



DEPARTMENT OF HEALTH

**ANNUAL ACCOUNTABILITY REPORT
FOR THE FISCAL YEAR 2010-2011**

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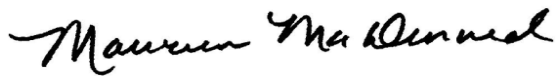
Annual Accountability Report for the Year 2009 - 2010

Department of Health

Accountability Statement

The accountability report of the Department of Health for the year ended March 31, 2011, is prepared pursuant to the *Finance Act* and government policies and guidelines. These authorities require the reporting of outcomes against the Department of Health's Statement of Mandate information for the fiscal year 2010-2011. The reporting of Department outcomes necessarily includes estimates, judgments and opinions by department management.

We acknowledge that this accountability report is the responsibility of department management. The report is, to the extent possible, a complete and accurate representation of outcomes relative to the goals and priorities set out in the department's 2010-2011 Statement of Mandate.



The Honourable Maureen MacDonal
Minister of Health



Kevin McNamara
Deputy Minister of Health

Message from the Minister of Health

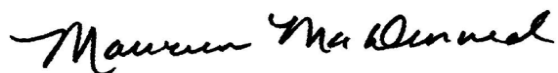
I am pleased to present the Accountability Report for the Department of Health for 2010-2011. The Department has made great progress on all of the initiatives outlined in the 2010-2011 Statement of Mandate that support better health care for Nova Scotia families.

Some of the accomplishments from the past year include:

- Releasing the first accountability report on Emergency Departments in Nova Scotia
- Announcing the co-chairs and Advisory Committee responsible for making recommendations for Nova Scotia's first Mental Health and Addictions Strategy
- Officially opening 475 new nursing home beds and 228 replacement beds across the province
- Investing \$7.9 million for equipment and construction at the Nova Scotia Cancer Centre to improve cancer care and reduce wait times
- Developing a Fair Drug Prices plan to get fair prescription drug prices for seniors and others who get help with drug costs through Pharmacare programs and also announcing a plan for them to pay less for the generic form of Lipitor
- Funding coverage of Lucentis and Avastin for treatment of Wet Age-Related Macular Degeneration for beneficiaries of publicly-funded drug programs
- Providing seniors with more support to stay in their own homes and communities by expanding the Caregiver Benefit and introducing the Personal Alert Assistance Program and Supportive Care Program
- Launching the Extended Care Paramedic Program offering seniors in nursing homes access to enhanced, on-site health care from highly trained paramedics
- Announcing the *Better Care Sooner* Plan to improve the quality of emergency care, reducing overcrowding and wait times for patients in emergency rooms and providing better health care for families

Better Care Sooner, based on the recommendations of Dr. John Ross, the province's emergency care advisor, is the cornerstone for our plan to address the challenges which have plagued Nova Scotia's health care system for many years.

The year will also be remembered for the merger of the former Department of Health Promotion and Protection and the Department of Health. Health is a continuum that requires a focus on both prevention and treatment. The merger better positions the new department to meet the needs of Nova Scotians and to improve their health in the long-term.



The Honourable Maureen MacDonald
Minister of Health

Financial Results 2010 – 2011

| Item | 2010/2011 Estimate (\$ thousands) | 2010/2011 Actuals (\$ thousands) | Variance Estimate/Actuals (\$ thousands) |
|--|---|--|--|
| <i>Executive Administration</i> | 52,698 | 49,002 | 3,696 |
| <i>Medical Payments</i> | 700,982 | 695,464 | 5,518 |
| <i>Pharmaceutical Services</i> | 265,073 | 256,459 | 8,614 |
| <i>Insured Services</i> | 31,191 | 26,475 | 4,716 |
| <i>Emergency Health Services</i> | 105,724 | 105,987 | (18) |
| <i>Home Care Services</i> | 168,609 | 166,558 | 2,051 |
| <i>Long Term Care Program</i> | 472,113 | 467,552 | 4,561 |
| <i>Public Health Programs</i> | - | 144 | (144) |
| <i>Provincial Programs and Initiatives</i> | 126,762 | 120,557 | 6,442 |
| <i>Other Programs</i> | 19,816 | 19,867 | (51) |
| <i>Other District Health Authorities Initiatives</i> | 24,340 | 19,383 | 4,956 |
| <i>District Health Authorities</i> | 1,551,606 | 1,560,237 | (8,630) |
| <i>Capital Grants & Healthcare Amortization</i> | 116,023 | 103,795 | 12,277 |
| <i>Total</i> | 3,634,935 | 3,591,335 | 43,987 |
| | | | |
| <i>Funded Staff</i> | 404.5 | 341.0 | 63.5 |
| <i>Staff Funded by External Agencies</i> | (7.6) | (7.0) | (0.6) |
| <i>Total FTE net</i> | 396.9 | 334.0 | 62.9 |

Explanation of Significant Variances:

The Department of Health spent \$43.6 million or 1.2% less than the 2010/11 budget. Administration had a savings of \$3.69 million due to operational efficiencies and FTE vacancies. Payments to physicians were \$5.5 million less than budget due to savings from lower than projected utilization. Pharmaceutical Services was under budget by \$8.6M due to lower than anticipated utilization as well as the use of generic drugs. Insured Services was \$4.7 million less due to lower anticipated out of province inpatient volumes as well as out of province travel assistance. Payments for the ground ambulance was \$262 thousand less due to overtime less than anticipated, vacancies as well as uncollected user fees bad debt. Home Care spent \$2 million less due to recruitment and retention funding no longer required. Long Term Care was under spent by \$4.5 million due to delays in opening new beds. Provincial Programs and Initiatives was under spent by \$6.3 million due to IT project timing delay, reduction in project costs, decrease in amortization due to assets not put into use. Other District Health Authorities

Initiatives was under spent by \$4.9 million due to vacancies, lower than anticipated call volumes with Health Link and a reduction in other program costs. Capital Grants were lower by \$12 million due to delays in projects.

The savings were partially offset by \$8.6 million more than budgeted for grants to the District Health Authorities for operating pressures as well as wage increases.

The FTE variance is due to regular vacancies throughout the year.

2010-2010 Department of Health Performance Measures/Outcomes

The following measures provide an overview of important information about health services in Nova Scotia and the health of Nova Scotians. In this report, the years in which data is available vary by measure. Some federal agencies collect data based on deadlines that differ from Nova Scotia's deadlines. In addition, the data contained in this report comes from various sources. These data sources have different reporting time periods. Capacity to report on data in a timely fashion is constantly undergoing improvement. For these reasons, primarily, the availability of data will vary by measure.

Each year, outcome measures are reviewed during the Statement of Mandate process for the upcoming year. The following table identifies those measures which have been modified and the rationale for the change.

