

**ANNUAL ACCOUNTABILITY REPORT
FOR THE FISCAL YEAR 2011-2012**



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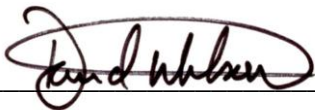
Annual Accountability Report for the Year 2011 - 2012

Department of Health and Wellness

Accountability Statement

The accountability report of the Department of Health and Wellness for the year ended March 31, 2012, is prepared pursuant to the *Finance Act* and government policies and guidelines. These authorities require the reporting of outcomes against the Department of Health and Wellness Statement of Mandate for the fiscal year 2011-2012. The reporting of the Department of Health and Wellness outcomes necessarily includes estimates, judgments and opinions by Department of Health and Wellness management.

We acknowledge that this accountability report is the responsibility of the Department of Health and Wellness 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 of Health and Wellness 2011-2012 Statement of Mandate.



The Honourable David A. Wilson
Minister of Health



Kevin McNamara
Deputy Minister of Health

Message from the Minister of Health and Wellness

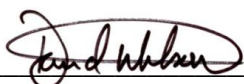
I am pleased to present the Accountability Report for the Department of Health and Wellness for 2011-2012.

This past year our department worked with many partners across the province to develop and implement programs to promote good health, support early childhood development, prevent chronic disease and injury and protect Nova Scotians from emerging public health threats. We also outlined several strategies and plans that will help us improve, over the long term, health care for Nova Scotia families.

Some of our accomplishments over the past year include:

- Completed work on a provincial childhood obesity prevention strategy – THRIVE!
- Ensured that everyone in our province had the opportunity to receive the influenza vaccine by making immunization free for all Nova Scotians
- Funded sport and recreation facilities and trail development to increase opportunities for physical activity
- Passed legislation to better protect young people from the harmful effects of tanning beds - people under 19 years of age are banned from using tanning beds
- Passed legislation, the first of its kind in Canada, to make wearing ski helmets mandatory
- Launched Nova Scotia's first ever Mental Health and Addictions Strategy, *Together We Can*, to help improve care for those living with mental illness and addictions and their families
- Continued work on community living units for patients with mental illness and invested money in opiate replacement program for the Annapolis Valley
- Continued the implementation of *Better Care Sooner* including the opening of the first Collaborative Emergency Care Centre
- Releasing the second Accountability Report on Emergency Departments
- Expanded RESTORE province-wide, enabling advanced care paramedics to administer Tenectopase (TNK), a new generation clot-busting medication
- Received an award for our health equipment loan program, and also for our extended care paramedic nursing home program – where seniors can be treated at home and not in hospital
- Reduced administration costs in our District Health Authorities
- Released the Physician Resource Plan to help plan for the appropriate number of physicians
- Opened 132 new beds and 377 replacement beds in 2011/12
- Implemented the Fair Drug Prices plan to get fair prescription drug prices
- Enhanced services for children with autism

The department had worked very strategically to meet our goals that focused on both the prevention and treatment of disease. We made great strides to improve the health care system and are proud of the innovation from our staff to make life better for Nova Scotia families.



The Honourable David A. Wilson
Minister of Health and Wellness

Financial Results 2011 – 2012

Item	2011/2012 Estimate (\$ thousands)	2011/2012 Actuals (\$ thousands)	Variance Estimate/Actuals (\$ thousands)
<i>Executive Administration</i>	67,925.4	61,271.0	(6,654.4)
<i>Physician Services</i>	721,872.0	721,362.1	(509.9)
<i>Pharmaceutical Services</i>	258,620.0	268,020.8	9,400.8
<i>Insured Services</i>	31,133.0	38,120.9	6,987.9
<i>Emergency Health Services</i>	108,515.0	110,184.0	1,669.0
<i>Continuing Care</i>	2,966.1	2,812.0	(154.1)
<i>Home Care Services</i>	174,153.0	178,284.4	4,131.4
<i>Long Term Care Program</i>	514,886.2	498,742.9	(16,143.3)
<i>Addiction Services</i>	835.0	1,476.3	641.3
<i>Physical Activity Sport and Recreation</i>	16,408.0	16,346.4	(61.6)
<i>Public Health Programs</i>	14,119.0	13,452.2	(666.8)
<i>Provincial Programs and Initiatives</i>	128,649.3	120,974.2	(7,675.1)
<i>Other Programs</i>	19,494.0	19,536.3	42.3
<i>Other District Health Authorities Initiatives</i>	24,927.0	18,466.1	(6,460.9)
<i>District Health Authorities</i>	1,591,136.0	1,593,554.2	2,418.2
<i>Capital Grants & Healthcare Amortization</i>	92,620.0	95,295.1	2,675.1
<i>Total</i>	3,768,259.0	3,757,898.9	(10,360.1)
<i>Funded Staff</i>	526.2	447.8	(78.4)
<i>Staff Funded by External Agencies</i>	(20.8)	(24.0)	(3.2)
<i>Total FTE net</i>	505.4	423.8	(81.6)

