- 2012-13: **5.63 infections** per 100 procedures
- 2013-14: **6.19 infections** per 100 procedures

This indicator did improve overall. Eastern Health continues to work toward consistently improving Surgical Site Infection rates for C-sections. For example, Eastern Health initiated a campaign through posters and prenatal classes asking women not to shave the abdomen and perineal area pre-delivery. Work with Infection Prevention and Control to collect data and audit cases is also ongoing.

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
- 2012-13: **16.82 infections** per 100 procedures
- 2013-14: **14.15 infections** per 100 procedures

Eastern Health improved its Surgical Site Infection rate related to Colorectal Surgery over the past three years.

Ventilator Acquired Pneumonia (VAP) 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
- 2012-13: **0.95 pneumonia** per 1,000 ICU ventilator days
- 2013-14: **2.24 pneumonia** per 1,000 ICU ventilator days

This indicator fluctuated during the past three years and therefore did not improve overall due to a number of factors. Similar to the CLI and AMI initiatives, consistent achievement of this indicator was more complex than originally anticipated since the VAP involves an evidence-based "bundle" of interventions and compliance with all elements of the bundle is necessary to prevent infections and improve outcomes. When there is non-compliance with even one element of the bundle, the overall compliance rate falls. Eastern Health continues to educate clinicians and stress the importance of compliance to all components of the VAP bundle in a consistent and reliable manner and to focus on addressing the most significant practice gaps. Eastern Health performed better than the initiative's benchmark of 3.00 for this indicator for each of these years.

• Increased rates of medication reconciliation implementation and compliance	Percentage of Medication Reconciliation **implementation**, Acute Care Inpatient Units: • March 2012: **78.57 per cent** • March 2013: **92.68 per cent** • March 2014: **100 per cent** Percentage of Medication Reconciliation **compliance** in sites where implemented Acute Care Inpatient Units: • March 2012: **39.13 per cent** • March 2013: **50.00 per cent** • March 2014: **57.5 per cent** Rates of Medication Reconciliation implementation and compliance have increased. Medication Reconciliation has been implemented across all Acute Care Inpatient Units. Positive trending of Medication Reconciliation compliance continues through such work as education sessions that reinforce the importance of processes. Support to programs now focuses on the auditing process, as the transfer of compliance audits to individual programs is 100% complete and this helps to solidify ownership of Medication Reconciliation within each program. Compliance will continue to be monitored in the 2014-17 Strategic Plan.
• Decreased Workers' Compensation hours per Full Time Equivalent position (FTE)	Workers' Compensation hours per full-time equivalent (FTE): • 4th Quarter 2011-12: **12.07 hours** • 4th Quarter 2012-13: **11.41 hours** • 4th Quarter 2013-14: **11.39 hours** Eastern Health decreased Workers' Compensation hours per Full Time Equivalent during 2011-14 by working with the Workplace Health Safety and Compensation Commission (WHSCC) to return employees to work once medically cleared by WHSCC. The medical management of employees once off work is under full management of WHSCC; thus, Eastern Health does not become involved until employees are cleared to return to work. A working group has been developed to look at reducing any delays within Eastern Health's scope of responsibility. There are also monthly case conferences between WHSCC and Eastern Health and a joint planning day is scheduled for the upcoming fiscal year in an attempt to improve understanding of all parties involved in the processes within both organizations.

• Decreased lost time incident rate	Employee lost time incident rate: • 4th Quarter 2011-12: **1.54** • 4th Quarter 2012-13: **1.72** • 4th Quarter 2013-14: **1.58** Eastern Health's lost time incident rate did not decrease between 2011 and 2014. Analysis of lost time incidents reveals that approximately 40% are due to patient handling. Eastern Health has prioritized safe patient handling, including through a pilot project in three sites that have high rates of injuries. Additional initiatives entail education to staff on incident/accident reporting, hazard assessments, violence prevention and prevention of slips/trips/falls.
• Decreased median duration of Workers' Compensation claims	The median duration of Workers' Compensation claims was not available for 2011-12, as it was previously measured as an average. The median calculation better reflects the duration of claim (in weeks). Median duration of Workers' Compensation claims: • 2012-13: **8.71 weeks** • 2013-14: **5.86 weeks** The median duration of Workers' Compensation claims decreased over the previous fiscal year. Eastern Health continues to work with WHSCC to return employees to work once medically cleared by that organization. As noted above, the medical management of employees once off work is under full management of WHSCC and Eastern Health does not become involved until employees are cleared to return. A working group is in place to examine ways to reduce any delays within Eastern Health's scope of responsibility and there are monthly case conferences with WHSCC.

Discussion of Results for 2011-14 Overall

During the course of the 2011-14 planning cycle Eastern Health made significant strides toward its goal of increasing the safety and quality of its programs and services for the benefit of its patients, residents, clients, employees, physicians, volunteers and students. There have been major improvements in terms of foundational pieces – such as increasing education and awareness on infection prevention and control procedures – that support the ongoing work over the long term and help to reinforce an overall culture of quality and safety throughout the organization.

A signification aspect of strengthening the culture of quality and safety also involves improving data collection, analysis, monitoring and reporting on progress. Since 2011, Eastern Health has put tremendous effort into improving all aspects of data management and monitoring to identify baseline measures and benchmarks to work toward and/or maintain. In particular, scorecards of key performance indicators have been developed for various programs and services, including a quarterly scorecard for the Board of Trustees that outlines all of the indicators in the Strategic Plan.

Furthermore, Eastern Health has demonstrated its commitment to quality and safety by increasing its auditing practices and openly reporting on results. Hand hygiene is a key area example whereby regular audits provide opportunities for continuous learning and improvement as the organization strives to meet national standards. Since 2011, the organization has also well established its Clinical Safety Reporting System (CSRS) for electronic reporting of occurrences. This system plays a key role in reinforcing a culture of reporting and, again, supports continuous learning and improvement.

Eastern Health's strategic issue of Quality and Safety aligns with the Provincial Government's Strategic Direction of *Accountability and Stability of Health and Community Services*. This focus on quality and safety will continue into the next strategic plan for 2014-17.

For the 2013-14 fiscal year, the third-year objective, measure and indicators are outlined in the table that follows:

2013-14 Objective: By March 31, 2014, Eastern Health will have demonstrated effectiveness of its Safety Plan and further established regular clinic audits in all clinical programs.	
Measure: Demonstrated effectiveness of Safety Plan and further established clinical audits	
Indicators Outlined for 2013-14	**Actual Performance for 2013-14[9]**
Demonstrated effectiveness of Safety Plan as evidenced by the following measures:	During 2013-14 Eastern Health demonstrated effectiveness of its Safety Plan, as evidenced by the following measures:
• Increased reporting of occurrences, close calls, occurrences not resulting in harm to the client, and occurrences resulting in harm to the client (adverse events).	Since the number of occurrences in an organization can fluctuate from year to year, data is not comparable from one year to the next and Eastern Health must focus on *percentages* to determine whether reporting is increasing over time. There were 16,497 occurrences reported during the 2013-2014 fiscal year, 15,925 (97%) of which have been investigated and closed.[10] **Closed Occurrences**[11] While Eastern Health continues to encourage reporting of occurrences, the degree to which clients experience harm is a key indicator for clinical safety; to *decrease* the number of adverse events that result in harm while *increasing* the reporting of close calls. During the fiscal year, the closed occurrences indicate: • 13% of closed occurrences were close calls or not client related, in other words they did not reach a client (a 2% increase compared with the previous year);

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

10 The above results include occurrences which were reported during the 2013-14 fiscal year but closed by April 21, 2014. This was done to give occurrences reported near the end of the year time to be investigated and closed. This data is current as of April 21, 2014.

11 A closed occurrence is an occurrence that has been investigated and coded. Some occurrences require follow up actions to be identified and an action plan developed to address them.

	• 73% of occurrences did not result in harm to the client (a 2% decrease from the previous year due to the nature of the occurrences); • 14% of occurrences resulted in harm to the client (the same percent as the previous year, due to the nature of the occurrences). Of those, 97% were considered minor/temporary harm and included incidents such as abrasions.
• Decreased readmission to selected services.	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) for 2013-14: **3.04 per cent** (compared with 3.48 percent for the previous year). 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) for 2013-14: **2.03 per cent** (compared to 2.46 per cent the previous year) Both of these rates decreased in 2013-14 in comparison to the previous year. Examples of Eastern Health's initiatives to reduce readmissions are outlined in the three-year results section.
• Decreased Alternate Level of Care Days as a percentage of total patient days.	Alternate Level of Care (ALC) days as a percent of total adult patient days (Medicine and Surgery only, Health Sciences Centre and St. Clare's Mercy Hospital) for 2013-14: **17.39 per cent** (as compared to 15.29 the previous year). This indicator did not decrease in comparison to previous years; however, as noted in the three-year results section, this is due to a number of ongoing, complex issues such as demands that outstrip capacity for some community services. In addition, ongoing demands for long-term care beds also affect ALC. Eastern Health continues to implement a number of initiatives to address these issues and thereby reduce ALC days, which also carry into the new Strategic Plan 2014-17
• Decreased rate of Methicillin-Resistant *Staphylococcus Aureus (*MRSA) infection.	Rate of MRSA infections in long-term care for 2013:14: **0.75 infections per 10,000 patient/resident days** (compared with 1.11 the previous year). Rate of new MRSA infections in acute care, health care associated infections for 10,000 patient days (excluding Janeway) for 2013-14: **4.05 infections per 10,000 patient/resident days** (compared with 5.41 the previous year) The rate of MRSA infection decreased between 2011 and 2014, mainly due to a number of practices put in place by Eastern Health (see three-year results section for details).

• Increased hand hygiene compliance.	The latest Hand Hygiene Audit (Spring 2014) result was: **45 per cent of observations practised appropriate hand hygiene** (compared to 49 per cent the previous year) As indicated in the three-year results section, Eastern Health's latest Hand Hygiene Audit did not see compliance increasing from previous years due to a number challenges, including education around particular procedures and audits. For example, hand hygiene compliance audits occur during a particular period. The compliance rate does not necessarily mean that health care workers do not wash their hands; rather, the audit tool measures whether health care providers are washing their hands at the right times and in the right ways for that particular period. Significant work continues to address identified challenges and Hand Hygiene remains a priority in Eastern Health's Strategic Plan 2014-17.
• Improved *Safer Health Care Now!* Performance measures selected by the organization.	Central line-associated blood stream infection rate per 1,000 central line days (Critical Care Health Sciences Centre and St. Clare's Mercy Hospital) for 2013-14: **0.6 infections** per 1,000 central line days. This improved from 1.2 the previous year, as planned. Percentage of Acute Myocardial Infarction (AMI) Perfect Care: • 4th Quarter 2013-14 Carbonear Hospital: **51 per cent** • June 2013 Health Science Centre**: 85 per cent** As indicated in the three-year results section, this indicator did not improve as planned, as consistent achievement of this indicator was more complex than originally anticipated. Similar to the CLI indicator, AMI Perfect Care is a SHN! initiative that involves an evidence-based "bundle" of interventions and compliance with all elements of the bundle is necessary to improve patient outcomes. When there is non-compliance with even one element of the bundle, the overall compliance rate falls. Eastern Health continues to educate clinicians and stress the importance of compliance to all components of the CLI bundle in a consistent and reliable manner, which includes reviewing data entry methods. As well, it is important to note that due to its overall success with this indicator the Health Sciences Centre has moved to a maintenance model of reporting for selected months only (i.e. less frequent reporting). Surgical Site Infection rate per 100 procedures for C-Sections at Health Sciences Centre for 2013-14: **6.19 infections** per 100 procedures. This is not an improvement over the previous fiscal year; however, Eastern Health continues to work toward addressing challenges (e.g. upgrading of the cleaning and measures in the Delivery Room to Operating Room standards).

	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 for 2013-14: 14.15 infections per 100 procedures, which was an improvement over the previous year when the rate was 16.82 infections per 100 procedures. Eastern Health continues to work toward improving Surgical Site Infection rates. As indicated in the three-year results section, this indicator fluctuated during the past three years and therefore did not improve overall due to a number of factors. Similar to the AMI and CLI indicators, consistent achievement of this indicator was more complex than originally anticipated since the VAP involves an evidence-based "bundle" of interventions and compliance with all elements of the bundle is necessary to prevent infections and improve outcomes. When there is non-compliance with even one element of the bundle, the overall compliance rate falls. Eastern Health continues to educate clinicians and stress the importance of compliance to all components of the VAP bundle. Eastern Health performed better than the initiative's benchmark of 3.00 for this indicator for each of these years.
• Increased rate of implementation of Medication Reconciliation across the region.	Percentage of Medication Reconciliation **implementation**, Acute Care Inpatient Units: March 2014: **100 per cent** (compared to 92.68 per cent the previous year) The rate of implementation of Medication Reconciliation increased over previous years and has now been implemented across all Acute Care Inpatient Units.
• Decreased Worker's Compensation hours per full-time equivalent position (FTE).	Workers' Compensation hours per full-time equivalent (FTE): 4th Quarter 2013-14: **11.39 hours** (compared with 11.41 the previous year). The median duration of Workers' Compensation claims decreased over the previous fiscal year. Eastern Health continues to work with WHSCC to return employees to work once medically cleared by that organization. Additional details are provided in the three-year results section.
• Decreased lost time incident rate.	For 4th Quarter 2013-14 the lost time incident rate was **1.58** (compared with 1.72 the previous year). This decreased as planned; see the three-year results section for additional details.
• Decreased median duration of Workers' Compensation claims.	The median duration of Workers' Compensation claims for 2013-14 was **5.86 weeks**, which is a decrease from 2012-13 when it was 8.71 weeks. Work continues in this area as noted in the three-year results section.