Some measures were stated in terms of action taken, and therefore cannot be measured numerically. In these cases, the standard template will not be used, however, a statement explaining progress made is provided.

Complete reports on the measures for the 2010-2011 fiscal year can be found on the pages that follow.

Please see below a table explaining the rationale for unreported and modified performance measures.

| Unreported Measures | Rationale |
|---|---|
| Develop indicators to measure system-wide performance | Development of a performance measures framework is the first step in developing indicators to measure system-wide performance. Development of this framework was deferred until 2011-12 pending completion of the accountability framework. |
| Redesign orientation content and develop self-evaluation for DHA and IWK boards | A desired outcome of the Department of Health was to develop an accountability framework that specifies roles resulting in improved governance of Nova Scotia health care. A focus was to redesign orientation content and develop self-evaluation for DHA/IWK boards. Due to shifting priorities, this has become part of a larger initiative of improving governance and accountability by developing an accountability framework for the whole department, which will happen in 2011-12. |

| Modified Measures | Rationale |
|--|--|
| Number of Inquiries (or Calls) Using Health Link | A more patient-centric approach has been taken, and now multiple patients may be served with one call and therefore the measure switched from number of calls to number of patients. |
| Electronic Health Record (EHR Initiative): Number of Clinical Users of SHARE | The Statement of Mandate stated that the target for an increase in EHR uptake was 130 physicians. The target should have been for 75 new clinical users of SHARE. |

Percentage of Patients Receiving Hip and Knee Replacement Within National Benchmark

As part of the National Wait Time Guarantee, benchmarks for five wait time procedures were set. Hip and knee replacement wait times are part of this National Wait Time benchmark. The national benchmark for each of these procedures was set to 26 weeks (or 6 months).

What Does the Measure Tell Us?

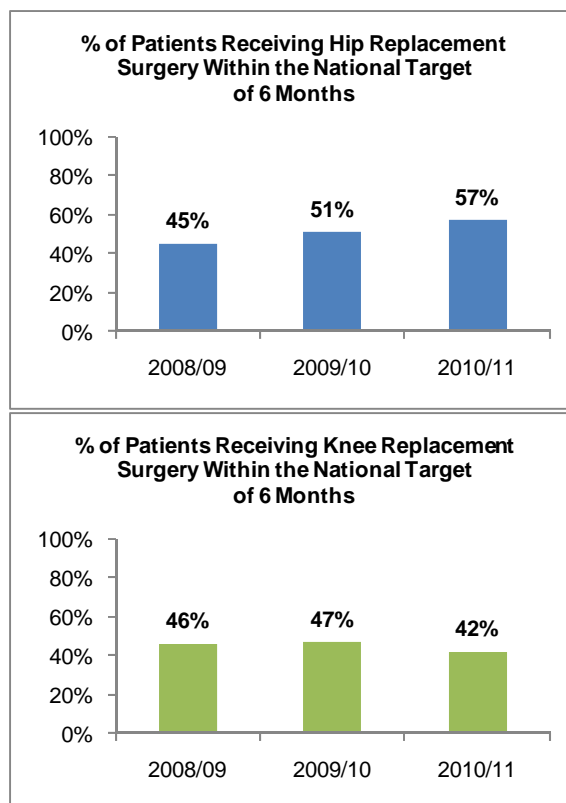
This measure tells us the percentage of patients each year who received hip or knee replacements within the national benchmark during the period April 1–September 30, 2010.

Where Are We Now?

In 2009-10, 51% of patients received hip replacement surgery within 6 months, and 47% of patients received knee surgery within 6 months. In 2010-11, 57% of hip replacement surgeries and 42% of knee replacement surgeries were completed within 6 months. The target was to have an upward trend in each of these areas, however, the target for knee surgeries was not met due to increasing demands for these surgeries. Joint replacement remains the most challenging area. Nova Scotia has the highest proportion of seniors aged 65 years and a higher proportion of obese adults than the Canadian average. Both of these are factors which contribute to the increased need for joint replacement surgery in Nova Scotia.

Where Do We Want To Be In the Future?

Our goal is for all patients to receive hip and knee replacement surgery within the national benchmark of 6 months. To move us towards our goal, pre-habilitation clinics have been funded in each district providing orthopaedic surgery, with performance reporting required against established deliverables. Through the Nova Scotia Surgical Care Council, a provincial orthopaedic working group has been established with representation from each orthopaedic service to work collaboratively toward improved access to high quality orthopaedic surgery. The Patient Access Registry Nova Scotia (PAR NS), implemented in 2010, is providing better and more timely data to support initiatives to improve access to orthopaedic surgery. In April 2011, access to wait list reports was made available to all surgeons in the province, further facilitating the management of patient wait times.



Source: Healthcare Quality, Safety and Wait Time Improvement Branch, NS Dept of Health

Note: Data for Apr–Sep only is reported for each year to coincide with the *Canadian Institute for Health Information* reporting period

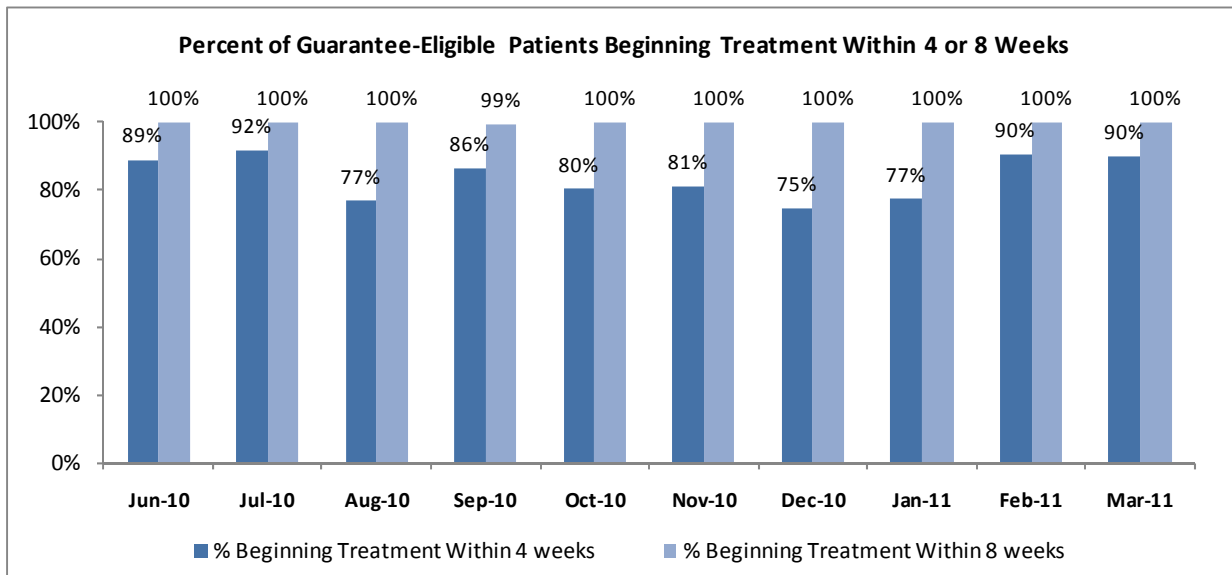
Note: Prior to 2010-11, data was obtained from MSI Billing System. Starting in 2010-11, data is obtained from the Patient Access Registry Nova Scotia (PAR-NS). However, the data is still comparable across the years reported.