Explanation of Significant Variances:

The Department of Health and Wellness spent \$10 million or .3% less than budget. Long Term Care was under spent by \$16.1 million mainly due to construction delays in opening of new beds. Provincial Programs and Initiatives were under spent \$7.7 million due to IT project timing delays, reduction in project costs, lower than expected use of blood products and surpluses in Provincial Programs due to vacancies and operational efficiencies. Other District Health Authority (DHA) Initiatives were under budget \$6.5 million due to delays in Nurse Practitioners initiatives and lower than expected 811 call volumes. In addition, Executive Administration and other areas had savings of \$6.7 million mainly due to operational efficiencies and vacancies.

These savings were partially offset by increases of \$9.4 million in Pharmaceutical Services due to delayed implementation of cost reduction strategies and cost increases in cancer drugs. Insured Services was over budget \$7 million due to an increase in utilization of out of country patients. Home Care Services increased by \$4.0 million due to an increase in utilization for home support and nursing services as well as medical supplies. There was an increase in Capital Grants of \$2.7 million due to additional requirements for DHAs emergency infrastructure and

equipment funding which was offset by capital construction delays. Other increases also included operational pressures of \$2.4 million in DHAs and \$1.7 million increase in Emergency Health Services mainly due to gross accounting reporting requirements for ambulance user fees; however, this is offset by an increase in revenue.

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

2011-2012 Department of Health and Wellness 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.

Complete reports on the measures for the 2011-2012 fiscal year can be found on the pages that follow.

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

Modified Measures	Rationale
Percentage of Service Inquiries investigated and closed within 10 days	Due to a policy change in 2011-12, the requirement to investigate and close inquiries within 10 days was extended to 20 days to allow for a more robust review of any issues that came forward. Therefore the measure is now the "Percentage of Service Inquiries investigated and closed within <i>20 days</i> "

Percentage of Patients with Total Length of Stay from Triage to Emergency Department Departure within Emergency Care Standards

As part of the Better Care Sooner plan, Nova Scotia will be the first province to adopt and implement emergency care standards by the year 2014. Dr. Ross, who was appointed as the first provincial advisor on emergency care, developed these standards. These standards will ensure hospitals have minimum requirements for patient access, triage, patient transfer, staffing qualifications, equipment, and site performance. The following two measures are part of the site performance standards. The department is currently working with the DHAs (DHAs) to ensure compliance with these standards.

a. Percentage of Canadian Emergency Department Triage and Acuity Scale (CTAS) 1-3 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 8 Hours

What Does the Measure Tell Us?

This measure tells us about the percentage of patients with a CTAS score between 1 and 3 whose length of stay in the Emergency Department (ED) falls within the standard. CTAS 1 refers to patients with a life- or limb- threatening condition; CTAS 2 refers to patients with severe pain or unstable vital signs and CTAS 3 refers to patients with moderate illness that may require tests. Meeting the standard means that these patients are admitted or discharged from the ED within 8 hours of being registered or triaged.

Where Are We Now?

In 2011-12, the percentage of patients in all emergency departments (provincial, regional and community) with a total length of stay from triage to emergency department departure being within 8 hours was 86% provincially (the range across all EDs, provincial, regional and community, is from 70% - 99%). 2011-12 is the baseline year.

Where Do We Want To Be In the Future?

Our goal is that by the year 2014, the total length of stay in the Emergency Department from triage to departure (admission or discharge) for CTAS 1 - 3 patients should be 8 hours or less, 90% of the time. The Department of Health and Wellness and the DHAs are working collaboratively to improve the flow of patients through the Nova Scotia emergency care system.

b. Percentage of CTAS 4 – 5 Patients with Total Length of Stay from Triage to Emergency Department Departure Being Within 4 Hours

What Does the Measure Tell Us?