Further established regular clinical audits as demonstrated by :

• Developed audit tools and processes as supported by programs such as Nursing Professional Practice and Allied Health Professional Practice.	During 2013-14 Eastern Health developed audit tools and processes as supported by programs such as Nursing Professional Practice and Allied Health Professional Practice. Examples include: • Nursing Professional Practice partnered with Quality, Patient Safety and Risk Management to conduct an audit of medication administration practices of nurses. This audit focuses specifically on the Positive Identification of Patients (PIP) prior to medication administration. • The Cardiac/Critical Care Program has developed an audit tool for all critical care units in city hospitals focusing on topics such as: sedation/ analgesia/delirium and pressure ulcer prevention. Audits are completed on a regular basis in all Critical Care units in city hospitals. Tools have been drafted for Dr. G. B. Cross Memorial Hospital and Carbonear General Hospital but have not been fully implemented to date. • A standardized documentation audit tool has been developed for all Allied Health disciplines and a documentation audit policy revised to be consistent with the new approach. To date, audits have been completed within Occupational Therapy, Therapeutic Recreation and Physiotherapy. • Respiratory Therapy has developed draft clinical audit tools for high volume practices to audit compliance with best practice standards, such as Arterial Blood Gas Sampling.

Discussion of Results for 2013-14

The Safety Plan and clinical audits were the main aspects of Eastern Health's focus on quality and safety during 2013-14. The reporting of occurrences was consistent over the previous year, including the reporting of close calls, which indicates that the culture of reporting is being reinforced. This is important because research indicates that organizations that report more occurrences usually have a more effective safety culture. Eastern Health encourages such reporting as a way of continually learning and improving.

The organization has also made progress in terms of developing audit tools and processes, particularly for Nursing and Allied Health, as noted in the examples provided. Medical Services also strengthened its focus on quality and safety during 2013-14, such as reviewing data in its Quality Indicator Report and monitoring compliance to the chart completion policy.

As outlined in the three-year update, positive trending of Medication Reconciliation compliance continues across sites and is included in the 2014-17 Strategic Plan.

4.2. Access

Access to clinical health services is a significant issue for Eastern Health. Patients, clients and residents want timely access to programs and services and health providers want the same thing to ensure positive outcomes for those they serve.

This Regional Health Authority serves a very diverse and geographically-dispersed population. High rates of chronic disease, an aging population and increased levels of acuity all combine to put increased pressure on waitlists and wait times within the health sector.

Throughout this planning cycle, Eastern Health has worked closely with the Department of Health and Community Services and other stakeholders to establish and meet appropriate wait time targets. Research also helps determine acceptable wait times, and the use of evidence assists decision makers, health care providers and clients to understand the complexities associated with access to priority health care services.

During 2011-12, Eastern Health established a number of baseline wait times in addition to those that have been determined as per the Federal/Provincial/Territorial agreement with the Department of Health and Community Services in 2005. Since that time, numerous strategies and initiatives have been undertaken to meet, exceed and/or maintain benchmarks.

It is important to note that it is not possible to compare 2011-12 surgery wait times to future years since the reporting methodology changed for a number of procedures. While all patients are included in the volumes of cases completed, calculations for wait times no longer include patients who had inactive wait times, such as periods of time when they were out of the province. The impact on comparing previously-reported wait times may vary according to surgery type, volume of emergency cases and volume of waitlist patients who had a period of inactive wait times.

The overall three-year goal, measure, and objectives related to access are outlined in the table below:

3-Year Goal: By March 31, 2014, Eastern Health will have improved access to identified programs and services.	
Measure: Improved access	
2011-14 Goal Indicators as Outlined in the Strategic Plan	**2014 Summary Results**
Improved access in the following identified areas:	During the 2011-14 planning cycle Eastern Health improved access in the following identified areas:
• Decreased wait time for access to long-term care beds	Manual data collection to measure wait times for access to long-term care beds took longer to compile than anticipated; thus there is no data available for the 2011-12 fiscal year. Residents' median wait time (in days) for urgent long-term care placement (regional) for subsequent years is as follows: • March 2013: **23 days** • March 2014: **15 days**

	This wait time has decreased based on a number of initiatives: • A computerized waitlist management system was developed and implemented, a vast improvement over manual data collection. • A process improvement initiative commenced, which included such aspects as "process mapping" to identify areas for improvement in the placement process. • A waitlist management policy was implemented and the waitlist updated to ensure that it complies with the policy (e.g. clients not ready for placement were removed from the list).
• Decreased wait time for non-urgent primary mental health and addictions	Average wait time in days for Priority 3 patients (scheduled/elective) to access Adult Primary Mental Health and Addictions services (excludes child and adolescent specific clinics): • 4th Quarter 2011-12 (Regional): **176.10 days** • 4th Quarter 2012-13 (Regional): **175.5 days** • 4th Quarter 2013-14 (Regional): **211.9 days** Wait times for non-urgent primary mental health and addictions have not decreased, as the various initiatives to improve wait times have taken longer than originally anticipated. Efforts continue in an attempt to consistently reduce the wait time for non-urgent primary mental health and addictions, which include the following: • Waitlist reviews have been completed for all services. • A number of new therapy groups have been introduced that enable more timely access to services. • A brief intervention option (The Change Clinic) has been introduced at most of the community services offering individuals more timely access to service. • The plan to introduce Central Intake in the adult system is based on Eastern Health's experience with it in the children's system as well as the feedback from the public about the need for one phone number as a point of contact. Thus, it is anticipated that Central Intake will provide one point of contact for our primary mental health and addictions services, reduce any duplication in referrals and streamline referrals to the most appropriate service. The major challenge is ensuring timely and accurate wait time data given the current unavailability of electronic wait time reports. Plans are in place to improve this with the recent implementation of Community Wide Scheduling, which is a centralized booking process via Eastern Health's Meditech software.

• Decreased wait time for specialists (non-urgent orthopaedics, 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** • March 2013: **81.50 days** • March 2014: **47.00 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 days** • March 2013: **269 days**[12] • March 2014: **123 days** Wait times for Orthopedics Specialists have decreased based on a number of changes during 2011-14. Notably, the implementation of Orthopedic Central Intake has resulted in patient referrals being screened and triaged for appropriateness and acuity and then prioritized for booking. This initiative continues to demonstrate sustained reductions in wait times for all orthopedic patients. Urgent priority I patients seen by Rheumatology Specialists within 30 days: • 4th quarter 2011-12: **11.10 per cent** • 4th Quarter 2012-13: **13.7 per cent** • 4th Quarter 2013:14: **13.9 per cent** The percentage of urgent priority I patients seen by Rheumatology Specialists within 30 days did increase, meaning that more patients were able to be seen and therefore the wait time did improve slightly between 2011-14. A number of initiatives are in place to continue addressing wait times within Rheumatology, as demand continues to be very high for this service. In particular, an interdisciplinary team was implemented, which includes a Nurse Practitioner, Physiotherapist and Occupational Therapist in addition to the physician. This approach involves increasing patient knowledge through a complete education/treatment program and assisting in overall improvement of chronic disease management. The strategies of empowering patients and offering access to various experts on the team are anticipated to improve wait times to the overall program. Obtaining wait time data through Community Wide Scheduling for the Mental Health and Addictions program took longer than anticipated; therefore, there is no data available for psychiatry 2011-14 timeframe.

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

	Plans have been developed for Adult Central Intake whereby psychiatry referrals will be centralized, thus improving waitlist management (e.g. through recognizing priority levels of referrals). As well, in preparation of the implementation of Adult Central Intake during 2014-17, a Psychiatric Nurse has been assigned temporarily to a waitlist project to review the current waitlist and help determine the status of patients on the list.
• Decreased 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** • March 2013: **4.88 months** • March 2014: **1.88 months** Throughout the three-year period of 2011-14, Audiology significantly decreased wait times based on a number of changes in practice. For example, reminder phone calls to patients two to three days before their appointments helped to reduce the number of "no-shows". As well, a training course was offered for the Audiologists in Electronystagmography (ENG) testing (i.e. special balance testing as a result of problems in the inner ear), thereby increasing capacity to perform such testing. Obtaining wait time data for other therapeutic outpatient, community-based supports (non-urgent) for the period of 2011-14 was more complex than originally anticipated; however, significant efforts have made towards improving data collection and management. This work will continue through both operational planning and development of additional scorecards of key performance indicators in a number of program areas. For example, further development of Community Wide Scheduling and waitlist reporting in Cognos software are helping Eastern Health's programs to manage performance, analyse capacity and implement process improvement initiatives.
• Decreased wait time for knee replacement	Percentage of Knee Replacements completed within benchmark of 182 days (city sites only): • 2011-12: **44 per cent** • 2012-13: **74 per cent** • 2013-14: **93 per cent** Eastern Health has decreased wait times for knee replacements since 2011. The organization is involved in the Provincial Government's Wait Time Strategy and related initiatives to decrease wait times for knee replacement surgeries. Orthopedic Central Intake (mentioned above) has had the main impact on wait times for knee replacements; in addition, two new orthopedic surgeons were hired during 2013.

• Decreased wait time for hip replacement	Percentage of Hip Replacements completed within benchmark of 182 days (city only): • 2011-12: **71 per cent** • 2012-13: **80 per cent** • 2013-14: **92 per cent** Similar to knee replacement surgeries, wait times for hip replacements have decreased since 2011 as a result of various initiatives. In addition to Orthopedic Central Intake, discussions and plans have begun to identify and address those patients who have waited the longest for hip replacement surgery.
• Decreased wait time for hip fracture surgery	Percentage of Hip Fracture surgeries completed within benchmark of 48 hours (city only): • 2011-12: **85 per cent** • 2012-13: **82.3 per cent** • 2013-14: **80.1 per cent** During 2011-14 the wait time for hip fracture surgery did not decrease due to a number of challenges. While this procedure is considered an emergency surgery, many factors influence the ability to complete the surgery as per the benchmark. For example, another emergency surgery might take priority. As well, fractured hips as a result of trauma are treated only at the HSC site, which may result in delays related to patient transfers. Eastern Health has been working to decrease wait times for hip fracture surgeries, particularly by way of implementing best practices identified by a national initiative, Bone and Joint Canada, to optimize the surgical management of patients with fractured hips. This includes characterizing hip fracture patients through a priority classification system for timely procedures.
• Decreased wait time for cataract surgery (for patients who are at high risk)	Percentage of Cataract Surgeries completed within benchmark of 112 days, for patients who are at high risk (local anaesthetic, first eye only; city only): • 2011-12: **65 per cent** • 2012-13: **73.5 per cent** • 2013-14: **80.7 per cent** This wait time decreased between 2011 and 2014. Eastern Health continues to address issues identified to ensure regular service and decrease wait times, particularly by actively addressing staff sick leave to avoid surgery cancellations.