Percentage of Patients Beginning Radiation Therapy Within 8 Weeks

One of the department's key areas is the Healthcare Quality, Safety and Wait Time Improvement branch. A desired outcome in this area is for 100% of radiation therapy patients who are eligible for the wait-time guarantee to begin treatment within 8 weeks of being deemed ready to treat.

What Does the Measure Tell Us?

This measure tells us the percentage of patients each month who began their first radiation therapy treatment within 8 weeks of being ready to treat who are eligible for the wait-time guarantee. Patients who are not eligible for the wait-time guarantee include, but are not limited to, clinical trial participants and patients who voluntarily choose not to be included. This measure also indicates how many guarantee-eligible patients began their first treatment within the national benchmark of 4 weeks.



Source: Healthcare Quality, Safety and Wait Time Improvement Branch, NS Dept of Health

Where Are We Now?

Reporting of this measure began in June 2010. Since then, there was only one instance of a guarantee-eligible patient waiting more than 8 weeks (in September 2010). In terms of the 4-week national benchmark for radiation therapy, 90% was achieved for the most recent month (March 2011). Since June 2010, cumulatively 85% of patients began treatment within 4 weeks.

Where Do We Want To Be In the Future?

Our goal is to continue to monitor the wait times for guarantee-eligible patients to ensure that 100% of patient continue to begin treatment within 8 weeks.

Note: The measure in the Statement of Mandate was for patients assessed, however, it should have read number of patients beginning treatment.

Increase in the Number of Long-term Care Beds Opened

Long-term care provides accommodation, supervisory care, personal care, and nursing services to individuals who can no longer live independently in the community with family and other supports available. The number of long-term care beds is an indicator of the capacity to provide long-term care accommodation. The Department of Health licenses or approves three types of long-term care facilities. They are: Community Based Options, Residential Care Facilities, and Nursing Homes or Homes for the Aged.

What Does the Measure Tell Us?

The measure indicates the increase in the number of beds which increases capacity provided to long-term care clients. An increase in capacity is intended to ease access to the Continuing Care system.

Where Are We Now?

The Continuing Care Strategy provided for the addition of 1,320 new long term care beds to be added to the system over ten years. Cabinet approved an increase of 846 new long-term care beds for the first phase of the new Strategy beds. Prior to the announcement of the Strategy, an additional 275 new long-term care beds had been approved. In total, 1,121 new long term care beds are currently being added to the system.

As of March 31, 2011 852 of the 1,121 new long-term care beds have opened for occupancy, with 490 beds being opened in 2010-11 of which 156 beds were forecasted to be open in 2009-10. Therefore 334 beds were opened out of an expected target of 360. This variance is due to various changes in occupancy forecasting.

Where Do We Want to Be in the Future?

In fiscal year (FY) 2011-12 it is anticipated that 131 long-term care beds will open for occupancy. The occupancy date of the remaining 138 beds has not been determined.

Planning for the balance of the 1,320 new long-term care beds provided for in the Continuing Care Strategy (474) is underway.

Current Bed Numbers and Forecasted Bed Numbers

| Forecast Occupancy | Strategy Beds | Pre – Strategy Beds | Total |
|---------------------------|----------------------|----------------------------|--------------|
| Open | 618 | 234 | 852 |
| FY 2011-12 | 106 | 25 | 131 |
| FY 2012 + | 122 | 16 | 138 |
| Total | 846 | 275 | 1121 |

An Inventory of Services Offered in French

French Language Services within the department is working towards a desired outcome for the French Language Services is for Francophone communities to receive health care in their language of choice.

One of the initiatives of French Language Services is to develop an inventory of services that are offered in French. The inventory of services is identified through the French language services plans that are completed by the DHAs/IWK.

The Department of Health, the Department of Health Promotion and Protection, and the Office of Acadian Affairs, in partnership with Réseau Sante, consulted with the Acadian/Francophone community to identify health and wellness needs and priorities. An inventory was then developed and is monitored regularly for continuous improvement.

Number of Facilities with Operating Rooms that Implement a Surgery Checklist

Providing safer patient care helps to ensure high quality care is delivered throughout Nova Scotia. One way to measure this is by tracking the number of facilities with operating rooms that implement a surgery checklist.

What Does the Measure Tell Us?

This measure shows the percentage of facilities in Nova Scotia with operating rooms using a standardized check list. This list was created under the Safe Surgery Saves Lives Campaign. An increase in this percentage will mean that more patients are receiving standardized high quality and safer care.

Where Are We Now?

All DHAs and the IWK are currently using the surgery checklist, which exceeds the target of 75% of facilities using the checklist.

Where Do We Want to Be in the Future?

The Department of Health will continue to support the districts in their use of the surgery checklist and checklist content will continue to be monitored.

Improved Emergency Health Services Including Appropriateness, Access and Patient Flow

Emergency room problems, including access to care and patient flow, have challenged Nova Scotia's health care system for many years. Government has committed to addressing these issues by keeping emergency rooms open, reducing waits for patients and by providing better care for today's families. *Better Care Sooner* is government's plan to improve emergency care across our province.

What Does the Measure Tell Us?

The development of the *Better Care Sooner* Plan, released in December 2010, is an indication of progress towards improved emergency care. We want patients who require emergency care, to have their journey through the emergency department to be as short, safe and as comfortable as possible. That is what *Better Care Sooner* is all about. This plan outlines a number of changes and enhancements to our current health system, and provides opportunities to evaluate the effect of these changes in the short and long-term, including:

- The development of Collaborative Emergency Centres
- Expansion of province-wide training of our paramedics
- Improved communication with and care for patients while in emergency rooms
- Better assessment and treatment of our seniors and mentally ill in emergency rooms
- New nurse practitioners in nursing homes

Where Are We Now?

