Capital District Health Authority Management Discussion and Analysis

For the Fiscal Year Ended March 31, 2013 (unaudited)

The following is the management discussion and analysis of Capital Health's operations for the fiscal year ending March 31, 2013. It should be read in conjunction with Capital Health's audited financial statements.

Capital Health is the largest of 10 district health authorities in Nova Scotia, including the IWK Health Centre. Formed in 2001, it is responsible for delivering core health services in the Halifax Regional Municipality and the Municipality of the District of West Hants. Capital Health also delivers tertiary and quaternary acute care services to residents throughout Atlantic Canada as a major referral centre for this region, and is home to the region's largest teaching hospital, the QEII Health Sciences Centre.

Financial Highlights from 2012-13

Capital Health has now completed the third year of a three-year business plan process. We have taken this three-year approach to ensure we are creating a more financially sustainable system for those we serve by making wise investments to support innovation and improved patient care.

We know, however, that we are doing this work within the context of a system that continues to face challenging fiscal realities. Today our focus is on allocating our resources more effectively.

We have worked hard over the past three years to demonstrate that we are responsible fiscal stewards of the public's resources, and that not only can we achieve savings and improve efficiency, but we can do so while improving care and the patient experience. Three-year business planning has enabled us to reinvest some of our savings into strategic initiatives that will positively impact patient care, patient safety and patient outcomes, as well as support our academic mandate.

Some examples of our prudent fiscal responsibility include:

Leaning of supply chain management:

Centralizing the way in which we manage our supplies, in both outpatient and inpatient areas, allows us to achieve some economies of scale and to reduce redundancies across service areas, which will result in significant savings with no impact to patient care.

Reviewing care delivery models:

We're looking at how we deliver care through reviews of our health-care teams, the scope of care provided and the care environment itself. These reviews help ensure patients receive the right care, at the right time, by the right care team. By applying this lens, we ensure that we provide responsible, and responsive, health-care services that are patient-centred but also fiscally sustainable.

Enhancing linkages with the community to ensure smoother, more efficient transitions from hospital to home:

We are exploring models that leverage partnerships across service areas to support these transitions, such as the Home Again initiative where patients are moved back to their home communities with enhanced supports. Under this initiative, patients are closely monitored and and either gradually integrated into the regular home-care program, or assessed and placed on the wait list for long-term care. These patients may otherwise wait in hospital for longer than necessary while these types of transitions are completed.

Multi-year planning has allowed us to invest the appropriate time, energy and engagement — both internal and external — in developing long-term changes to how we deliver care and how we operate as a health-care organization.

Another area where we have made significant improvement has been our ability to reduce administrative costs. Since 2008-09, we have been reducing overall administrative expenses each year. The most recent data available (for 2011-12) shows Capital Health's administrative costs at just four per cent of our total expenses – among the lowest in the country.

Capital District Health Authority
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Overview of Financial Statements

In the 2012-13 fiscal year, Capital Health adopted Canadian public sector accounting (PSA) standards. The adoption of PSA standards is accounted for by retroactive application with restatement of prior periods as of April 1, 2011, and March 31, 2012.

The most significant transitional adjustments are as follows:

- Recognition of vested sick-leave benefits
- Recognition of internally restricted deferred capital revenue
- Reclassification of unrealized gain (loss) attributable to portfolio investments
- Consolidation of Partners for Care using the modified equity method

A Statement of Change in Net Debt has been presented, which represents the expenditures less revenue, as well as acquisitions of tangible capital assets and other items explaining the difference between the surplus (deficit) of the period and the change in net debt for the period.

A Statement of Remeasurement Gains and Losses has been presented, which represents the unrealized gains and losses in financial assets as a result of recording portfolio investments at fair value.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as of March 31, 2012 and 2013 (in thousands)

	2013	**2012** (restated)
Financial assets	$316,745	$320,266
Liabilities	($327,322)	($339,412)
Non-financial assets	$304,633	$317,431
Accumulated surplus	$294,056	$298,285

Changes to financial assets in 2012-13 were the result of:

- Lower cash and short-term investments ($7.5 million less) than the previous year-end due to biweekly funding from the Department of Health and Wellness not being received until the first week of April 2013, offset by a reduction of amounts receivable outstanding from the Department of Health and Wellness, patient accounts and general receivables.
- Lower accounts receivable ($4.9 million less) than the previous year-end because payment time has been improved for billings to other provinces for services to their residents and collection processes have been enhanced for other receivables.
- Larger amounts due from the Department of Finance ($16.1 million more) than at the previous year-end because retirement allowances paid to employees during the latter part of the year are yet to be received. Also, the employer future benefits (an actuarial valuation of the costs of future retirement allowances for current employees and the subsequent medical and insurance benefits paid to these retirees) have increased due to anticipated increasing costs of these entitlements.