• Decreased 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): • 2011-12: **100 per cent** • 2012-13: **100 per cent** • 2013-14: **100 per cent** Wait time for Coronary Artery Bypass Grafts (CABG) surgeries was met consistently for the duration of 2011-14; therefore the wait time did not decrease but stayed the same in keeping with the benchmark for this procedure.
• Decreased 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): • 2011-12: **96 per cent** • 2012-13: **96.4 per cent** • 2013-14: **97.9 per cent** Eastern Health's wait times for cancer treatment have decreased over the 2011-14 timeframe.
• Decreased wait time for breast, bladder, colorectal, lung, and prostate cancer surgeries	Percentage of Breast Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only): • 2011-12: **79.1 per cent** • 2012-13: **69.0 per cent** • 2013-14: **80 per cent** Percentage of Bladder Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only): • 2011-12: **57.7 per cent** • 2012-13: **46.1 per cent** • 2013-14: **45.1 per cent** The wait times for bladder cancer surgeries have fluctuated for the duration of 2011-14 and therefore not decreased overall. This is due to a number of factors, including the need for additional surgeons. An aggressive physician recruitment strategy has been developed and implementation has been progressing for this service. Two further surgeons are expected to start work during the 2014-15 fiscal year, for a total of eight. As well, a central intake model is being explored to augment efficiencies in this division. Percentage of Colorectal Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only): • 2011-12: **75.1 per cent** • 2012-13: **68.5 per cent** • 2013-14: **77.9 per cent**

	Percentage of Lung Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only): • 2011-12: **56.5 per cent** • 2012-13: **59.3 per cent** • 2013-14: **72.3 per cent** Percentage of Prostate Cancer Surgeries completed within 42 days as per internal Eastern Health target (city only): • 2011-12: **68.2 per cent** • 2012-13: **63.6 per cent** • 2013-14: **73.2 per cent**
• Decreased wait time for Diagnostics (Magnetic Resonance Imagine [MRI], Computerized Axial Tomography [CT], Ultrasound, Endoscopy, Cardiac Echocardiogram)	Percentage of MRIs completed within 30 days - Non Urgent (city only): • 2011-12: **4.55 per cent** • 2012-13: **18.65 per cent** • 2013-14: **26.09 per cent** Percentage of CTs completed within 30 days - Non Urgent (Regional): • 2011-12: **59.93 per cent** • 2012-13: **64.55 per cent** • 2013-14: **76.86 per cent** Percentage of Ultrasounds completed within 30 days - Non Urgent (excludes Obstetrics and echocardiograms) (Regional): • 2011-12: **20.72 per cent** • 2012-13: **27.64 per cent** • 2013-14: **19.36 per cent** The wait time for Ultrasounds completed within 30 days (Non Urgent) did not decrease during 2011-14 due to increasing demands for this service across the region. In response, Eastern Health developed and implemented a number of initiatives to address Diagnostic Imaging wait times based on the Provincial Government's urgency categories. Examples include restructuring the daily exam scheduling template and establishing daily exam targets per technologist to increase capacity and increase exam volumes. Considerable effort was also put toward capturing reliable data on the number of patients who do not present for their scheduled exam and attempting to reduce no-shows through reminder calls to patients prior to their appointments. In addition, a third MRI system began at St. Clare's, thereby increasing capacity. Percentage of non-urgent (Priority 2) Endoscopies completed within 60 days, city only, fiscal annual data: • 2011-12: **49.34 per cent** • 2012-13: **39.17 per cent** • 2013-14: **26.05 per cent**

The wait time for endoscopies did not decrease between 2011-14 due to increasing demand. Eastern Health continues to implement a number of initiatives in an effort to decrease Endoscopy wait times, including the implementation of an Action Plan developed by the regional Endoscopy Committee. Examples entail a waitlist review of over 11,000 patients, the development of pathways for urgent cases and increasing capacity through redevelopment at St. Clare's.

Average wait time in days for non-urgent Cardiac Echocardiograms (Cardiac Program only):

- 4th Quarter 2011-12: **177 days**
- 4th Quarter 2012-13: **282 days**
- 4th Quarter 2013-14: **109 days**

There are a number of reasons for the reduced wait time for non-urgent Cardiac Echocardiograms (Cardiac Program only) during this three-year period:

- All Echo-sonographer positions were filled as of 2013, thus stabilizing staffing with four full-time positions.
- Renovations of the new Echocardiogram space were completed in 2013-14, which can now accommodate a third Echocardiogram machine.
- Work has begun toward addressing issues with the methods for measuring wait times for this service. For example, data entry for a "custom-defined screen" in Community Wide Scheduling is a specific screen for this program that includes such features as urgency ratings to help improve scheduling.

- Improved rate of patients who left without being seen in the Emergency Room

Rate of Emergency Department patients who left the Emergency Department without being seen by a physician (Regional):

- 2011-12: **4.40 per cent**
- 2012-13: **4.72 per cent**
- 2013-14: **5.40 per cent**

For the duration of 2011-14 this rate did not improve due to a number of ongoing challenges such as patient flow (e.g., lack of bed availability at various sites) and a vacant Nurse Practitioner position for a period of time at one site. However, there have been considerable efforts put toward addressing identified challenges for the Emergency program.
For instance, Eastern Health has worked with a consultant to adjust staffing levels to match capacity and demand, which resulted in additional Nurse Practitioner and Physician hours added at the Health Sciences and St. Clare's.

In addition, a "lean team" has been formed for the Health Sciences Centre consisting of clinical staff, support staff, and leadership to improve processes in the Emergency Department. As well, Eastern Health contracted with the Newfoundland and Labrador HealthLine to provide follow-up to patients who leave without being seen and who have been triaged as urgent or emergent (for whom there may be some risk).

Given the on-going challenges with wait times in the Emergency Department, Eastern Health has included this as a priority to carry over into its next Strategic Plan for 2014-17. Thus, the organization can build on the initiatives implemented to date to address the challenges and work toward continuously improving wait times.

Discussion of Results for 2011-14 Overall

The period between 2011 and 2014 was significant for Eastern Health in terms of developing baseline measures and striving to meet and/or maintain benchmarks related to wait times. Enormous efforts were put into improving access by identifying barriers and working collaboratively across programs to identify solutions. Monitoring access indicators helps Eastern Health track progress over time and determine whether strategies implemented are as effective as planned.

There are many examples of process improvements and data analysis that took place throughout the organization in an effort to achieve the goal of improved access to programs and services during this three-year planning cycle. In particular, Eastern Health's Wait Time Strategy, led through the Clinical Efficiency program in collaboration with the Provincial Government, focused on improving patient access to appropriate services, improving the efficiency of resource utilization across the continuum and implementing waitlist management systems across various program areas. The progress made in this area is in line with government's Strategic Direction: *Access to Priority Services.*

While the majority of initiatives took place in acute care, during this three-year timeframe progress was also made in long-term care and community services. Eastern Health will continue to have a focus on access in its Strategic Plan 2014-17 to build on the momentum gained thus far.

Report on Performance - Access

For the 2013-14 fiscal year, the specific third-year objective, measure and indicators related to access are outlined as follows:

2013-14 Objective: By March 31, 2014, Eastern Health will have monitored strategies toward meeting and/or exceeding national benchmarks where they exist..	
Measure: Strategies Monitored	
Indicators Outlined for 2013-14	**Actual Performance for 2013-14**
Monitored strategies toward meeting and/or exceeding national benchmarks where they exist, as evidenced by:	For the one-year period of 2013-14, Eastern Health monitored strategies toward meeting and/or exceeding national benchmarks where they exist, as evidenced by:
• Decreased wait time for access to long-term care beds	Residents' median wait time (in days) for urgent long-term care placement (regional) for March 2014 was **15 days**, as compared to 23 days during the previous year. Details on this indicator are outlined in the three-year results section for 2011-14.
• Decreased 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) for 4th Quarter 2013-14 (Regional): **211.9 days** (compared with 175.5 days the previous year). Wait times for non-urgent primary mental health and addictions have not decreased, as the various initiatives to improve wait times have taken longer than originally anticipated. Efforts continue in an attempt to consistently reduce the wait time for non-urgent primary mental health and addictions, as outlined in the three-year results section.
• Decreased wait time for specialists (non-urgent orthopaedics and urgent rheumatology)	Orthopedics Specialists Median Wait-Time-One (family physician request to initial specialist assessment) for priority 1 and 2 patients within target for March 2014: **47.00 days** (compared with 81.50 days in the previous year). Orthopedics Specialists Median Wait-Time-One (family physician request to initial specialist assessment) for priority 3 and 4 patients within target for March 2014: **123 days** (compared with 269 days the previous year) Both of these wait times have significantly decreased over the previous years, due mainly to the implementation of Orthopedic Central Intake (described in the three-year results section). Urgent priority I patients seen by Rheumatology Specialists within 30 days for 4th Quarter 2013:14: **13.9 per cent** (compared with 13.7 percent with previous year)

	Although the wait time for urgent rheumatology did not decrease from the previous year, mainly due to high demand and limited capacity for this service, a number of initiatives are in place to continue addressing this issue (see three-year results section for details).
• Established baseline wait time for psychiatry	As pointed out in the three-year performance section, obtaining wait time data on Mental Health and Addictions took longer than anticipated; therefore, there is no data available for 2013-14. Examples of work to address wait times are also included in that section.
• Decreased 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 2014: **1.88 months** (compared to 4.88 the previous year). Audiology has significantly decreased wait times. Additional detail is provided in the three-year results section. Obtaining wait time data for other therapeutic outpatient, community-based supports (non-urgent) has been more complex than originally anticipated. Additional detail is provided in the three-year results section.
• Decreased wait time for knee replacement	Knee Replacements completed within benchmark of 182 days (city only) in 2013-14: **93 per cent** (compared with 74 percent the previous year). This decreased wait time was a significant improvement over the previous two years. This is mainly due to Orthopedic Central Intake (mentioned above) and the addition of two new orthopedic surgeons during 2013.
• Decreased wait time for hip replacement	Hip Replacements completed within benchmark of 182 days (city only) for 2013-14: **92 per cent** (compared to 80 per cent the previous year) Similar to knee replacement surgeries (mentioned above), wait times for hip replacements have greatly decreased since 2011, due in large part to Orthopedic Central Intake and additional surgeons.
• Decreased wait time for hip fracture surgery	Hip Fracture surgeries completed within benchmark of 48 hours (city only) for 2013-14: **80.1 per cent** (compared with 82.3 percent the previous year). The wait time for hip fracture surgery did not decrease from the previous year due to a number of challenges. As pointed out above, while this procedure is considered an emergency surgery, many factors influence the ability to complete the surgery as per the benchmark. For example, another emergency surgery might take priority. As well, fractured hips as a result of trauma are treated only at the HSC site, which may result in delays related to patient transfers.

	Eastern Health has been working to decrease wait times for hip fracture surgeries, particularly by way of implementing best practices identified by a national initiative, Bone and Joint Canada, to optimize the surgical management of patients with fractured hips. This includes characterizing hip fracture patients through a priority classification system for timely procedures.
• Decreased wait time for cataract surgery (for patients who are at high risk)	Percentage of Cataract Surgeries completed within benchmark of 112 days, for patients who are at high risk (local anaesthetic, first eye only; city only) for 2013-14: **80.7 per cent** (compared with 73.5 per cent the previous year). This wait time decreased from the previous two years. Eastern Health continues to address issues identified to ensure regular service and decrease wait times (e.g. actively addressing staff sick leave to avoid surgery cancellations).
• Decreased 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) for 2013-14: **100 per cent** (the same as the previous year) As indicated in the three-year results section, wait time for Coronary Artery Bypass Grafts (CABG) surgeries was met consistently for the duration of 2011-14; therefore the wait time did not decrease but stayed the same in keeping with the benchmark for this procedure.
• Decreased 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) for 2013-14: **97.9 per cent** (compared with 96.4 per cent the previous year). This wait time decreased in comparison to the two previous years.
• Decreased wait time for breast, bladder, colorectal, lung, and prostate cancer surgeries	Percentage of Breast Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only) for 2013-14: **80 per cent** (compared to 69.0 per cent the previous year). Percentage of Bladder Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only) for 2013-14: **45.1 per cent** (compared to 46.1 per cent the previous year; see three-year results section for details). Percentage of Colorectal Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only) for 2013-14: **77.9 per cent** (compared to 68.5 per cent the previous year). Percentage of Lung Cancer Surgeries completed within 21 days as per internal Eastern Health target (city only) for 2013-14: **72.3 per cent** (compared to 59.3 per cent the previous year).

	Percentage of Prostate Cancer Surgeries completed within 42 days as per internal Eastern Health target (city only) for 2013-14: **73.2 per cent** (compared to 63.6 per cent the previous year). Additional detail is provided in the three-year results section.
• Decreased wait time for Diagnostics (Magnetic Resonance Imagine [MRI], Computerized Axial Tomography [CT], Ultrasound, Endoscopy, Cardiac Echocardiogram)	Percentage of MRIs completed within 30 days - Non Urgent (city only) for 2013-14: **26.09 per cent** (compared with 18.65 per cent the previous year). Percentage of CTs completed within 30 days - Non Urgent (Regional) for 2013-14: **76.86 per cent** (compared to 64.55 per cent the previous year). Percentage of Ultrasounds completed within 30 days - Non Urgent (excludes Obstetrics and echocardiograms) (Regional): for 2013-14: **19.36 per cent** (compared to 27.64 per cent the previous year). As pointed out previously, the wait time for Ultrasounds completed within 30 days (Non Urgent) did not decrease during 2011-14 due to increasing demands for this service across the region. Additional details are outlined in the three-year results section. Percentage of non-urgent (Priority 2) Endoscopies completed within 60 days, city only, fiscal annual data for 2013-14: **26.05 per cent** (compared to 39.17 percent the previous year). As pointed out above, the wait time for endoscopies did not decrease due to demand exceeding capacity. Eastern Health continues to implement a number of initiatives in an effort to decrease Endoscopy wait times, such as implementing an Action Plan developed by the regional Endoscopy Committee (see three-year results section above for details). Average wait time in days for non-urgent Cardiac Echocardiograms (Cardiac Program only) 4th Quarter 2013-14: **109 days** (compared to 282 days the previous year). This wait time decreased significantly over previous years (see three-year results section for details).
• Decreased rate of patients who left without being seen in the Emergency Room	Percentage of Emergency Department patients who left the Emergency Department without being seen by a physician (Regional) 2013-14: **5.40 per cent** (compared to 4.72 per cent the previous year) As pointed out in the description of the three-year indicators, the rate of patients who left without being see by a physician did not decrease over the past year due to a number of ongoing challenges such as lack of bed availability throughout acute care sites and a temporary Nurse Practitioner vacancy. However, considerable efforts have been put in place to address identified challenges. For example, during 2013-14 a Rapid Assessment

	Zone was implemented at the Emergency Department at the Health Sciences Centre and an evaluation of this initiative is already planned. Eastern Health has identified Emergency Department wait times in its next Strategic Plan for 2014-17.