Dr. John Ross' report, *The Patient Journey Through Emergency Care in Nova Scotia*, contained 26 recommendations that were used to inform the *Better Care Sooner* Plan. We are currently undertaking a number of actions relative to this plan, including:

- Working with DHAs in to ensure compliance with province-wide emergency care standards, as proposed by Dr. John Ross. These standards will ensure hospitals have minimum requirements for patient access, triage, patient transfer, staffing qualifications, equipment, and site performance
- Implementing Collaborative Emergency Centres (CECs), such as the province's first CEC in Parrsboro, which will result in faster, quality care by nurses, doctors, and other health-care providers
- Reviewing access and flow at some of our busiest emergency rooms in the province and working with health system partners to improve the care of seniors while in emergency room settings
- Using a \$3 million emergency department protection fund to help hospitals find doctors for difficult-to-fill shifts

- At the Halifax Infirmity, the province's largest hospital, a rapid assessment unit has been established. This unit takes in patients from across the province directly rather than directing them to go through the emergency room. Streamlining the arrival of patients in this fashion has helped to improve patient flow and decreased patients' length of stay in the emergency department.

Where Do We Want To Be In the Future?

Continued implementation of the *Better Care Sooner* plan will see:

- improvements in emergency care
- enhanced access to primary care
- more appropriate use of emergency room services
- reduced wait times for emergency care and overall improved experience for patients in emergency room settings
- all emergency rooms meeting defined standards

Moving forward with *Better Care Sooner*, the department will report on progress in these areas so that Nova Scotians may be aware of the short and long-term results of this work.

Number of Electronic Medical Record (EMR) Adoptions

2010-11 was the first of a three-year EMR adoption initiative that saw 128 newly adopted providers, which represents the largest number of providers to implement the provincially hosted Electronic Medical Record since the program was launched in 2005.

What Does the Measure Tell Us?

A very successful recruitment year in 2009-10 left the provincial program in a very strong starting position for 2010-11. The progress on EMR adoption indicates that EMR funding available through the Primary Health Information Management Program and the Physician Master Agreement are incentives that encouraged physicians to adopt the EMR, and that there is interest among providers to implement the provincial EMR.

Where Are We Now?

In 2010-11, 128 licensed providers implemented the provincially hosted Electronic Medical Record. This represents 98.5% of the targeted 130 providers.

Adding required resources for the three year EMR adoption initiative has been a slower process than anticipated. Without sufficient team resources in place, the provincial EMR Program has not been in a position to sufficiently promote. As a result, it is likely that the original target of 180 providers in 2011-12 will have to be modified.

Where Do We Want to Be in the Future?

The provincial EMR Program has targeted 360 additional EMR adoptions over the next two fiscal years. This progress will depend on the PHIM Program's ability to advance key business drivers including:

- Electronic delivery of transcribed reports from provincial hospital systems to Nightingale
- Enhanced post go-live training for existing and new clinics
- Enhanced Peer Network Support
- Enhanced Clinic Hardware/infrastructure Support

Once resources are in place and these program supports are introduced, it is anticipated that the overall target of an additional 490 health care providers for the three years will be met by March 31, 2013.

Retention Rate of New Nurse Graduates

One of the Department of Health's key areas is Nursing Advisory Services. A desired outcome in this area was to maintain or increase the number of nurses who graduate in Nova Scotia and continue to work in the province.

What Does the Measure Tell Us?

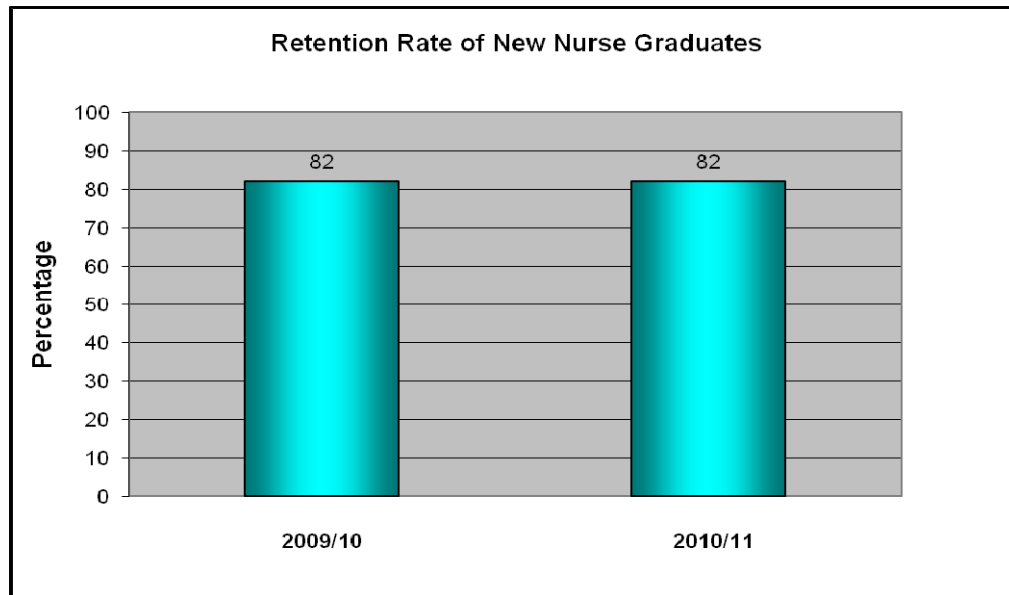
This measure is one way of showing how many new nurse graduates are remaining in Nova Scotia and are working in the nursing profession. Increasing the retention rate will ideally lead to an increased number of nurses working in the health care system.

Where Are We Now?

The target of 80% retention rate was exceeded with 82% of new nurse graduates remaining to work in Nova Scotia in 2010-11. The retention rate did not change from 2009-10.

Where Do We Want to Be in the Future?

Nursing Advisory Services is now a division of the Health Workforce Planning Branch and as part of a Review of nursing data will determine what additional indicators can be identified to determine progress.



Source: Nursing Advisory Services, NS Dept of Health

The target for 2011-12 remains at an 80% retention rate for new nurse graduates remaining to work in Nova Scotia.

Development of Wait Time Measures for Mental Health Programs

The reporting of wait time information for mental health programs and services will help the department determine if an increasing mental health services is occurring or at least being maintained. Meaningful wait time reports enable us to better understand the delivery of mental health services in the various districts and helps the province better manage resources.

Wait times for mental health outpatients are in development. It compares DHA performance to provincial wait time standards. A website launch with the report is planned for 2011-12.

Wait time information is publicly available through the wait time data section of the Department of Health's website.

Electronic Health Record Initiative – Number of Clinical Users of SHARE (Secure Health Access Record)

Nova Scotia continues to collaborate with Canada Health Infoway on the implementation and roll-out of the SHARE Provider Viewer and Clinical Repository. In September 2010, the first 75 clinical users of SHARE went live in a discovery phase. We reviewed and analyzed lessons learned and best practices from the discovery phase, made adjustments and are continuing roll-out. There are two lab interfaces outstanding for the Clinical Repository. These lab interfaces are a focus for this fiscal year and a requirement to meet adoption targets.

| Year | Number of New Clinicians Using SHARE | Total Clinicians Using SHARE |
|-------------------------|--------------------------------------|------------------------------|
| ACTUAL (2010-11) | 150 | 150 |
| TARGET (2011-12) | 1850 | 2000 |

Note : Implementation of two outstanding Lab Interfaces is required to meet adoption targets.