This measure tells us about the percentage of patients with a CTAS score of 4 or 5 whose length of stay in the ED falls within the standard. CTAS 4 refers to patients who have a possible bone fracture or large cuts; CTAS 5 refers to patients with a minor injury. Meeting the standard means that these patients are admitted or discharged from the ED within 4 hours of being registered or triaged.

Where Are We Now?

In 2011-12, the percentage of patients in all EDs (provincial, regional and community) with a total length of stay from triage to emergency department departure being within 4 hours was 83% provincially (the range across all EDs, provincial, regional and community, is from 59% - 100%). 2011-12 is the baseline year.

Where Do We Want To Be In the Future?

Our goal is that by the year 2014, the total length of stay in the Emergency Department from triage to departure (admission or discharge) for CTAs 4-5 patients should be 4 hours or less, 90% of the time. The Department of Health and Wellness and the DHAs are working collaboratively to improve the flow of patients through the Nova Scotia emergency care system.

Percentage of CTAS 4 – 5 Patients Being Seen in Emergency Departments

Many visits to rural community hospitals are for problems that can be adequately treated in a primary health care setting. The Better Care Sooner (BCS) plan, launched in December 2010, includes 32 actions primarily focused on improving primary and emergency care in Nova Scotia. This will ensure that patients receive care in the most appropriate setting.

What Does the Measure Tell Us?

This measure tells us about the percentage of CTAS 4 - 5 who are seen in an Emergency Department. CTAS 4 and 5 refers to patients with less urgent and minor injuries. Some patients within this group could receive care in a setting other than in an emergency department.

Where Are We Now?

In 2011-12, the percentage of patients with a CTAS level of 4 - 5 was 57% provincially. 2011-12 is the baseline year.

Where Do We Want To Be In the Future?

Nova Scotia wants to have a downward trend in the percentage of CTAS 4 - 5 patients being seen in the emergency department if it is not the most appropriate site for their care.

As part of the Better Care Sooner Action Plan, a number of actions are being taken to ensure that patients receive care in the most appropriate setting. Collaborative Emergency Centers are being launched in communities across Nova Scotia that will provide access to primary health care by a team of professionals, including doctors and nurse practitioners for extended hours, seven days per week. CECs also provide same-day or next-day access to appointments; advanced access to care, which means that a set number of appointments will be left open during the day at the Collaborative Emergency Centre in case patients arrive with more urgent needs; 24/7 access to emergency care and night time coverage provided by a collaborative team that is integrated with the Emergency Health System (EHS). A public awareness campaign to increase understanding of 811 and 911 was also launched. Additional Health and Wellness initiatives in progress to ensure that patients receive care in the most appropriate setting are: enhanced Primary Health Care; Mental Health and Addictions Strategy and the Physician Resource Plan.

Percentage of Time that Paramedics Can Pass Responsibility of Care to Hospital Staff Within 20 Minutes of Arrival to the Emergency Department

Extended Ambulance Offload Times in Nova Scotia limit capacity in the province wide EHS system and contribute to long wait times for patients. It is a commitment of “Better Care Sooner” to get people off ambulance stretchers and into Emergency Departments (ED) more quickly.

What Does the Measure Tell Us?

The measure shows the percentage of times that the Ambulance Offload standards are met. The standard is measured in minutes. The Nova Scotia standard was set using expert consultation. Offload Times are the duration between when an ambulance arrives at the ED and when the patient is accepted by the hospital and transferred off the EHS ambulance stretcher. The Department of Health and Wellness’ (DHW) established standard for ambulance off load times is within 20 minutes, with EDs expected to achieve this 90% of the time.

Where Are We Now?

This is first year that the ambulance offload standard is being reported. Provincially in 2011-12, the standard of ambulance offload within 20 minutes was met 39% of the time.

Where Do We Want to Be in the Future?

The effective date for this standard is Jan 1st 2014 and DHW is committed to continue to collaborate with the districts to work through health care system challenges in order to provide optimum ambulance offloads and meet the standard by identifying opportunities in the system using methods and technology that will result in the most efficient use of ambulances and paramedics.

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?