Discussion of Results for 2013-14

During this past year Eastern Health continued its focus on access through monitoring strategies in an effort to meet and/or exceed wait time benchmarks. In addition to the examples provided, the surgical services leadership team performed an entire utilization review of each individual surgical service using utilization data such as wait times, cases performed and bumped lists to determine the efficiency of the ORs from a service-specific demand perspective. With the hiring of new surgeons, combined with the consistent change in technology and standards of care, the services provided by the OR are always evolving and each specific service must ensure it has the required time allotments based on current data.

At the same time, with the focus of improving patient care through lean quality improvement processes, multiple frontline unit and site teams were initiated. The teams have used the lean principles of activities, connections, pathways and continuous improvement to foster team growth, break down inter-departmental and system silos and take ownership in leading system change. Two such initiatives being led by staff are targeting earlier patient discharge times and improvement of the transportation process for patients being discharged. These initiatives, even in their infancy, are having an impact on improving patient flow through the Post Op Recovery Room and the Emergency department, as well as having a positive impact on bed cleaning turnaround times. These improvements positively impact on patients to receive timely, appropriate care.

4.3. Sustainability

Eastern Health recognizes the importance of operating within the Provincial Government's fiscal framework. The organization prioritizes the efficient and effective use of its financial and human resources to ensure good stewardship over the long term. During the 2011-14 planning cycle, significant efforts were undertaken to identify inefficiencies throughout the organization and these efforts will continue into the next planning cycle for 2014-17.

The overall three-year goal, measure, and objectives related to sustainability are outlined in the table below:

3-Year Goal: By March 31, 2014, Eastern Health will have strengthened its sustainability through the efficient utilization and monitoring of its fiscal and human resources.	
Measure: Strengthened sustainability	
2011-14 Goal Indicators as Outlined in the Strategic Plan	**2014 Results**
• Balanced budgets	Budget variance indicates the level of actual expenditure as compared to the available budget for a given year. Budget Variance for 2011-14: • 2011-12: **1.3 per cent ($17.3 million)**[13] • 2012-13: **0.637 per cent ($8.28 million)** • 2013-14: **2.06 per cent ($27.5 million)** During 2011-14 Eastern Health did not have balanced budgets and in each of the three years operated with expenditure overruns due to numerous funding pressures, including staff compensation, medical/surgical supplies and pharmaceuticals (e.g. cancer drugs). Eastern Health ended fiscal year 2013-14 with a $27.5 million budget deficit (2.06 per cent) that required one-time stabilization funding from government to allow the Authority to achieve a balanced financial position. During this timeframe there have been a number of initiatives at various levels of implementation across this organization and all programs continue to monitor for opportunities to reduce costs and achieve efficiencies
• Decreased HR vacancy rate in selected areas	For the 3rd Quarter 2011-12, the vacancy rate for difficult to fill positions[14] was **0.36 per cent**. This data is not comparable to future years due to changes in calculation: to calculate this indicator in 2011-12, all difficult-to-fill groups were included in the numerator and the total number of vacancies at Eastern Health were included in the denominator (which

13 Eastern Health's Annual Performance Report 2011-12 reported a budget variance of 0.77 per cent. That variance amount was for the month of March 2012 only. The budget variance for the 2011-12 fiscal year was 1.3 per cent as noted above.

14 Eastern Health describes "difficult to fill" positions as those which Human Resources has been "actively recruiting for minimum two months; does not include Casuals".

included both difficult-to-fill and not difficult-to-fill groups). To have this indicator more accurately portray the challenges with difficult-to-fill positions, in 2012-13 five groups were identified as being traditionally difficult-to-fill: audiologists, clinical pharmacists, clinical psychologists, combined lab and X-ray technologists and prosthetists/orthotists.

The denominator that is now used in the calculation includes the total number of positions for these identified groups, which gives a more accurate picture for this overall indicator, as follows:

HR vacancy rate for difficult to fill positions:

- 3rd Quarter 2012-13: **8.72 per cent**
- 3rd Quarter 2013-14: **6.04 per cent**

The data for Nursing vacancies is comparable for the entire 2011-14 timeframe:
HR vacancy rate in Nursing (posted external; does not include Casuals):

- 3rd Quarter 2011-12: **1.31 per cent**
- 3rd Quarter 2012-13: **0.14 per cent**
- 3rd Quarter 2013-14: **0.28 per cent**

HR vacancy rate in Nursing (posted internal; does not include Casuals):

- 3rd Quarter 2011-12: **2.90 per cent**
- 3rd Quarter 2012-13: **1.86 per cent**
- 3rd Quarter 2013-14: **1.30 per cent**

During 2011-14, HR vacancy rates decreased, with the exception of an increase in Nursing (posted, external) between 2012-13 and 2013-14, mainly due to an increased need for some summer relief requirements. Throughout 2011-14 a number of strategies were put in place to address vacancy rates in partnership with the Department of Health and Community Services. Examples include bursaries, sign-on bonuses and the Government Market Adjustment Policy to improve market competitiveness. In addition, Eastern Health's Client Services Department has expanded to include Human Resources Planning, Learning and Organizational Development and Student Coordination, which will assist in long-term stability strategies.

Discussion of Results for 2011-14 Overall

Throughout 2011-14 Eastern Health put tremendous work into the goal of strengthened sustainability through the efficient utilization and monitoring of fiscal and human resources. Certainly, the majority of this work entailed operational improvement initiatives to improve fiscal accountability and increase efficiencies throughout the organization.

During the 2012-13 fiscal year, Eastern Health launched operational improvement initiatives for a two-year duration for anticipated savings of $43 million and a reduction of 550 full-time equivalents (FTEs) through attrition. During 2013-14, the organization conducted a clinical utilization review, the recommendations of which will continue into the 2014-17 planning cycle. Throughout all of this, Eastern Health introduced additional process improvement strategies and tools at the individual program level, such as the aforementioned lean initiatives.

While much of the sustainability focus has been on fiscal resources, the organization also made gains in terms of Human Resource initiatives during 2011-14. To date, Eastern Health has achieved Level II certification of the Excellence Canada Healthy Workplace Program, which is a national body that assists Eastern Health to advance its programs and strategies in keeping with industry best practices. Eastern Health is focusing on a broad array of planning and programming in the area of healthy workplace, as it recognizes that this contributes to higher engagement, a safer workplace and reduced absenteeism.

Eastern Health has also made gains with regard to difficult-to-recruit positions and numerous strategies have been put in place in collaboration with the Provincial Government. Such strategies entail financial incentives, sign-on bonuses, salary differentials, bursaries, and salary continuance, as per the Provincial Government's market adjustment policy.

Eastern Health's strategic issue of Sustainability aligns with government's Strategic Direction of *Accountability and Stability of Health and Community Services*. The focus on sustainability will continue into the next Strategic Plan for 2014-17.

For 2013-14, the final yearly objective, measure and indicators related to sustainability are outlined below:

2013-14 Objective: By March 31, 2014, Eastern Health will have demonstrated efficiencies in identified programs.	
Measure: Demonstrated efficiencies	
Indicators Outlined for 2013-14	**Actual Performance for 2013-14[15]**
• Continued benchmarking and consultation to identify ongoing opportunities for improving efficiencies throughout Eastern Health	During 2013-14 benchmarking and consultation to identify on-going opportunities for improving efficiencies throughout Eastern Health continued. Examples include: • Completed a review of clinical utilization and efficiency across the organization, which included recommendations for improvement. • Aramark Healthcare introduced and implemented its new ISISpro - Quality Assurance Program for Environmental Services, which optimizes productivity and delivers consistent results. • Streamlined services at the Central Kitchen, reducing operational costs and enabling more responsiveness to patient meal changes. • Participated in the Strategic Procurement Project lead by Deloitte for the Province. This project resulted in projected savings of $20 million annually to government and agencies including Eastern Health. • Identified approximately $3 million in cost savings for pharmacy and medical and surgical supplies purchased by means of a HealthPRO contract. • Achieved efficiencies through new lean initiatives between Pharmacy and Nursing at St. Clare's, including a 20% decrease in daily work associated with refills and a 49% decrease in missing medication requisitions.

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

• Decreased budget variance	Budget variance indicates the level of actual expenditure as compared to the available budget. During 2013-14 Eastern Health's budget variance did not decrease: • 2013-14: **2.06 per cent ($27.5 million)** (compared with $8.3 million the previous year) As pointed out in the three-year performance results section, Eastern Health ended fiscal year 2013-14 with a $27.5 million budget deficit (2.06 per cent) that required one-time stabilization funding from government to allow the Authority to achieve a balanced financial position. This deficit was based on a number of funding pressures, including staff compensation and drug costs; however, during 2013-14, numerous initiatives and monitoring for opportunities to reduce costs and achieve efficiencies continued throughout Eastern Health.
• Decreased HR vacancy rate in selected areas	HR vacancy rate for difficult-to-fill positions for 3rd Quarter 2013-14: **6.04 per cent**. HR vacancy rate for difficult-to-fill positions for 3rd Quarter 2013-14: **6.04 per cent** (compared to 8.72 per cent in previous year) HR vacancy rate in Nursing (posted external; does not include Casuals) for 3rd Quarter 2013-14: **0.28 per cent** (compared to 0.14 per cent in previous year) HR vacancy rate in Nursing (posted internal; does not include Casuals): for 3rd Quarter 2013-14: **1.30 per cent** (compared to 1.86 per cent in previous year) Both the vacancy rates for difficult-to-fill positions and nursing (internal postings) decreased from the previous fiscal year, while nursing (posted, external) did not decrease during that time mainly due to some summer relief requirements. The continued efforts to address vacancy rates are described in the overall 2011-14 results section.

Discussion of Results for 2013-14

During the past year, Eastern Health continued to implement and monitor strategies toward improving sustainability throughout the region, mainly through areas identified by operational improvement initiatives. In particular, Food Services and Environmental Services underwent significant changes. Services within city sites were contracted out to Morrison, resulting in approximately 70 permanent Dietary staff being re-assigned across other program areas. Compass-Crothall took over the contract for management of Environmental Services in St. John's and Avalon Central Laundry at Placentia Health Centre was consolidated with the Central Laundry Facility in St. John's.

In addition, Eastern Health had success in recruiting some of its traditionally difficult-to-fill positions, including Psychologists. Nursing recruitment did not present the same challenges as in previous years, as there were fewer vacancies overall.

4.4. Population Health

Population health can be described as an approach that focuses on improving the health of the whole population and reducing inequities among groups within the population. This approach takes into account a broad range of factors that influence health, known as the "determinants of health", and includes such things as literacy, education, employment, income, housing, social support networks, and healthy child development. This approach also looks at the roles and involvement of many stakeholders within the community, including citizens, schools, workplaces, and all levels of government.

It is important to know the health status of the population so that resources can be focused on prevention and intervention. For example, the population served by Eastern Health has high rates of diabetes, cancer and cardiovascular disease and poor rates of some health practices such as physical activity. 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 over the long term.

For the period of 2011-14, Eastern Health focused on increasing opportunities for stakeholder consultation and collaborating with community partners and all levels of government to improve Population Health, one of the provincial government's Strategic Directions. The overall three-year goal, measure, and objectives related to population health are outlined in the table below:

3-year 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.	
Measure: Implemented strategies	
2011-14 Goal Indicators as Outlined in the Strategic Plan	**2014 Summary Results**
• Improved opportunities to communicate the principles of population health with internal and external stakeholders	For the three-year period of 2011-14, Eastern Health improved opportunities to communicate the principles of population health with internal and external stakeholders in a number of ways, including: • Completed a Regional Health Status Report that provides a profile of the health of the population living within the Eastern Health region, which will help identify pathways for interpreting and sharing population health information. • Developed a comprehensive Health Promotion plan entitled *Working in Health Promoting Ways, Where We Live, Work and Play*, to support the integration of health promotion into practice and help improve the health of the population served. • Health Promotion implemented *Population Health: A Common Understanding* webinar series to increase awareness and education. From October to December 2013, six webinars were offered with 258 employees across the region. • Allied Health Professional Practice and Health Promotion collaborated on an education day to outline the principles of population health for 120 Allied Health professionals.