What Does the Measure Tell Us?

This number represents the number of clinical users (physicians, nurse practitioners, etc) using the SHARE Provider Viewer and Clinical Repository. There is no historical data since this is a baseline year and therefore is the first time this data is being reported.

Where Are We Now?

In Sept 2010, the target of 75 clinical users of the SHARE Provider Viewer and Clinical Repository going live in a discovery phase was met. We reviewed processes, implementation plans, data, usability, etc. and have incorporated changes in our approach. We are continuing the roll-out. The project has refocused resources to improve delivery outcome. A SHARE technical team will focus on delivery of two outstanding lab interfaces to the Clinical Repository. A SHARE adoption team will focus on the roll-out and adoption in the clinical community.

Where Do We Want to Be in the Future?

The implementation of the remaining two lab interfaces is a focus for 2011-12. The target for the number of new clinical users using SHARE is 2000 for 2011-12.

Regulations for Continuing Care and Service Level Agreements

The department will ensure that all legal authority is aligned to support the transfer of responsibility for Continuing Care to the DHAs.

Approaches to service level agreements are under negotiations with the service providers and DHAs.

Review of the Senior's Pharmacare Program

One of Pharmaceutical Services' focus is to ensure that drugs are available to Nova Scotians who need them. One way to check in and see how we are doing in this regard is to conduct a review of the drug program that is dedicated to Seniors; the Seniors' Pharmacare Program.

Reviewing the program helped to determine if improvements are required. The Seniors' Pharmacare program was reviewed and it was determined that no modifications to the program are required at this point in time.

The Seniors' Pharmacare Program needs to be sustainable and affordable into the future. Through legislation a drug pricing plan will be implemented on July 1, 2011 that will see a decrease in the cost of most generics to 45% of brand name products. This initiative will save seniors' and taxpayers money and help keep Pharmacare premiums and copayments affordable.

Expansion of the Number of Hospital Units Implementing the Collaborative Care Model

The Department of Health is working with all DHAs and the IWK to expand the implementation of a new collaborative care model. This new model is designed to provide high quality patient care in hospitals more efficiently by making the best use of staff skills, improving processes, and better supporting access to information and modern technology. A research evaluation indicates that it is making a positive difference for patients, health care providers and the health system.

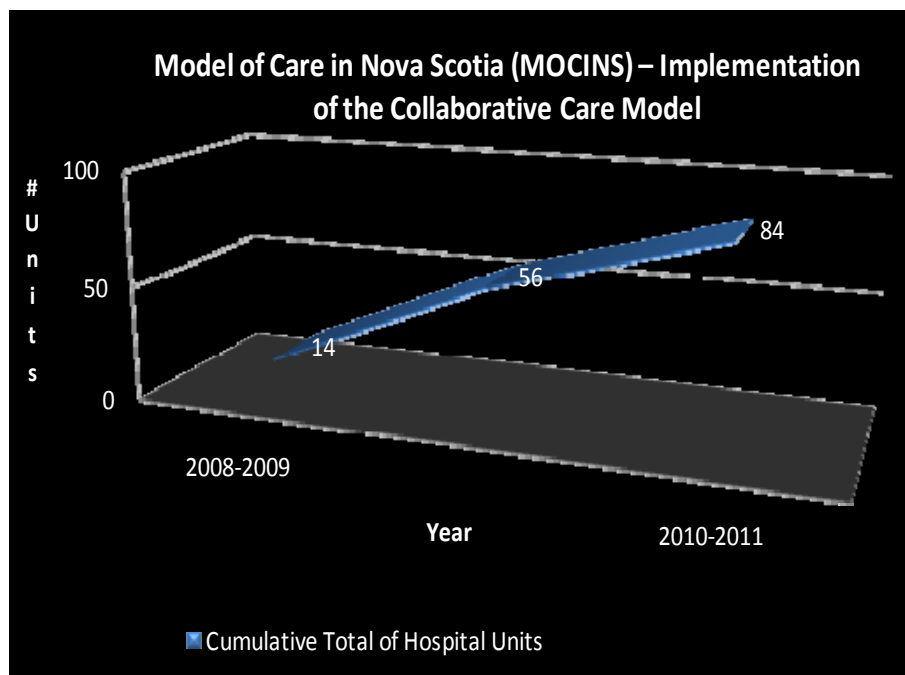
What Does the Measure Tell Us?

This measure is one way of showing the uptake of this new model of care. It also demonstrates the provincial commitment to implementing new ways of providing patient care that are both smart and sustainable.

Where Are We Now?

The target of an additional 25 hospital units to implement the collaborative care model in 2010-2011 was exceeded.

Approximately 28 new units were added for a cumulative total of 84 units now at various stages of implementing this new model. This represents the majority of medical surgical and maternal child units in Nova Scotia's hospitals.



Source: Information Management Branch, NS Dept of Health

Where Do We Want to Be in the Future?

DHAs and the IWK have already begun implementing this model more widely because of the success that they have seen in other districts. Over the next year, the Department of Health will continue to work with the DHAs and the IWK to provincially coordinate and monitor the ongoing implementation of the collaborative care model. Principles and processes of the collaborative care model will be used to support *Better Care Sooner*, particularly as improvements to emergency care are made. Ultimately the future would see the appropriate utilization of our health human resources so that Nova Scotians will continue to have access to the right health care providers at the right times when they need them.

Release a Health System All Hazards Plan

The department responded to recommendations in the Auditor General Report on Pandemic Planning and H1N1 lessons learned by committing to developing and releasing a health system all hazards plan.

In 2010-11 a review, which included health system stakeholder engagement, was completed. Implementation of the recommendations of the Auditor General's Special Report were progressed and the H1N1 lessons learned findings report was published.

Due to the process of incorporating the H1N1 lessons learned findings, this has resulted in a more comprehensive all hazards plan which was not released before the end of 2010-11. However, we are on track to release the Nova Scotia All Hazards Plan prior to reporting to the Auditor General in October, 2011.

Number of Annual Inquiries Using HealthLink 811

A Telecare service called HealthLink 811 provides Nova Scotians with access to Registered Nurses 24 hours a day, 7 days a week. Nurses provide health advice and health information over the phone including information about health services available in the caller's community. The benefits of HealthLink 811 include: helping individuals with self-care advice; being prepared with information during outbreaks and events; access to population health data and most importantly, improving access to primary health-care services. This service will also increase Nova Scotia's capacity to respond to adverse community events.

What Does the Measure Tell Us?