Changes to liabilities in 2012-13 were the result of:

- Higher employee future benefits ($12.4 million more) than the previous year-end. Refer to variance in amounts due from the Department of Finance under financial assets changes above.
- Lower deferred revenue ($28.5 million less) than at the previous year-end because the first payment of operating funding from the Department of Health and Wellness for 2013-14 was not received until April 2013. In 2011-12 the first payment for the next year was received in March 2012; therefore it was deferred revenue at year-end. This timing change was necessitated by the provincial requirement to follow Public Sector Accounting Board standards as of April 1, 2012.

Changes to non-financial assets in 2012-13 were the result of:

- Larger capital assets ($25.3 million more) than at the previous year-end because of purchases of capital and computer equipment as well as completion of infrastructure projects.
- Lower construction-in-progress costs ($35.7 million less) than at the previous year-end because a number of large ongoing construction projects were completed during the year. These included an expanded radiation therapy clinic, the Community Living Initiative (mental health bungalows), smoke stack removal, two cardiac catheterization laboratories and operating room light replacement.
- Lower inventories ($2 million less) than at the previous year-end. Inventories were abnormally high in 2011-12 due to a large purchase made in order to qualify for a product rebate. Inventories in 2012-13 have returned to the normal level.

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CONSOLIDATED STATEMENT OF OPERATIONS
as of March 31, 2012 and 2013
(in thousands)

	2013	2012 (restated)
Revenue	$947,762	$944,511
Expenses	($951,801)	($930,320)
Net surplus (Deficit) from operating and capital activities	($4,039)	$14,191
Accumulated surplus, beginning of year	$296,829	$282,638
Operating fund, end of year	$292,790	$296,829

Changes to revenues in 2012-13 were the result of:

- Larger operating grants from the Department of Health and Wellness ($14.8 million more) than the previous year because of additional funding received for bargaining unit wage increases.
- Lower capital grants from both the Department of Health and Wellness ($12.4 million less) and the hospital foundations ($8.9 million less) than during the previous year. During the previous year more large construction projects and equipment purchases were undertaken than normal. Refer to explanation in "Construction in progress" under non-financial assets changes.
- Larger recoveries ($6.6 million more) than during the previous year because the cost of these programs (primarily compensation in Acute Person-Centred Health and Community and Emergency Health programs) had increased, therefore funding from the parties responsible for them had to increase by the same amount.

CAPITAL HEALTH EXPENSE ALLOCATION 2012–13
Total Annual Expenditures: $951.8 million

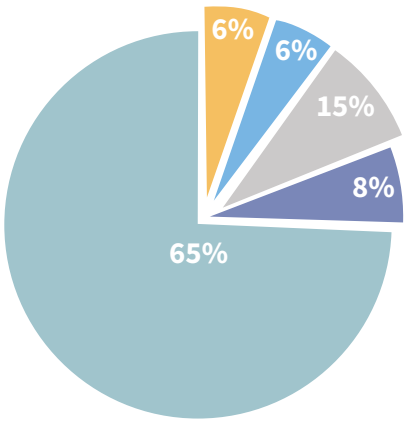
COMPENSATION: includes all salaries and benefits (full time equivalents). Also includes funds allocated for temporary staff.

OTHER: includes miscellaneous expenses such as linens, disposables, postage, courier, food, audiovisual, computer supplies, cleaning supplies, lab/office supplies, purchased services, equipment depreciation, and retirement allowances.

MEDICAL and SURGICAL: includes a variety of medical and surgical supplies such as prosthetics, defibrillators, pacemakers, instruments, needles/gloves/dressings, and miscellaneous supplies.

DRUGS: includes general drugs, anti-infectives, and anesthetic gases.

UTILITIES and PLANT MAINTENANCE: includes utilities such as fuel, power, natural gases, etc., telephone, minor equipment purchases, rentals, various building and equipment maintenance, and maintenance supplies.



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Changes to expenditures in 2012-13 were the result of:

- Higher expenditures in the Acute Person-Centred Health portfolio ($10.1 million more) than during the previous year because of negotiated contract settlements with bargaining units.
- Higher expenditures in Community and Emergency Health ($9.4 million) than during the previous year because of negotiated contract settlements with bargaining units.
- Lower expenditures in the Medicine portfolio ($2.2 million less) than during the previous year because of staff realignment from the Department of Medicine to various outpatient clinics across Capital Health.
- Higher utilities expenditures ($3.4 million more) than during the previous year because of natural gas and electricity rate increases.