	• Developed content for the Eastern Health website, Facebook, Twitter, *Story Line Blog* and intranet related to Population Health topics, such as *Healthy Living A-Z*
• Improved opportunities for programs and services to implement preventive approaches to health	Eastern Health improved opportunities for programs and services to implement preventive approaches to health throughout 2011-14. Examples include: • Launched a Chronic Disease Prevention and Management Strategy. A key component of this strategy involves Self-Management workshops facilitated by volunteer lay leaders, entitled *My Health, My Way*. Since the first workshop in June 2011, Eastern Health has completed 38 workshops with 356 of the 515 (69%) participants completing the program. • Launched the *Take Care Down There* sexual health campaign targeting 18-30-year olds to focus on four key messages: know your risk, talk to your partner, use a condom and get tested. This campaign aims to increase awareness of risky sexual behaviours and safer sex choices. • Celebrated World Breastfeeding Week in October with various initiatives, including a promotion of breastfeeding at various car dealerships where the main messages were delivered by way of a brochure called *24 Hour Crib Side Assistance.* • Multimedia Bereavement Resources developed by Pastoral Care and Ethics have been recognized as an innovative practice by the Health Council of Canada and Accreditation Canada. These resources have been used to build bereavement capacity throughout the region and the province.
• Improved collaboration with all levels of government and community partner agencies across various sectors	There are many examples of how Eastern Health has improved collaboration with all levels of government and community partner agencies across various sectors during this three-year period, such as: • The launch of a three-year initiative entitled *Journey in the Big Land,* aimed at enhancing cancer care services for Labrador Inuit, Innu and members of the NunatuKavut Community Council. The initiative was made possible with $800,000 from the Canadian Partnership Against Cancer and the help of patients, families, Labrador-Grenfell Health and other partner Aboriginal governments and organizations. • Increased opportunities to partner with private sector organizations, such as receiving funding from Bell Aliant Pioneers to help cover costs for increasing Telehealth services in the area of mental health and addictions.

	• Partnered with the provincial government for major infrastructure projects, including the building of new long-term care sites in Carbonear and St. John's, preparing for the installation of a positron emission tomography/computerized tomography (PET/CT) scanner at the Health Sciences Centre as well as developing plans for Mental Health and Addictions Facilities in Paradise, Harbour Grace and St. John's. • The Allied Health Regional Professional Practice Consultants provided 2,558 new consultations to internal and external stakeholders of Eastern Health. Major stakeholders included staff, managers, other RHAs and educational institutions.
• Improved mechanisms for public involvement	During 2011-14 Eastern Health improved mechanisms for public involvement in a number of ways, including: • Completed the last of its Community Health Needs Assessments throughout the region (i.e., five assessments in total). Each assessment included focus groups, key informant interviews, a call for public submissions as well as a call to participate in Advisory Committees to guide the process in each local area. Four of the five assessments have already provided 2-year follow-up presentations to the public on the progress made on recommendations. • The Board of Trustees held a number of community engagement sessions with representatives from various community-based groups around the region. Discussion topics varied, including opportunities to provide input into the 2014-17 Strategic Plan. • Held a number of public information sessions related to ongoing initiatives, such as a Public Information Session in Harbour Grace on the development of a new adult addictions treatment centre and a similar session in St. John's outlining the installation of a PET/CT scanner. • Developed a Community Engagement Framework that uses the International Association for Public Participation's *Spectrum of Public Participation*, which identifies five components: inform, consult, involve, collaborate and empower. • Finalized and released a Statement of Patients' Rights and Responsibilities based on an extensive public consultation process. • Gathered extensive client feedback through the Client Satisfaction/Experience of Care Survey. Obtaining this feedback and using it to inform program changes is an essential step to ensuring the organization continues to provide quality care to the people it serves.

	• Established the Eastern Health Ethics Community Interest Network and recruited community members to participate in ethics committees and provide feedback on ethics issues and policies. • Drafted *Accountability for Reasonableness (A4R): An Ethics and Values Framework for Planning and Decision-Making*. This framework is a tool that provides an ethics and values-based lens to assist programs and departments to prepare for and participate in priority setting, planning of budgets and other resource allocation decision-making.
• Improved mechanisms to implement an evidence-based approach to policy development	Eastern Health improved mechanisms to implement an evidence-based approach to policy development in a number of ways during the 2011-14 planning cycle: • Revised the organization's policy on Policy Development in October 2013. The purpose of the policy is (1) to ensure Eastern Health's policies are well-developed, evidence-based, serve their audience and are appropriately aligned with its mission, vision, values and strategic priorities and (2) to provide standardized, clear, consistent guidance and direction to the development, revision and rescission of policies. • Revised Eastern Health's Policy Development Framework and Policy Writing Guide. • The Research Department assisted professional practices/clinical programs in enhancing evidence-informed decision making and policy development through evaluations, satisfaction surveys, framework development and analysis. Research staff assisted in facilitating evidence-informed information sessions as required. The Research Department is actively involved in approximately 23 Applied Health Research projects and 100 clinical trials at any point in time. Examples of evidence-based approaches to policy development within specific programs include: • Developed and implemented a breastfeeding policy based on the guidelines, *Ten Steps to Successful Breastfeeding*, which has been established by the Baby Friendly Initiative, a program developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The regional breastfeeding policy enables Eastern Health to build a stronger breastfeeding culture in the region, monitor breastfeeding practices, train its employees, and to essentially help increase breastfeeding rates in the eastern region.

	• The Emergency Program developed and distributed an auditing tool and began auditing two of its policies for compliance: Transfer of Patients (inter-facility) and Medical Directive for Chest Pain. Several revisions have been undertaken based on new information or needs at particular sites.
Increased monitoring of outcomes in selected areas of population health, which include:	During 2011-14 Eastern Health increased monitoring of outcomes in selected areas of population health in a number of ways, most notably through the development of a Health Status Report specific to this region. Indicators include:
• Rate of physical activity	Rate of respondents aged 12 or older in the Eastern Health region who report physical activity during leisure time (moderately active or active): • 2009 Canadian Community Health Survey: **45.2 per cent** • 2011 Canadian Community Health Survey: **49.0 per cent** • 2012 Canadian Community Health Survey: **53.4 per cent**
• Breastfeeding initiation rate	Breastfeeding initiation rate: • February 2012: **63.64 per cent** • February 2013: **60.38 per cent** • February 2014: **78.08 per cent** The rate of breastfeeding initiation increased significantly during the 2011-14 planning cycle, due in large part to the number of initiatives to promote and encourage a culture of breastfeeding in this region. For instance, Eastern Health developed and implemented a breastfeeding policy based on World Health Organization (WHO) guidelines, completed an evaluation of the 20-Hour Baby Friendly Initiative, hired a new Lactation Consultant within the Public Health program and provided 30-hour training entitled *Making A Difference* throughout the region.
• Breastfeeding duration rate	Manual data collection of breastfeeding began in 2011-12 but took longer than anticipated; therefore data for that fiscal year is not available. Rate of breastfeeding duration (percentage of infants breastfed at 6 months) for 1st Quarter 2012-13: **29.55 per cent** During 2013-14 the process for collecting breastfeeding duration was reviewed and data quality issues were identified. Subsequently, a new process was put in place to collect breastfeeding duration information and ensure data quality; however, data is not available for the entire fiscal year and therefore cannot be compared to previous years. Although breastfeeding duration is now a mandatory field in CRMS documentation, the ability to extract the data in a quality report is not available. This is a top priority for Public Health and is being discussed with our provincial partners.

• Rate of participation (by age) for screening for colorectal cancer	The NL colon cancer screening program launched in late July 2012 in Corner Brook. The first phase of this self-referred screening program was available to residents of Western Health Region between the ages of 50-74 and at average risk for colorectal cancer. Residents who are eligible receive a home fecal test kit in the mail, and return the samples via the mail for analysis. Clients with a negative test result are re-screened every two years, while those with a positive result are navigated through to follow-up colonoscopy. The program expanded in June 2013 to offer colon cancer screening to residents of Central Health. The program is working towards full provincial implementation by 2015. For 2013-14 the screening program has a response rate of **77 per cent.** Since this program has not yet been launched in the Eastern Region, a baseline rate for that area is not yet available. This indicator is included in Eastern Health's Strategic Plan 2014-17.
• 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)	The National Action Committee on Immunization makes annual recommendations on seasonal immunization rates; therefore the target groups may change over time (e.g. the target age of young children and seniors); therefore data from year to year cannot be compared. In addition, Eastern Health is unable to determine the percentage of individuals with chronic health conditions that have been immunized since there is no source available to extract denominator data for this group. Rate of seasonal influenza immunization for seniors (as per the National Committee on Immunization recommendation): • 2011-12: **41.90 per cent** • 2012-13: **46.27 per cent** • 2013-14: **43.50[16] per cent** Rate of seasonal influenza immunization for children aged 6-23 months (as per the National Committee on Immunization recommendation): • 2011-12: **16.00 per cent** • 2012-13: **20.38 per cent** Rate of seasonal influenza immunization for children aged 6 months-5 years (as per the National Committee on Immunization recommendation): • 2013-14: **41.27 per cent**

16 Data for seniors during 2013-14 is includes age 60+

	Rate of seasonal influenza immunization for Eastern Health staff: • 2011-12: **32.4 per cent** • 2012-13: **35.30 per cent** • 2013-14: **39.45 per cent** The rate of seasonal influenza immunization for Eastern Health staff increased over the past three years, due in large part to awareness campaigns and increased uptake of volunteer peer immunizers in the workplace.

Discussion of Results for 2011-14 Overall

Eastern Health is firmly committed to a population health approach over the long term. Undoubtedly, this requires the collective effort of many partners and progress takes time. A great deal of improvement was made in fostering a population health approach across this organization for during the 2011-14 planning cycle. Examples include the development and launch of a health status report specific to Eastern Health, the implementation of a Health Promotion Plan and the development and implementation of a Community Engagement Framework, all of which guide the ongoing work to improve overall health.

Quantifiable measures, including rates of physical activity, breastfeeding and influenza immunization, have been monitored and Eastern Health recognizes that there are many factors that influence these rates. The organization puts considerable work into education, awareness and promotional campaigns and works very closely with community partners in an effort to bring about positive changes in these rates for the long term. This is also true for preventive measures, such as screening, as the organization understands that changing cultural norms requires sustained, collective efforts in order to bring about change over a long period of time.

Eastern Health's work to strengthen the population health approach supports the Provincial Government's Strategic Direction of *Population Health.* Given the sustained, long-term vision required, this priority area will continue into Eastern Health's 2014-17 Strategic Plan.

The yearly objective, measure and indicators related to sustainability for 2013-14 are outlined below:

2013-14 Objective: By March 31, 2014, Eastern Health will have contributed to improved programs and service delivery toward reducing inequities in the population.	
Measure: Contributed to improved programs and service delivery	
Planned for 2013-14	**Actual Performance for 2013-14[17]**
Contributed to improved programs and service delivery towards reducing inequities in the population, as demonstrated by the following:	
• Increased opportunities to address identified barriers in selected programs.	Eastern Health increased opportunities to address identified barriers in selected programs during 2013-14, as indicated in the following examples: • Further developed plans between Telehealth and Community Mental Health and Addictions in Rural Avalon to set up a pilot

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

project out of the Dr. A. A. Wilkinson Memorial Health Centre in Old Perlican. These plans involve increasing access to health professionals for mental health and addictions counseling to clients in this area. This service is intended to address barriers by increasing access, decreasing transportation costs and reducing the stigma associated with mental illness.

- Began an initiative entitled *Early Palliative Care Intervention in Lung Cancer Patients,* which involves developing a new triage and intervention system to ensure that patients who are newly diagnosed with late stage lung cancer have access to palliative care.
- The Mental Health and Addictions Program introduced a new Time Sensitive Counselling Option at many of its community sites. This option offers a timely response for those individuals who are interested in a brief intervention model.
- The Children's and Women's Health program, in conjunction with the Department of Health and Community Services, has completed a review of Autism wait times and has completed a full review of the Janeway Emergency Department. The program has begun implementing changes to reduce wait time at all transition points.
- Based on a recommendation from the Discovery Zone Community Health Needs Assessment, Eastern Health developed a local community advisory committee to review identified mental health issues and develop action plans to address these issues.

- Improved opportunities to identify and reach vulnerable populations

During 2013-14 Eastern Health improved opportunities to identify and reach vulnerable populations, as the following examples demonstrate:

- Distributed a total of $51,050 through the Community Addictions Prevention and Mental Health Promotion Fund. Recipients included the *Mental Health and Addictions Awareness Campaign* through the Tip-A-Vista Wellness Foundation in Bonavista and *Mental Health Matters* at Marystown Central High School.
- Distributed $50,000 in Community Development Grants to community partner agencies for projects that contribute to the overall health of communities, such as the *All Inclusive Community Cultural Group* at the St. John's Native Friendship Centre and the *Single Parent Family Support Program*, Buckmaster's Circle Community Centre, St. John's.