This measure is one way of assessing access to primary health care services in Nova Scotia. The measure will demonstrate the success of the HealthLink 811 promotional approach and will support future planning processes.

Where Are We Now?

The target of 168,750 identified in the Statement of Mandate was overstated as the projections were for 2011-12 and not 2010-11. The correct target should have read 143,750. The actual number of patients served by HealthLink in 2010-11 was 88,492.

The variance between the actual and target figures is due in part to lack of public awareness of the service precipitated by delays in the launch of the promotions campaign which began in late December 2010.

Where Do We Want to Be in the Future?

The original targets were developed based on jurisdictional information in the absence of local experience. As the service matures, future targets will need to be adjusted to reflect Nova Scotia trends.

Ultimately, the future would see an increase in individuals equipped with the information and support for self-care, a decrease in unnecessary visits to emergency departments and an increase in number of individuals seeking health information from locally accepted health information sources.

Percent of Population Receiving Care From a Primary Health Care Team

One of the Department of Health's focus is to improve access to primary health care for all Nova Scotians. This can be measured by the percentage of population receiving care from a primary health care team.

What Does the Measure Tell Us?

Studies indicate that primary health care teams, or collaborative team-based care, leads to improved patient safety, quality of life, and health outcomes for individuals with chronic conditions. Collaboration reduces the cost of patient care and increases access to care. In addition, team-based care has a positive impact on recruitment and retention of healthcare professionals.

Where Are We Now?

The composition of a primary health care team can vary, being comprised of a family physician working collaboratively with, for example, a nurse practitioner, family practices nurses, social workers, dietitians, physiotherapists and/or occupational therapists. Over the past number of years, building primary care teams to serve Nova Scotians has been a focus. Increasing the number of existing teams, while enhancing capacity within those that have been established, continues to be a priority.

The target percentage of 21% of Nova Scotians having access to services from primary health care teams in 2010-11 was achieved. We have enrolled thirty-one family practice nurses in a one-year continuing education program to enable registered nurses to work to full scope of practice in primary care settings. This program has demonstrated improved access to more comprehensive care. Through the *Better Care Sooner* Plan, four Nurse Practitioners (NPs) were recently allocated to Primary Health Care teams in DHAs 1, 2, 5 and 8 to provide primary care to residents in select facilities. A plan is being developed to determine the site, types of services, and operational budget for a new primary health care team to support an underserved population.

Where Do We Want to Be in the Future?

The department's plan is to continue to develop additional providers to work in primary health care teams by supporting the family practice nurse education program in 2011-12. Four nurse practitioners will be hired to augment care in long term care within the districts. Using a population based approach, additional providers will be added to augment primary health care teams.

Number of Primary Health Care Providers Who Have Undergone Advanced Training

Another key outcome of the Primary Health Care branch is to enhance health status through emphasizing personal responsibility. One way to achieve this is to provide advanced training in this area to more primary health care providers.

What Does the Measure Tell Us?

Education and training play a significant role in supporting primary health care providers to work effectively as members of interdisciplinary teams. Increasing the number of collaborative interdisciplinary team members working together with a shared purpose, to deliver comprehensive patient-centred care based on best practice, results in better health outcomes, a satisfied team, and is a more cost-effective approach.

Where Are We Now?

An Interdisciplinary Team Forum was hosted to support providers working in collaborative teams across the province in Fall 2010. A total of 90 providers and decision makers from the DHAs / IWK, Provincial Programs, and the Department of Health participated in the forum. Topics included advanced access, self-management support, shared care, workflow practices and efficiencies, optimizing the EMR, and utilizing provincial data to support practice improvements. Twenty-nine participants (30%) completed the evaluation. On a success scale of 1-5, the mean score was 4.4.

Thirty-one family practice nurses enrolled in a one-year continuing education program to enable registered nurses to work to full scope of practice in primary care settings. This program has demonstrated improved access to more comprehensive care.

The revised provincial Building a Better Tomorrow Together (BBTT) program was launched. It is an interactive module-based continuing education program for health care providers. All health care providers are encouraged to participate, preferably with their teams. In 2010-11:

- 79 attendees participated in a 3 day training workshop
- 49 participants attended a half day BBTT session
- 13 individuals attended a 1 day continuing education session for facilitators
- in excess of 750 providers participated in BBTT modules

Where Do We Want to Be in the Future?

In 2011-12 it is anticipated that an additional 30 nurses will enrol in the Family Practice Nursing Program. In response to *Better Care Sooner*, emergency care standards and provider learning needs will be reviewed as they relate to collaborative emergency centres. An educational plan to address any gaps will be developed. BBTT, team collaboration days and other educational opportunities such as shared care mental health will be offered to support providers working in collaborative teams. The BBTT program will be adding two modules; Cultural Competence and Self Management Support. The Health Literacy Tool will be introduced through a web-based application for providers and a half day workshop for facilitators.

Note : The Statement of Mandate did not specify targets for number of providers who have undergone advanced training nor for expanding chronic disease self-management. The later is discussed in this measure, however.

Participation rates in the Colon Cancer Prevention Program (CCPP)

Nova Scotia has one of the highest incidence rates of colon cancer in Canada. Colon cancer is the second-highest leading cause of cancer death in NS. Screening can identify colon cancer early, when it is more likely to be successfully treated and cured. Screening can also prevent colon cancer by detecting growths in the colon (polyps) that can be removed before they become cancerous. By developing an organized colon cancer prevention program, the intention is to increase the number of eligible Nova Scotians who participate in routine, biennial screening. This is measured by progress in making the program available to all DHAs and the participation rate which is the number of Nova Scotians who complete the screening test out of those who are invited to do so. Phasing in the program means that it takes a full two years after introducing the program in a DHA for all members of the target population to be invited for screening.

What Does the Measure Tell Us?

Over the long-term, the expectation is that as a result of full provincial implementation and strong participation in the program, there will be fewer lives lost to colon cancer and those cancers that are diagnosed will be found sooner, improving the chances for survival.

Where Are We Now?

In the first 24 months of the CCPP (launched in 2009), over 120,000 Nova Scotians were sent a FIT - Fecal Immunochemistry Test (40,209 between April 2009 and March 2010; 80,612 between April 2010 and March 2011). In the last 12 months, the CCPP has expanded from the three “early adopter” districts; Cape Breton DHA, Guysborough Antigonish Strait DHA and South Shore Health – to the remaining districts.

Capital Health, the largest health district with approximately 40% of the provincial population, implemented the program on March 25, 2011. To date, 29% of recipients completed the kit, with participation rates being higher for females than males.