CHANGES TO NET SURPLUS (deficit) from operating and capital activities in 2012-13 (in thousands)

	2013	2012 (restated)
Current year operating surplus	$27	$6,645
Current year capital surplus (Deficit)	($5,021)	$8,267
Income (Loss) from consolidation of Partners for Care	$955	($721)
Net surplus (Deficit) from operating and capital activities	($4,039)	$14,191

Major Corporate Trends

Case Costing

Capital Health began case costing in 2011 with the aim of gaining a better understanding of the services we provide, as well as when, for whom, by whom, and at what cost they are provided. Our intent is to use this information and knowledge to analyze and evaluate and to better understand how our services are provided.

In the current environment of decreasing resources, increasing demand for services, and greater emphasis on quality, case costing information can help when faced with decisions about which types of services to deliver, and how to deliver them. Not only is case cost data important for Capital Health's decision making, it can also be used in health-care system reform efforts by providing support to funding, research and policy development. Case cost data can be used to demonstrate good value for resources to provide answers to important management and planning questions that cannot be answered with traditional management and financial information alone.

The project is being undertaken in partnership with the IWK Health Centre, the Province of Nova Scotia and the Canadian Institute for Health Information. We are working with our departments to develop the most detailed data extracts possible and will work to refine the data to support patient-level costing over the next year. We expect to have our first test reports ready by fall, 2013. These initial reports will require refinement, but help us pinpoint areas to focus effort on data improvement.

Renewed Strategic Plan

Over the past five years, we have made great strides in advancing our strategic plan, Our Promise. Capital Health has become more person-centred in the delivery of care and services and is engaging citizens and communities in our plans and decisions now more than ever. Our academic commitment has been reaffirmed and many innovations have been introduced. We have changed the culture of leadership and have worked to ensure the organization and the services provided are sustainable. While we have achieved a great deal of positive change through Our Promise, we recognized that we need to be focused in our efforts. As such, through a collaborative effort with Capital Health employees, physicians, partners and members of the public, we created our renewed strategic plan, Our Promise in Action. This plan contains 14 areas of focus to help us more clearly identify and commit to achieving our strategic priorities.

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Electronic Health Record

Connecting people and their health information electronically is essential to providing real-time access to health information. We have heard from patients, physicians and staff about how essential this is to transforming health and the health-care system. An Electronic Health Record has been identified in Capital Health's business plans and strategic plan and aligns with the Department of Health and Wellness' long-term goals for provincial clinical services.

This project will significantly improve clinical flow and patient safety upon implementation. We will work with the Department of Health and Wellness to determine a vendor approach that will meet both the needs of Capital Health and the long-term goals of the province. In the meantime, we will start to build the foundation pieces to support our Electronic Health Record under the direction of our steering committee. Key committees and working groups will be struck to develop the standards, policies and guide the project. Frontline staff and physicians will participate in design, build, testing, training and end-user acceptance.

Merged Services Nova Scotia and the Provincial Shared Services Review

Merged Services Nova Scotia remains the health-care system's most important effort to make the system more financially sustainable by reducing administrative and support services costs and improving standardization across the sector. Capital Health fully supports the implementation of activities in supply chain, IT and telecommunications, finance and payroll and human resources departments in 2013-14. In addition to this work, the government asked Merged Services Nova Scotia to participate in the Nova Scotia Shared Services Review on behalf of the district health authorities and IWK Health Centre, to look for further efficiencies across the public sector. Recommendations are expected in fall 2013.

Innovative Care, Flexible Facilities

Innovative Care, Flexible Facilities has been a major project as we continue to work to improve our infrastructure. This work is essential to achieving our mission to be a world-leading haven for people-centred health, healing and learning. The focus is about being better, not bigger. It is a significant step in improving health care for Nova Scotians and others in the Atlantic region.

The provincial government announced its support for a feasibility study to define the best way to complete much-needed upgrades within the district over the next five years. The proposed construction of a five-storey addition to the Halifax Infirmary building at Capital Health's QEII Health Sciences Centre, as well as the expansion of a third inpatient floor and three-story addition at Dartmouth General Hospital, will help address plans for the eventual demolition of the 44-year-old Centennial Building at the QEII's Victoria General site. This study is the first step in the overall plan to concentrate inpatient specialty services at the Halifax Infirmary site, which will improve patient flow at the hospitals and increase access to care for Dartmouth residents and their community.

In addition to this work, the Capital Health Addictions and Mental Health Program began preparing for the eventual departure from the Purdy Building, built in 1958 on the Nova Scotia Hospital site.

Design work and cost estimates have been completed and the business case has been sent to the Department of Health and Wellness for review and approval. The estimate for this phase is approximately $8.2 million.