	• Offered a free seven-week program for cancer survivors. *Cancer Transitions, Moving Beyond Treatment* is designed to provide cancer survivors with support and education as they continue on their path to wellness. In an evaluation of the pilot program, 88% of participants reported that *Cancer Transitions* made an important difference in their lives and was relevant to their experience of moving forward. This program will continue to be offered in future. • Began preliminary discussions with the Newfoundland and Labrador Statistics Agency to get updated data on poverty and begin to build a profile for the Eastern Health region. • Through the Janeway Lifestyle Program, offered a free public information session in St. John's entitled *A Parent's Guide to a Healthy School Year* and partnered with the Brighter Futures Coalition and the Smallwood Community Resource Centre in Marystown to offer a program for parents of preschool children entitled *Good Health for EveryBody.* • Began developing a video for residents and families in long-term care, entitled *Your Role in Safety*, that highlights important safety messages that residents and families should know about residing in a long-term care facility. • The Peer Support project with the Consumers' Health Awareness Network Newfoundland and Labrador (CHANNAL) expanded to include the Case Management service and another acute care unit within the Waterford Hospital.
• Begun implementation of a Community Engagement Framework	Eastern Health began implementation of its Community Engagement Framework during this past fiscal year. Community engagement is the process of working collaboratively and interactively with communities to address issues affecting their well-being. Eastern Health has developed a Community Engagement Framework that uses the International Association for Public Participation's *Spectrum of Public Participation*, which identifies five components: inform, consult, involve, collaborate and empower. Implementation activities include the development of a Management Essentials course to inform managers and encourage them to seek out community partners. The first sessions are scheduled for early in the 2014-15 fiscal year. Eastern Health also used this framework when consulting with community representatives in the development of its 2014-17 Strategic

	Plan. Sessions took place from April to November 2013 in Marystown, Clarenville, Placentia, Carbonear and St. John's. Representatives from various community organizations attended. In addition to the community meetings, a consultation session occurred with representatives from the Faculty of Medicine at Memorial University.
• Further implemented the Health Promotion Plan to include a focus on: - Healthy eating (including breastfeeding) - Tobacco-free living - Physical activity	Throughout 2013-14, Eastern Health further implemented the Health Promotion Plan to include a focus on healthy eating (including breastfeeding), tobacco-free living and physical activity. Examples include: • Began planning for the *Colour it Up* campaign, which is designed to increase fruit and vegetable consumption. • In collaboration with the Wellness Coalitions, delivered *Choosing Healthy Food and Beverages* workshops to Coalition members in several locations. A six-month follow up survey reported that 74% of respondents had made changes in the food provided at various community functions. • Partnered with Baby-Friendly Newfoundland and Labrador to promote the benefits of breastfeeding through a variety of community-based activities. • Completed an evaluation of the 20-Hour Baby Friendly Initiatives (BFI), Promoting Healthy Eating -Breastfeeding. • Provided guidance on menu development for the Newfoundland and Labrador Winter Games Food Service committee, which received positive feedback and resulted in media coverage as a good news story.
Monitored selected areas of population health, which include:	
• Rate of physical activity	Rate of respondents aged 12 or older in the Eastern Health region who report physical activity during leisure time (moderately active or active), 2012 Canadian Community Health Survey: **53.4 per cent**. This data is the most recent available at the time of drafting this report, and indicates an increase in comparison to previous years.
• Rate of breastfeeding initiation	Breastfeeding initiation rate for February 2014: **78.08 per cent** This rate increased over the previous fiscal years, as outlined in the three-year results section.
• Baseline rate of breastfeeding duration	As indicated in the three-year results section, 2013-14 breastfeeding duration data is unavailable. During 2013-14 the process for collecting breastfeeding duration was reviewed and data quality issues were identified. Subsequently, a new process was put in place to collect breastfeeding duration information and ensure data quality; however, data is not available for the entire fiscal year and therefore cannot be compared to previous years.

	Although breastfeeding duration is now a mandatory field in CRMS documentation, the ability to extract the data in a quality report is not available. This is a top priority for Public Health and is being discussed with our provincial partners.
• Rate of participation (by age) for screening for colorectal cancer	As mentioned in the three-year results section, the Provincial Colorectal Screening Program expanded in June 2013 to residents of Central Health. The program is working towards full provincial implementation by 2015. Currently more than 70% of requested home screening kits are returned to the laboratory for analysis. This program has not yet been launched in the Eastern Region; therefore, a baseline rate for this region is not yet available. This indicator will be included in Eastern Health's Strategic Plan 2014-17.
• Rate of seasonal influenza immunization in seniors, children, and Eastern Health staff, as per National Action Committee on Immunization's annual recommendations	The rate of seasonal influenza immunization for seniors (as per the National Committee on Immunization recommendation) in 2013-14 was **43.50 per cent**. Since the data for seniors this past year includes ages 60+, the data is not comparable to the two previous years when it included age 65+. The rate of seasonal influenza immunization for children aged 6 months-5 years (as per the National Committee on Immunization recommendation) in 2013-14 was **41.27 per cent**. Since the age range has changed over previous years, data are not comparable. The rate of seasonal influenza immunization for Eastern Health staff in 2013-14 was **39.45 per cent**. This was an increase over the two previous years, as outlined in the three-year results section.

Discussion of Results for 2013-14

In keeping with its population health approach, Eastern Health made gains to improve programs and services toward reducing inequities in the population during 2013-14. In other words, the organization recognizes that some groups within the population are more at risk to experience poor health than others and a great deal of effort has been directed at reducing risks associated with low income, lack of education and/or disabilities.

From the many examples cited above, it is obvious that Eastern Health is encouraging and supporting increased education and awareness around health equity, public health policy, prevention and early intervention, the impacts of living in poverty as well as health promotion. Champions within Eastern Health are working continually with community stakeholders and partner agencies to identify and respond to needs and to find new ways of working together to improve overall health.

5. Opportunities and Challenges Ahead

Given Eastern Health's position as the largest integrated health authority in Newfoundland and Labrador, providing both regional and provincial services, it faces many opportunities and challenges on a number of levels. While balancing competing demands in a complex and ever-changing environment, the organization is committed to continuous improvement and strengthening partnerships to provide the best possible service.

Successfully completing the accreditation process through Accreditation Canada and receiving the designation of ***Accredited with Commendation*** in March 2014 was a significant achievement whereby Eastern Health's operations and processes were validated by a national external body. Eastern Health will continue to work toward achieving high standards in preparation for the next Accreditation Canada survey scheduled for 2017.

Eastern Health has been identifying opportunities for continuous improvements in a number of other ways over the past three years, and this focus will continue into the next planning cycle. For example, the organization achieved Ontario Laboratory Association (OLA) accreditation for all laboratories in Eastern Health, enrolled in the National Surgical Quality Improvement Program (NSQIP), received a three-year peer review program status of its biomedical department from the Canadian Medical and Biological Engineering Society and introduced the MORE OB® program in obstetrics. A review of clinical utilization and efficiency also took place during the 2013-14 fiscal year, which entailed recommendations for improvement that will continue into the next planning cycle.

Partnerships are essential for Eastern Health to carry out its mission. The organization is continually working to strengthen existing collaborative relationships and develop new ones at local, regional, provincial, national and even international levels. Examples of such opportunities and/or potential opportunities to continue into the next strategic planning cycle include the *Journey in the Big Land* initiative for cancer care, the Provincial Government's HealthLine for improving emergency department services, and the Wellness Coalitions and their member agencies all over the region.

At the same time, demographics will continue to present challenges for some years to come. The health authority must respond to service demands based on the changing population of its communities as well as changes to its own labour force. Likewise, financial sustainability is an on-going challenge as the high demands for services must be contained within a limited budget. Operational improvement initiatives will continue to provide opportunities to identify and realize efficiencies throughout the system.

Improving employee and physician engagement also continues to be a challenge. Eastern Health is committed to finding ways to work collaboratively to improve engagement and renew a sense of pride in the organization.

Access to services is a major issue for Eastern Health. Access is about having the right intervention for the right client at the right time and in the right place. It involves improving the client experience throughout the continuum, since access to long-term care beds, to community services and to acute care interventions all impact one another. Access is a strategic priority for the organization in its 2014-17 Strategic Plan

As Eastern Health transitions into the next strategic plan for 2014-17 it is well-positioned to be a leader in the community and to celebrate the many success stories that take place within this organization on a daily basis. In so doing, Eastern Health will continue to focus on its mission for 2011-17: *improving programs and services to increase safety, quality, accessibility, efficiency and sustainability and to contribute to the overall health of the population*.

Non-consolidated financial statements

Eastern Regional Health Authority – Operating Fund

March 31, 2014

Building a better working world

Eastern Regional Health Authority – Operating Fund

TABLE OF CONTENTS

March 31, 2014

STATEMENT OF MANAGEMENT RESPONSIBILITY

The accompanying non-consolidated financial statements of the **Eastern Regional Health Authority – Operating Fund** as at and for the year ended March 31, 2014 have been prepared by management in accordance with Canadian public sector accounting standards and the integrity and objectivity of these statements are management's responsibility. Management is also responsible for all the notes to the financial statements and schedules.

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

The external auditor, Ernst & Young LLP, conducts an independent examination in accordance with Canadian generally accepted auditing standards and expresses an opinion on the financial statements for the year ended March 31, 2014.

George Butt, CA
Vice President, Corporate Services

Chris O'Grady, CGA
Director of Financial Services

INDEPENDENT AUDITORS' REPORT

To the Board of Trustees of the
Eastern Regional Health Authority

We have audited the non-consolidated financial statements of the **Eastern Regional Health Authority – Operating Fund**, which comprise the non-consolidated statement of financial position as at March 31, 2014, and the non-consolidated statements of operations and accumulated deficit, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's responsibility for the non-consolidated financial statements

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

Auditors' responsibility

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

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

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

Opinion

In our opinion, the non-consolidated financial statements present fairly, in all material respects, the financial position of the **Eastern Regional Health Authority – Operating Fund** as at March 31, 2014 and the results of its operations, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis of presentation and restrictions on use

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

Ernst & Young LLP

St. John's, Canada,
June 25, 2014.

Chartered Accountants

NON-CONSOLIDATED STATEMENT OF OPERATIONS AND ACCUMULATED DEFICIT

Year ended March 31
[in thousands of dollars]

	Budget	2014	2013
	$	$	$
	[note 19]		
Revenue			
Provincial plan	1,175,985	**1,175,985**	1,149,258
MCP	75,567	**75,697**	74,483
Other	35,932	**39,422**	39,951
Provincial plan capital grant *[note 8]*	—	**22,121**	23,497
Resident	18,405	**17,711**	18,560
Inpatient	12,498	**13,302**	10,779
Outpatient	8,369	**8,061**	9,091
Other capital contributions *[note 8]*	—	**5,758**	6,713
	1,326,756	**1,358,057**	1,332,332
Expenses			
Patient and resident services	354,299	**361,334**	362,744
Client services	223,984	**218,638**	210,918
Diagnostic and therapeutic	189,707	**188,356**	179,020
Support	159,287	**165,898**	164,273
Ambulatory care	138,635	**145,620**	142,729
Administration	115,334	**115,988**	113,861
Medical services	98,620	**100,465**	98,875
Amortization of tangible capital assets	—	**42,556**	31,813
Research and education	16,410	**15,735**	16,526
Interest on long-term debt	10,187	**9,354**	9,469
Other	18,335	**5,322**	8,031
Employee future benefits			
Accrued severance pay (recovery)	—	**(3,579)**	6,840
Accrued sick leave (recovery)	—	**(3,782)**	1,780
Accrued vacation pay (recovery)	—	**180**	(678)
	1,324,798	**1,362,085**	1,346,201
Annual surplus (deficit)	1,958	**(4,028)**	(13,869)
Public Health Laboratory transfer		**(219)**	—
Accumulated deficit, beginning of year		**(76,365)**	(62,496)
Accumulated deficit, end of year		**(80,612)**	(76,365)

See accompanying notes

NON-CONSOLIDATED STATEMENT OF CHANGES IN NET DEBT

Year ended March 31
[in thousands of dollars]

	Budget	2014	2013
	$	$	$
	[note 19]		
Annual deficit	—	**(4,028)**	(13,869)
Changes in tangible capital assets			
Acquisition of tangible capital assets	—	**(27,879)**	(30,210)
Amortization of tangible capital assets	—	**42,556**	31,813
Decrease in net book value of tangible capital assets	—	**14,677**	1,603
Changes in other non-financial assets			
Net (increase) decrease in prepaid expenses	—	**(823)**	2,218
Net increase in supplies inventory	—	**(140)**	(892)
(Increase) decrease in other non-financial assets	—	**(963)**	1,326
Decrease (increase) in net debt	—	**9,686**	(10,940)
Net debt, beginning of year	—	**(449,079)**	(438,139)
Public Health Laboratory transfer	—	**(717)**	—
Net debt, end of year	—	**(440,110)**	(449,079)