Colon Cancer Prevention Program – Participating Districts, March 2010*



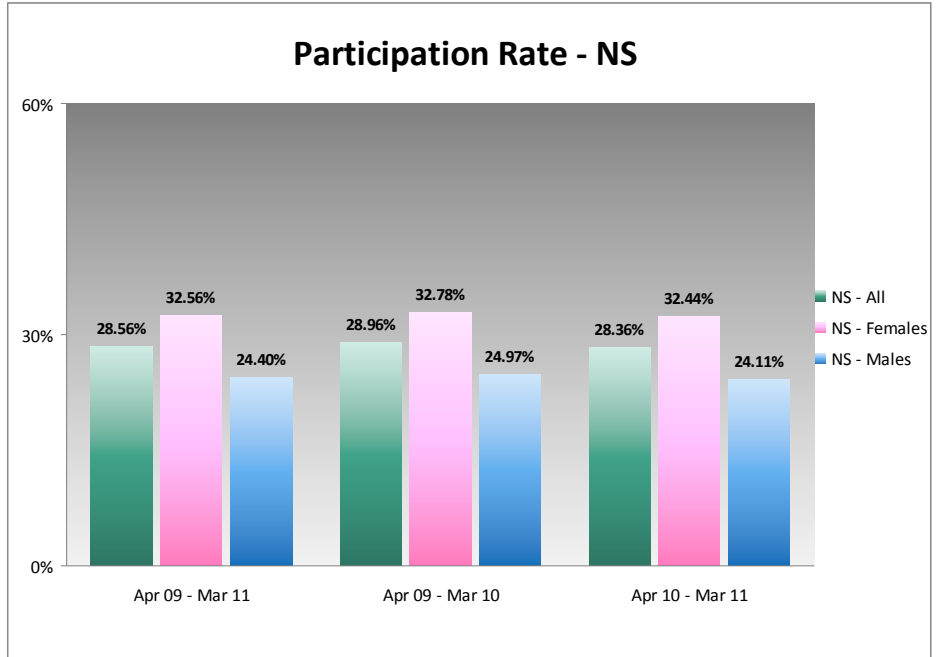
Colon Cancer Prevention Program – Participating Districts, March 2011*



**Participation Rates are Displayed in Colour*

Where Do We Want to Be in the Future?

The target for 2011-12 is to maintain a minimum participation rate in the CCPP of 30%. Cancer Care Nova Scotia is working to modify report to align with the pan-Canadian Quality Framework, including reports on colonoscopy findings and a series of provider quality measures. Next steps for the program include setting quality targets and benchmarks for participation, program components and provider quality, and developing frameworks/supports to help attain these targets.



Source: Cancer Care Nova Scotia

Note: On average it takes 8 – 12 weeks for people to submit the kit after they have received it. Therefore, the actual participation rate is likely higher as those individuals receiving screening kits in March and April of 2011 may only be sending in their complete kits at the time of writing.

Program Enhancements to Self-Managed Care Allowances

On April 1, 2011 government implemented the Supportive Care Program which will support low income seniors with cognitive impairments with funding of \$500/month to purchase home support services (i.e., personal care, respite, meal preparation, and light housekeeping) that would otherwise be delivered through the provincial home care program. Under this program a person may also be eligible to receive reimbursement for snow removal services, up to a maximum of \$495/year. Given that clients meeting the eligibility criteria would not have the capacity to manage this care, their substitute decision makers are responsible for the coordination and management of the funded services.

As of May 31, 2011, only 2 people were receiving Supportive Care Program funding.

Additionally, the Personal Alert Assistance Program was introduced on January 1, 2011. The program provides low-income Nova Scotia seniors living alone, who have had a history of falls, require assistance with a mobility device, and were receiving home care services on December 31, 2010 by providing financial assistance up to \$480/year to purchase a Personal Alert System.

Develop Mi'kmaq Health Framework –Develop Cultural Competence Guide

The development of the Mi'kmaq Health Framework began in 2009-2010. The purpose of the framework is to provide direction to the Nova Scotia Department of Health to better understand and address service barriers and gaps in Mi'kmaq and Aboriginal health. Committees and staff were established, terms of reference developed, and research conducted on Aboriginal (Health) policy frameworks and engagement strategies. First Nations and Aboriginal partners and other health system partners were engaged throughout the framework development process via an advisory committee. Presentations were delivered to key stakeholders and partners.

The Department of Health, along with our First Nation partners has also developed a cultural competence guide specific to First Nations in Nova Scotia.

What Does the Measure Tell Us?

Measures will support the province in establishing a formal, organized and consistent process and structure for accountability and transparency to address access issues relating to health services for Aboriginal people in Nova Scotia. These can also contribute towards the transformation of the Nova Scotia health care system to a model of care where cultural safety is embedded in all aspects of policy development, program planning and delivery.

Where Are We Now?

The framework will be finalized in 2011-2012.

An initial cultural competence guide has been completed. Along with our First Nation partners, and other organizations, the Department of Health has committed to discussing and planning next steps for the cultural safety training module.

Through the vision and goals of the framework, the department will aim to achieve the following objectives: to provide an Aboriginal lens through which provincial health policy can be developed and refined; to create the conditions for effective, collaborative development of provincial policies relating to Mi'kmaq and Aboriginal health throughout the lifecycle and across the continuum; and to develop strategies to aid in resolving disparities in health status and achieve equitable access to health services for all Mi'kmaq and other Aboriginal people in Nova Scotia.

Through the cultural competence guide, we will aim to increase cultural safety within the health care system by increasing awareness of those providing health care to First Nations people in Nova Scotia.

Note: Mi'kmaq Health Framework is now used instead of the term Aboriginal Health Framework

Action Plan Developed Following Analysis of the Department's Recommendations From the Domestic Violence Prevention Committee Report

A Domestic Violence Action Plan was designed to support sustained change. The Department of Health will be taking the lead on a training partnership across government departments and agencies to examine ways to enhance health services and supports for victims and perpetrators of domestic violence, using a comprehensive provincial approach.

The Domestic Violence Prevention Committee, made up of community and government members, released its report in June 2009, which included 70 recommendations.

In December 2010, the premier presented the province's action plan to prevent and reduce domestic violence.

Implementation of the plan has now begun. Progress is being tracked through the Domestic Violence Implementation Management Committee. In addition an internal Department of Health working group is being developed to formalize a coordinated approach to training for partners to make sure resources are put to best use and that consistent materials are available.

The department will work to have the plan be supported by current and new investments to strengthen government, community, and individual capacity to reduce domestic violence in the long term with a sustained focus on addressing the underlying factors that lead to domestic violence. This will involve working with diverse offices and a targeted group of service providers to develop and test training materials tailored to integrate health equity and culturally specific approaches.

This longer-term planning will help us realize our vision of all persons in Nova Scotia living free from domestic violence and abuse.