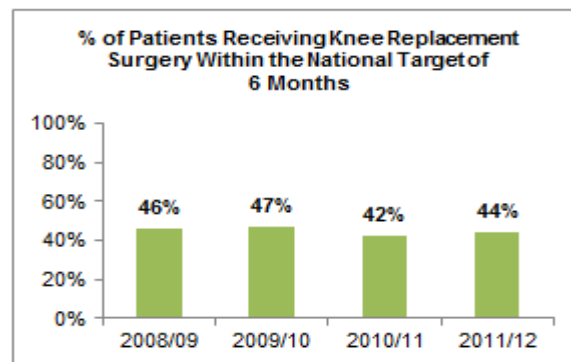
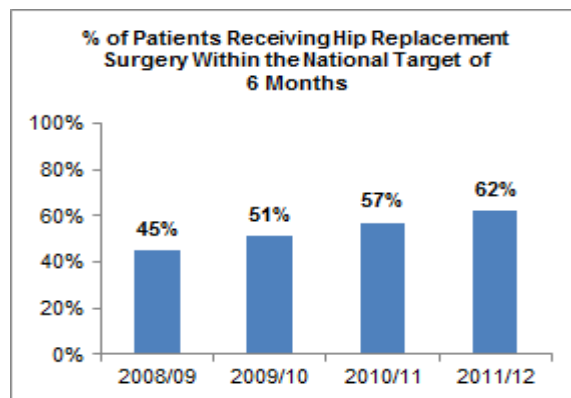
This measure tells us the percentage of patients each year who received hip or knee replacements within the national benchmark as per the Canadian Institute for Health Information's (CIHI) reporting period.

Where Are We Now? ¹

In 2010-11, 57% of hip replacement surgeries and 42% of knee replacement surgeries were completed within 6 months. In 2011-12, 62% of hip replacement surgeries and 44% of knee replacement surgeries were completed within 6 months. This indicates an upward trend over the previous year. However, demand for these surgeries continues to create challenges for maintaining or improving wait times. Nova Scotia has the highest rate of arthritis in Canada, with one in four people affected. Patients often require hip or knee replacement due to osteoarthritis, which is common among people of middle age. In addition, Nova Scotia has the highest proportion of seniors aged 65 years and a higher proportion of obese adults than the Canadian average. These factors 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. The clinics streamline access to hip and knee services and improve quality of care while patients are waiting. 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 2011, access to wait list reports was made available to all surgeons in the province, further facilitating the management of patient wait times. In 2012, a Hip and Knee Replacement Wait Time Improvement Action Plan was developed and submitted to the Minister. The Department is moving ahead with the short-term recommendations of the report, with a focus on reducing the number of long waiting orthopaedic patients through improved wait list management practices.



Improvement Branch, NS Dept of Health

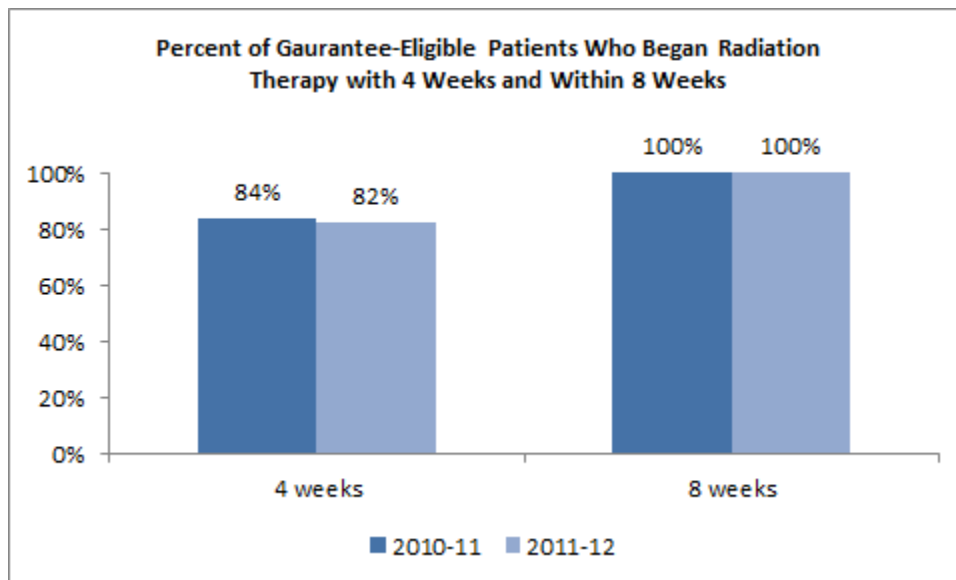
¹ Prior to 2010-11, data was obtained from MSI Billing System. Starting in 2010-11, data is obtained from the Patient Access Registry Nova Scotia (PAR-NS). However, the data is still comparable across the years reported

Percentage of Patients Beginning Radiation Therapy (RT) Within 8 Weeks and 4 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?