See accompanying notes

NON-CONSOLIDATED STATEMENT OF FINANCIAL POSITION

As at March 31
[in thousands of dollars]

	2014 $	2013 $
Financial assets		
Cash	—	13,288
Accounts receivable *[note 3]*	**25,050**	31,924
Due from government/other government entities *[note 4]*	**106,646**	62,135
Advance to General Hospital Hostel Association	**1,120**	1,248
Sinking fund investment *[note 10]*	**14,969**	13,506
	147,785	122,101
Liabilities		
Bank indebtedness	**3,319**	—
Accounts payable and accrued liabilities *[note 6]*	**107,061**	106,076
Due to government/other government entities *[note 7]*	**21,770**	23,087
Accrued vacation pay	**47,769**	47,454
Employee future benefits		
Accrued sick leave *[note 16]*	**59,636**	63,288
Accrued severance pay *[note 15]*	**110,799**	113,908
Deferred contributions *[note 8]*		
Deferred capital grants	**80,190**	65,984
Deferred operating contributions	**20,883**	12,910
Long-term debt *[note 9]*	**136,468**	138,473
	587,895	571,180
Net debt	**(440,110)**	(449,079)
Non-financial assets		
Tangible capital assets *[note 5]*	**339,085**	353,264
Supplies inventory	**15,537**	15,397
Prepaid expenses	**4,876**	4,053
	359,498	372,714
Accumulated deficit	**(80,612)**	(76,365)

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

See accompanying notes

Approved by the Board:

Director

Director

Eastern Regional Health Authority – Operating Fund

NON-CONSOLIDATED STATEMENT OF CASH FLOWS

Year ended March 31
[in thousands of dollars]

	2014 $	2013 $
Operating transactions		
Annual deficit	**(4,028)**	(13,869)
Adjustments for:		
Amortization of tangible capital assets	**42,556**	31,813
Capital grants – provincial and other	**(27,879)**	(30,210)
(Decrease) increase in accrued severance pay	**(3,579)**	6,840
(Decrease) increase in accrued sick leave	**(3,782)**	1,780
Net change in non-cash assets and liabilities related to operations *[note 11]*	**(16,555)**	14,373
Cash (used in) provided by operating transactions	**(13,267)**	10,727
Capital transactions		
Construction and purchase of tangible capital assets	**(27,879)**	(30,210)
Capital asset contributions	**27,879**	30,210
Cash provided by capital transactions	**—**	—
Investing transactions		
Sinking fund payments	**(1,463)**	(1,443)
Cash used in investing transactions	**(1,463)**	(1,443)
Financing transactions		
Repayment of long-term debt	**(2,005)**	(2,528)
Repayment of advance to General Hospital Hostel Association	**128**	126
Cash used in financing transactions	**(1,877)**	(2,402)
Net (decrease) increase in cash during the year	**(16,607)**	6,882
Cash, beginning of year	**13,288**	6,406
(Bank indebtedness) cash, end of year	**(3,319)**	13,288
Supplemental disclosure of cash flow information		
Interest paid	**9,354**	9,469

See accompanying notes

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

1. NATURE OF OPERATIONS

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

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

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

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

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of accounting

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

Basis of presentation

These non-consolidated financial statements reflect the assets, liabilities, revenue and expenses of the Operating Fund. Trusts administered by Eastern Health are not included in the non-consolidated statement of financial position *[note 12]*. These non-consolidated financial statements have not been consolidated with those of other organizations controlled by Eastern Health because they have been prepared for the Authority's Board of Trustees and the Department of Health and Community Services [the "Department"]. Since these non-consolidated financial statements have not been prepared for general purposes, they should not be used by anyone other than the specified users. Consolidated financial statements have also been issued.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[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]

Revenue recognition

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

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

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

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

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

Expenses

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

Asset classification

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

Cash

Cash includes cash on hand and balances with banks.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[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]

Inventory

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

Tangible capital assets

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

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

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

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

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

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

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

Impairment of long-lived assets

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

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[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]

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.

Employee future benefits

Accrued severance

Employees are entitled to severance benefits as stipulated in their conditions of employment. The right to be paid severance pay vests with employees with nine years of continual service with Eastern Health or another public sector employer. Severance is payable when the employee ceases employment with Eastern Health or the public sector employer. The severance benefit obligation has been actuarially determined using assumptions based on management's best estimates of future salary and wage changes, employee age, years of service, the probability of voluntary departure due to resignation or retirement, the discount rate and other factors. Discount rates are based on the Province's long-term borrowing rate. Actuarial gains and losses are deferred and amortized over the average remaining service life of employees.

Accrued sick leave

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

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[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]

Pension costs

Employees are members of the Public Service Pension Plan and the Government Money Purchase Plan [the "Plans"] administered by the Government. Contributions to the Plans are required from both the employees and Eastern Health. The annual contributions for pensions are recognized as an expense as incurred and amounted to $38,827,731 for the year ended March 31, 2014 [2013 – $39,673,213].

Sinking funds

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

Contributed services

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

Financial instruments

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

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

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

Use of estimates

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

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

3. ACCOUNTS RECEIVABLE

Accounts receivable consist of the following:

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

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

4. DUE FROM GOVERNMENT/OTHER GOVERNMENT ENTITIES

	2014 $	2013 $
Government of Newfoundland and Labrador	**105,249**	60,279
Other government entities	**1,397**	1,856
	106,646	62,135

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

5. TANGIBLE CAPITAL ASSETS

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

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

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

5. TANGIBLE CAPITAL ASSETS [Cont'd]

During 2014, the Authority recorded an impairment of certain building and equipment in the amount of $9,995,000 due to conditions indicating that the future economic benefits associated with the underlying assets are less than the net book value. This has been included in amortization expense.

6. ACCOUNTS PAYABLE AND ACCRUED LIABILITIES

	2014 $	2013 $
Accounts payable and accrued liabilities	**66,747**	59,146
Salaries and wages payable	**38,089**	42,435
Employee/employer remittances	**2,225**	4,495
	107,061	106,076

7. DUE TO GOVERNMENT/OTHER GOVERNMENT ENTITIES

	2014 $	2013 $
Federal government	**11,826**	11,007
Government of Newfoundland and Labrador	**7,914**	10,408
Other government entities	**2,030**	1,672
	21,770	23,087

8. DEFERRED CONTRIBUTIONS

	2014 $	2013 $
Deferred capital grants [a]		
Balance at beginning of year	**65,984**	50,597
Receipts during the year	**42,085**	45,597
Recognized in revenue during the year	**(27,879)**	(30,210)
Balance at end of year	**80,190**	65,984
Deferred operating contributions [b]		
Balance at beginning of year	**12,910**	7,750
Receipts during the year	**1,252,090**	1,213,312
Recognized in revenue during the year	**(1,244,117)**	(1,208,152)
Balance at end of year	**20,883**	12,910

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

8. DEFERRED REVENUE [Cont'd]

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

[b] Deferred operating contributions 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.

9. LONG-TERM DEBT

	2014 $	2013 $
Sinking fund debenture, Series HCCI, 6.9%, to mature on June 15, 2040, interest payable semi-annually on June 15 and December 15 [the "Debenture"].	**130,000**	130,000
Royal Bank of Canada (Central Kitchen), 6.06% loan, unsecured, maturing in May 2014, payable in monthly instalments of $101,670.	**208**	1,380
Newfoundland and Labrador Housing Corporation, 2.75% mortgage, maturing in December 2020, repayable in blended monthly instalments of $18,216, secured by land and building with a net book value of $2,411,234.	**1,346**	1,525
Royal Bank of Canada (Veterans Pavilion), 4.18% loan, unsecured, maturing in April 2013, payable in blended monthly instalments of $55,670.	—	55
Canadian Imperial Bank of Commerce loan, unsecured, bearing interest at the prime lending rate less 0.625 basis points, maturing in 2016, repayable in monthly instalments of $21,200 plus interest.	**612**	866
Newfoundland and Labrador Housing Corporation 10% mortgage, maturing in December 2028, repayable in blended monthly instalments of $8,955, secured by land and building with a net book value of $840,230.	**841**	864
Bank of Montreal, 4.96% term loan, unsecured, amortized to December 2013, repayable in blended monthly instalments of $7,070.	—	67

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

9. LONG-TERM DEBT [Cont'd]

	2014 $	2013 $
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 $51,771.	**72**	82
Canada Mortgage and Housing Corporation mortgages on land and buildings with a net book value of $4,619,334 – 8% on Blue Crest Home, repayable in blended monthly instalments of $7,777, maturing in November 2025.	**712**	748
10.5% on Golden Heights Manor, repayable in blended monthly instalments of $7,549, maturing in August 2027.	**660**	681
2.65% on Golden Heights Manor, repayable in blended monthly instalments of $20,482, maturing in June 2023.	**2,017**	2,205
	136,468	138,473

Future principal repayments to maturity are as follows:

	$
2015	945
2016	752
2017	621
2018	539
2019	561
Thereafter	133,050
	136,468

10. SINKING FUND

A sinking fund investment, established for the partial retirement of the Debenture *[note 9]*, is held in trust by the Government. The balance as at March 31, 2014 included interest earned in the amount of $5,251,000 [2013 – $4,536,000].

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

The semi-annual interest payments and mandatory annual sinking fund payments on the Debenture are guaranteed by the Government.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

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

	2014 $	2013 $
Accounts receivable	**6,874**	(9,240)
Supplies inventory	**(140)**	(892)
Prepaid expenses	**(823)**	2,218
Accounts payable and accrued liabilities	**985**	(1,841)
Due from/to government/other government entities	**(45,828)**	4,259
Accrued vacation pay	**315**	(678)
Deferred capital grants	**14,206**	15,387
Deferred operating contributions	**7,973**	5,160
Public Health Laboratory cash flow change	**(117)**	—
	(16,555)	14,373

12. TRUST FUNDS

Trusts administered by the Authority have not been included in these non-consolidated financial statements as they are excluded from the Government reporting entity. As at March 31, 2014, the balance of funds held in trust for residents of long-term care facilities was $4,285,180 [2013 – $3,989,210]. These trust funds consist of a monthly comfort allowance provided to residents who qualify for subsidization of their boarding and lodging fees.

13. CONTINGENCIES

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

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

14. CONTRACTUAL OBLIGATIONS

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

	2015 $	2016 $	2017 $	2018 $	2019 $	Thereafter $
Future operating lease payments	12,257	11,977	10,912	8,717	7,468	63,597
Managed print services	2,494	2,494	—	—	—	—
Vehicles	277	195	59	17	—	—
	15,028	14,666	10,971	8,734	7,468	63,597

15. ACCRUED SEVERANCE PAY

The Authority provides a severance payment to employees upon retirement, resignation or termination without cause. In 2014, cash payments to retirees for the Authority's unfunded employee future benefits amounted to approximately $7,775,000 [2013 – $7,331,000]. The last actuarial valuation for both the accrued severance pay and accrued sick leave was performed effective March 31, 2012, and an extrapolation of that valuation has been performed to March 31, 2014.