Reorganized Health Services for Nova Scotians Affected by Stroke

Stroke is a leading cause of death and disability in Canada, with the cost to the Canadian health-care system estimated at \$3 billion annually. Cardiovascular Health Nova Scotia developed a stroke strategy based on evidence that showed coordinated, clustered stroke care in one site and on one unit provides better outcomes for patients. Specifically, organized stroke care units reduce death and disability for individuals recovering from a stroke. Key components of this strategy include reorganizing and enhancing existing stroke care services, a commitment to monitor the impact of these service improvements, and supporting continued education regarding caring for stroke patients.

What Does the Measure Tell Us?

There are a number of ways in which we can measure the impact of these service enhancements on patient process and patient care. For example, we can consider the number of patients treated on an established stroke unit, the percentage of patients receiving neuro-imaging during admission, and the percentage of patients discharged home with less disability. An increase in these areas can be linked with improvement in patient process and care.

Where Are We Now?

A reorganization of Health Services for Nova Scotians Affected by Stroke has happened. In partnership with our provincial program, Cardiovascular Health Nova Scotia (CVHNS), we have collaborated with DHAs to enhance and improve stroke care in seven sites using targeted strategies: recommending stroke program plans, clustering stroke patients, implementing stroke coordinator positions, providing access to secondary prevention, providing professional education, and organizing learning and sharing forums.

Working with health system partners, CVHNS has identified the indicators required to monitor stroke service enhancements throughout the province.

Results from a pilot in South West DHA showed the positive impact of organized stroke care:

- 90% of all patients who were admitted to hospital and were discharged with a diagnosis of stroke or Transient ischemic attack (TIA or mini-stroke) were treated on a stroke unit during their stay
- 9% increase in patients receiving neuroimaging during their admission.
- more patients were discharged home with less disability

Where Do We Want to Be in the Future?

Districts will continue to show improvements as we reorganize and enhance stroke care across the province. Cardiovascular Health Nova Scotia is working with DHAs to:

- (a) Continue to support the full implementation of all seven district stroke programs by working closely with district coordinators
- (b) Continue to deliver targeted professional education, hold stroke forums on identified topics and support the stroke coordinators in their roles
- (c) Implement an accompanying interim and long term strategy to collect indicator data and monitor trends and impact of stroke service enhancements

Applicable Response Time Standards

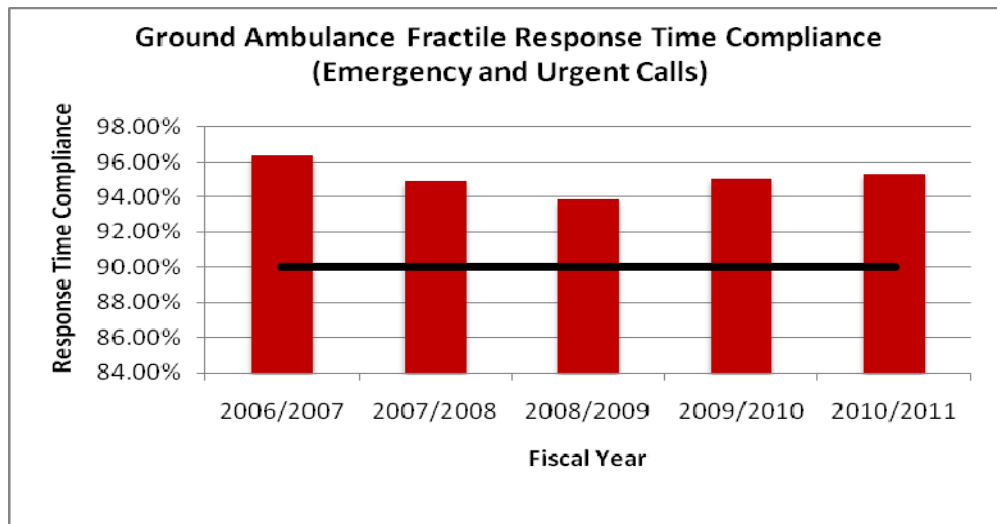
This is a measure of response time compliance for all calls in the ground ambulance categories: emergency, and urgent. An example of the importance of response time compliance is the response of paramedics to cardiac arrests. When an individual sustains a cardiac arrest, for each minute that passes the likelihood of survival reduces by 10%. By having a rapid response time, this allows paramedics to provide life saving interventions such as chest compressions, early defibrillation, and other advanced care. A rapid response is also beneficial for other major diseases, injury, trauma, stroke, and respiratory illnesses.

What Does the Measure Tell Us?

The measure shows the percentage of times that response time standards are met. The standard is measured in minutes. The Nova Scotia standard was set, using expert consultation. The Nova Scotia standard is to meet the response time target (in minutes) 90% of the time (response time compliance).

Where Are We Now?

The response time compliance of 90% is being met. Due to challenges in the health care system, such as Emergency Department wait times, Emergency Health Services saw a decrease in response time compliance in 2007-08 and 2008-09; however,



Source: Emergency Health Services Branch, NS Dept of Health

The response time compliance improved from 93.84% in 2008-09 to 95.31% by 2010-2011. EHS continues to collaborate with the districts to work through these health care system challenges in order to provide optimum response time compliance.

Where Do We Want to Be in the Future?

The Department of Health is dedicated to working with partners to continually improve response times by identifying opportunities in the system using methods and technology that will result in the most efficient use of ambulances.

Number of Nurse Practitioners Augmenting Care in Nursing Homes

A recent report from the Health Council of Canada documents that inter-professional collaborative primary health care teams improve the management of chronic disease, mental health and care for the elderly. Strengthening primary care in continuing care was one of the key priorities identified in the Continuing Care Strategy released in 2006.

What Does the Measure Tell Us?

The addition of four NPs is intended to improve on-site delivery of healthcare for seniors in select long term care facilities. The four new NPs working in nursing homes will provide more proactive alternatives to emergency and acute care.

Where Are We Now?

The target was to have 4 NPs augmenting care in nursing homes. Four DHAs have been selected: Cumberland DHA, Cape Breton DHA, South Shore DHA and South West Nova DHA. The DHAs are at varying stages in the process of determining communities and facilities that will be supported by the NP. District leadership is negotiating with the facilities to define roles and responsibilities of the NP and are working to establish collaborative relationships with physicians. The NPs have been recruited in three DHAs and recruitment is underway for the remaining position.

Where Do We Want to Be in the Future?

It is anticipated that residents of long term care facilities will receive a broader range and continuity of primary health care in their home on a regular basis from a consistent team of providers who know their personal history and understand their individual needs. A team approach will increase the ability of all primary health care team members and staff within the facilities to optimize their respective scopes of practice.

Enhanced care from NPs will result in:

- a decreased number of hospitalizations of long term care residents
- a decreased length of stay in hospital
- an increased ability for residents to die in their place of choice
- decreased expenditures in acute care