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

	2014 $	2013 $
Accrued benefit liability, beginning of year	**113,908**	107,068
Accrued benefit liability, beginning of year – PHL	**470**	—
Benefits expense		
Current service cost	**7,697**	7,696
Interest cost	**4,116**	4,129
Other	**(7,617)**	2,346
	118,574	121,239
Benefits paid	**(7,775)**	(7,331)
Accrued benefit liability, end of year	**110,799**	113,908

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

15. ACCRUED SEVERANCE PAY [Cont'd]

	2014 $	2013 $
Current year benefits cost	**7,697**	7,696
Amortization of actuarial gain/loss during the year	**1,021**	838
Benefits interest expense	**4,116**	4,129
Total expense recognized for the year	**12,834**	12,663

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

Discount rate – liability	3.90% as at March 31, 2014 3.60% as at March 31, 2013
Discount rate – benefits expense	3.60% in fiscal 2014 3.85% in fiscal 2013
Rate of compensation increase	0% for 2012, 0% for 2013, 2% for 2014, 3% for 2015, and 3.25% thereafter plus 0.75% for promotions and merit as at March 31, 2014 3.5% plus 0.75% for promotions and merit as at March 31, 2013

16. ACCRUED SICK LEAVE

The Authority provides sick leave to employees as the obligation arises and accrues a liability based on anticipation of sick days accumulating for future use. In 2014, cash payments to employees for the Authority's unfunded sick leave benefits amounted to approximately $8,149,000 [2013 – $7,869,000]. The actuarial valuations for both the accrued severance pay and accrued sick leave were performed effective March 31, 2012, and an extrapolation of that valuation has been performed to March 31, 2014.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

16. ACCRUED SICK LEAVE [Cont'd]

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

	2014 $	2013 $
Accrued benefit liability, beginning of year	**63,288**	61,508
Accrued benefit liability, beginning of year – PHL	**130**	—
Benefits expense		
Current service cost	**6,274**	6,411
Interest cost	**2,249**	2,340
Other	**(4,156)**	898
	67,785	71,157
Benefits paid	**(8,149)**	(7,869)
Accrued benefit liability, end of year	**59,636**	63,288

	2014 $	2013 $
Current year benefits cost	**6,274**	6,411
Amortization of actuarial gain/loss during the year	**417**	348
Benefits interest expense	**2,249**	2,340
Total expense recognized for the year	**8,940**	9,099

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

Discount rate – liability	3.90% as at March 31, 2014 3.60% as at March 31, 2013
Discount rate – benefits expense	3.60% in fiscal 2014 3.85% in fiscal 2013
Rate of compensation increase	0% for 2012, 0% for 2013, 2% for 2014, 3% for 2015, and 3.25% thereafter plus 0.75% for promotions and merit as at March 31, 2014
	3.5% plus 0.75% for promotions and merit as at March 31, 2013

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

17. RELATED PARTY TRANSACTIONS

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

	2014 $	2013 $
Transfers from the Province	**1,215,089**	1,165,320
Transfers from other government entities	**87,335**	95,266
Transfers to other government entities	**(96,852)**	(89,962)
	1,205,572	1,170,624

18. FINANCIAL INSTRUMENTS AND RISK MANAGEMENT

Financial risk factors

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

Credit risk

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

Liquidity risk

Liquidity risk is the risk that the Authority will not be able to meet its financial obligations as they become due. The Authority has an authorized credit facility [the "Facility"] of $64,000,000. As at March 31, 2014, the Authority had $64,000,000 in funds available on the Facility [2013 – $64,000,000]. To the extent that the Authority does not believe it has sufficient liquidity to meet current obligations, consideration will be given to obtaining additional funds through third-party funding or from the Province, assuming these can be obtained.

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

19. BUDGET

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

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

The following presents a reconciliation of budgeted revenue for the year ended March 31, 2014:

	Revenue $	Expenditures $	Annual surplus $
Original Budget	**1,253,244**	**1,251,286**	**1,958**
Adjustments during the year for service and program changes, net	**46,010**	**46,010**	**—**
Revised Original Budget	**1,299,254**	**1,297,296**	**1,958**
Stabilization fund approved by the Government	**27,502**	**27,502**	**—**
Final Budget	**1,326,756**	**1,324,798**	**1,958**

NOTES TO NON-CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2014
[All amounts are in Canadian dollars, except amounts disclosed in tables, which are presented in thousands of Canadian dollars]

20. EXPENSES BY OBJECT

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

	2014 $	2013 $
Salaries	**705,903**	699,302
Supplies – other	**234,587**	225,975
Direct client costs	**128,808**	127,398
Employee benefits	**106,296**	121,108
Supplies – medical and surgical	**62,826**	61,261
Drugs	**49,438**	49,175
Amortization of tangible capital assets	**42,556**	31,813
Maintenance	**22,317**	20,700
Interest on long-term debt	**9,354**	9,469
Total expenses	**1,362,085**	1,346,201

SUPPLEMENTARY SCHEDULES

NON-CONSOLIDATED SCHEDULE OF EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2014	2013
	$	$
	[unaudited]	*[unaudited]*
Patient and resident services		
Acute care	**199,067**	201,416
Long-term care	**144,673**	140,339
Other patient and resident services	**17,594**	20,989
	361,334	362,744
Client services		
Community support programs	**166,709**	165,650
Family support programs	**10,259**	9,971
Health promotion and protection	**16,881**	15,033
Mental health and addictions	**24,789**	20,264
	218,638	210,918
Diagnostic and therapeutic		
Other diagnostic and therapeutic	**84,750**	80,489
Clinical laboratory	**54,642**	50,159
Diagnostic imaging	**48,964**	48,372
	188,356	179,020
Support		
Facilities management	**64,451**	64,897
Food services	**30,859**	30,137
Other support	**30,987**	30,444
Housekeeping	**29,410**	29,189
Laundry and linen	**10,191**	9,606
	165,898	164,273
Ambulatory care		
Outpatient clinics	**82,262**	78,726
Emergency	**32,529**	31,966
Dialysis	**16,003**	16,761
Other ambulatory	**14,826**	15,276
	145,620	142,729

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

Year ended March 31
[in thousands of dollars]

	2014	2013
	$	$
	[unaudited]	*[unaudited]*
Administration		
Other administrative	**37,736**	38,687
Materials management	**18,998**	18,693
Systems support	**19,444**	16,270
Human resources	**13,793**	14,395
Executive offices	**14,346**	14,509
Finance and budgeting	**10,852**	10,867
Emergency preparedness	**819**	440
	115,988	113,861
Medical services		
Physician services	**78,305**	76,304
Interns and residents	**22,160**	22,571
	100,465	98,875
Other		
Undistributed	**5,322**	8,031
Research and education		
Education	**13,043**	13,933
Research	**2,692**	2,593
	15,735	16,526
Interest on long-term debt		
Interest on long-term debt	**9,354**	9,469
Total shareable expenses	**1,326,710**	1,306,446

NON-CONSOLIDATED SCHEDULE OF REVENUE AND EXPENSES FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2014 $ *[unaudited]*	2013 $ *[unaudited]*
Revenue		
Provincial plan	**1,175,985**	1,149,258
MCP	**75,697**	74,483
Inpatient	**13,302**	10,779
Resident	**17,711**	18,560
Outpatient	**8,061**	9,091
Other	**38,707**	39,256
	1,329,463	1,301,427
Expenditures		
Compensation		
Salaries	**705,903**	699,302
Employee benefits	**113,477**	113,166
	819,380	812,468
Supplies		
Other	**234,587**	225,975
Medical and surgical	**62,826**	61,261
Drugs	**49,438**	49,175
Plant operations and maintenance	**22,317**	20,700
	369,168	357,111
Direct client costs		
Community support	**122,601**	121,409
Family support	**4,356**	4,331
Mental health and addictions	**1,851**	1,658
	128,808	127,398
Lease and long-term debt		
Long-term debt – interest	**9,354**	9,469
Long-term debt – principal	**2,753**	3,276
	12,107	12,745
	1,329,463	1,309,722
Surplus (deficiency) for government reporting	—	(8,295)
Long-term debt – principal	**2,753**	3,276
Surplus (deficiency) before non-shareable items	**2,753**	(5,019)

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

Year ended March 31
[in thousands of dollars]

	2014 $ *[unaudited]*	2013 $ *[unaudited]*
Adjustments for non-shareable items		
Provincial plan capital grant	**22,121**	23,497
Other capital contributions	**5,758**	6,713
Amortization of tangible capital assets	**(42,556)**	(31,813)
Interest on sinking fund	**715**	695
Accrued vacation pay	**(180)**	678
Accrued sick leave	**3,782**	(1,780)
Accrued severance pay	**3,579**	(6,840)
	(6,781)	(8,850)
Deficiency as per statement of operations	**(4,028)**	(13,869)

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

Year ended March 31
[in thousands of dollars]

	2014	2013
	$	$
	[unaudited]	*[unaudited]*
Revenue		
Provincial plan	**39,104**	42,434
Deferred grants – previous year	**65,984**	50,597
Foundations and auxiliaries	**4,630**	6,515
Transfer from PHL	**164**	—
Transfer from operations	—	179
Transfer to operations	**(2,817)**	(3,223)
Transfer to other regions	**(124)**	(506)
Other	**1,128**	198
Deferred grants – current year	**(80,190)**	(65,984)
	27,879	30,210
Expenses		
Equipment	**18,367**	18,161
Construction in progress	**(9,928)**	1,096
Buildings	**19,014**	10,650
Vehicles	**426**	303
	27,879	30,210
Surplus on capital transactions	—	—

NON-CONSOLIDATED SCHEDULE OF ACCUMULATED DEFICIT FOR GOVERNMENT REPORTING

Year ended March 31
[in thousands of dollars]

	2014 $ *[unaudited]*	2013 $ *[unaudited]*
Assets		
Current assets		
Cash	—	13,288
Accounts receivable	**131,696**	94,059
Supplies inventory	**15,537**	15,397
Prepaid expenses	**4,876**	4,053
	152,109	126,797
Advance to General Hospital Hostel Association	**1,120**	1,248
	153,229	128,045
Liabilities		
Current liabilities		
Bank indebtedness	**3,319**	—
Accounts payable and accrued liabilities	**128,831**	129,163
Deferred revenue – operating revenue	**20,883**	12,910
Deferred revenue – capital grants	**80,190**	65,984
	233,223	208,057
Accumulated deficit from Public Health Laboratory	**(18)**	—
Accumulated deficit for government reporting	**(80,012)**	(80,012)

Appendix I

Regional Mandate

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

Responsibility of Authority

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

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

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

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

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

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

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

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

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

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

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

- the services provided by the authority,

- how they may gain access to those services, and

- how they may communicate with the authority respecting the provision of those services by the authority;

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

Appendix II

Definitions of Quantifiable Indicators from the Report on Performance Section

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

Quality and Safety: Quantifiable Indicators

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

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

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

Rate of MRSA LTC infections: The purpose of this indicator is to determine the incidence and trend of new Methicillin-Resistant Staphylococcus Aureus (MRSA) infections for long-term care as well as identify cases that are associated with healthcare delivery. MRSA has become a significant and growing public health concern as healthcare-associated infections are a major cause of excess

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

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

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

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

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

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

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

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

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

Percentage of Medication Reconciliation compliance (Acute Care Inpatient Units): This indicator identifies the audit results of the MedRec process as determined by Accreditation Canada criteria. 75 per cent of the charts audited. This is a regional report and the percentage is reported as a point in time.

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

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

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

Access: Quantifiable Indicators

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

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

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

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

- Priority 1 - Urgent: Acute non-traumatic inflammatory rheumatic disorders requiring prompt intervention. Should be seen within 1-4 weeks by Rheumatologist. Target is 95 per cent within benchmark
- Priority 2 - Semi Urgent: Sub-acute non-traumatic inflammatory rheumatic disorders. Will be referred to Internal Medicine.
- Priority 3 - Routine: Chronic non-inflammatory rheumatic disorders. Referral will be redirected to general practice.

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

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

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

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

Percentage of Hip Fracture surgeries completed within 48 hours (city only – HSC and St. Clare's Mercy Hospital): Improving timely access for hip

fracture repair is one of the priority areas identified by the Federal First Ministers in 2004. Wait times are measured from the time the patient comes into the Emergency Department to the time of surgery. The provincial government has mandated quarterly wait time reporting.

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

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

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

Cancer Surgeries - It is not possible to compare 2011-12 wait times to subsequent years, as the reporting methodology has changed. While all patients are included in the volumes of cases completed, calculations for wait times no longer include patients who had inactive wait times (e.g. while they were out of province). The impact on comparing previously reported wait times may vary according to surgery type, volume of emergency cases and volume of waitlist patients who had a period of inactive wait times.

DI - Percentage of MRIs completed within 30 days - Non Urgent - (city only – HSC and St. Clare's Mercy Hospital). This indicator is an aggregate of all MRI wait times within Eastern Health.

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

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

Percentage of non-urgent (Priority 2) Endoscopies completed within 60 days (city only – HSC and St. Clare's Mercy Hospital): This indicator is identifying the percentage of Priority 2 Endoscopy patients who received care within 60 days.

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

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

Sustainability: Quantifiable Indicators

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

HR vacancy rate for difficult to fill (actively recruiting for minimum 2 months, does not include Casuals): This indicator includes vacancies

in five professional areas that have historically been difficult to recruit: Clinical Pharmacist, Combined Lab and X-Ray Technologist, Clinical Psychologist, Prosthetist/Orthotist Clinician/Technician and Audiologist.

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

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

Population Health: Quantifiable Indicators

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

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

Rate of participation (by age) for screening for colorectal cancer: The NL colon cancer screening program launched in late July 2012 in Corner Brook. The first phase of this self-referred screening program was available to residents of Western Health Region between the ages of 50-74 and at average risk for colorectal cancer. Residents who are eligible receive a home fecal test kit in the mail, and return the samples via the mail for analysis. Clients with a negative test result are re-screened every two years, while those with a positive result are navigated through to follow-up colonoscopy. The program expanded in June 2013 to offer colon cancer screening to residents of Central Health. The program is working towards full provincial implementation by 2015.

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

Seasonal Influenza Immunization rate - seniors aged 65+ (reported yearly): Seniors have been identified as one of the groups at highest risk from influenza and recommended for immunization.
Seasonal Influenza Immunization rate- children (reported yearly): The National Advisory Committee on Immunization recommends children aged 6-23 months be immunized to reduce the morbidity and mortality associated with influenza.

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

Eastern Health

Waterford Bridge Rd. • St. John's, NL • A1E 4J8
Tel: (709) 777-1300
www.easternhealth.ca