The first measure tells us the percentage of patients who began their first RT 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. The second measure indicates how many guarantee-eligible patients began their first treatment within the national benchmark of 4 weeks. An 8-week wait time guarantee was selected as a time frame consistent with the other Atlantic provinces who established guarantees for this service and enables the Atlantic provinces to support each other with RT services if they are unable to meet the 8 week time line.



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, Nova Scotia achieved 82% within benchmark for fiscal year 2011-12. Since June 2010, cumulatively 83% 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. Additional Radiation Therapy capacity is being implemented in Halifax for 2012-13 which is expected to improve performance within the 4-week clinical target.

Number of Facilities with Operating Rooms that Implement a Safe Surgical Checklist

Providing safer patient care helps to ensure high quality care is delivered throughout the Nova Scotia Healthcare system. One way to measure this is by tracking the number of facilities with operating rooms (ORs) that implement a safe surgical checklist (SSC).

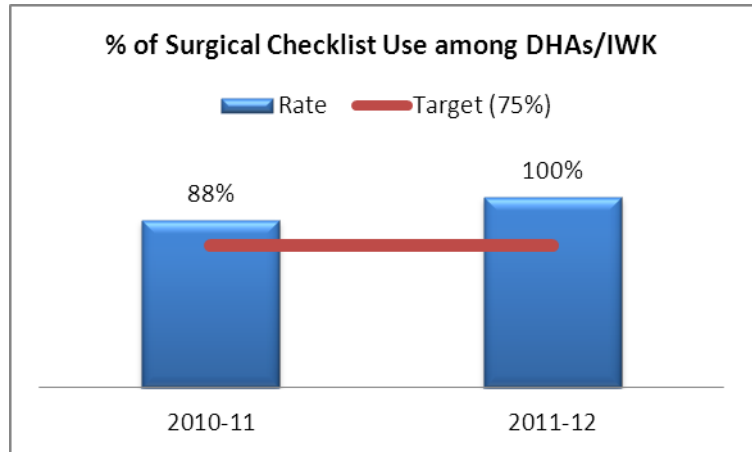
What Does the Measure Tell Us?

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

Where Are We Now?

All DHAs (DHAs) and the IWK Health Centre are currently using a safe surgical checklist, which has increased from 88% in the 2010-11 fiscal year. The adherence rate of 100% exceeds the target of 75% of facilities using the checklist.

The table below provides the number of ORs in each DHAs/IWK, and of those, the number and rate of ORs using a safe surgical checklist.



District	# of facilities with ORs	# of OR facilities using SSC	District rate of SSC use
1-SSH	1	1	100%
2-SWH	1	1	100%
3-AVH	2	2	100%
4-CEEHA	1	1	100%
5-CHA	1	1	100%
6-PCHA	1	1	100%
7-GASHA	1	1	100%
8-CBDHA	5	5	100%
9-Capital	4	4	100%
IWK	1	1	100%

Source: Information self-reported by each DHA/IWK, May 2012.

Where Do We Want to Be in the Future?

The Department of Health will continue to support the DHAs/IWK in their use of the safe surgical checklist. The checklist content will continue to be monitored.

Health Care Services Offered in French and Number of Health and Wellness Documents Published in French

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

One of the initiatives French Language Services conducts to support this is the maintenance of an inventory of health services that are offered in French. The inventory was created in partnership with Office of Acadian Affairs and the Réseau Sante in 2011-12. The inventory is maintained through review of the French language services plans that are completed by the DHAs/IWK.

Another initiative to achieve this outcome is a steady increase in materials and documents published in French. Over the past year, the Department of Health and Wellness supported the translation of a number of publications, including mental health brochures, an Ice Helmet handout, a Runner's Handbook and materials related to the newly released childhood obesity strategy "THRIVE!" - a plan for a healthier Nova Scotia – that focus on breastfeeding, are moving forward

Number of Clients Receiving Home Care Services

Home care is an integral part of the continuum of care. Home care provides service to Nova Scotians of all ages who need care in their homes and communities to help them remain as independent as possible as long as possible. Home care services are meant to add to the help persons can receive from others such as family, community, or friends.

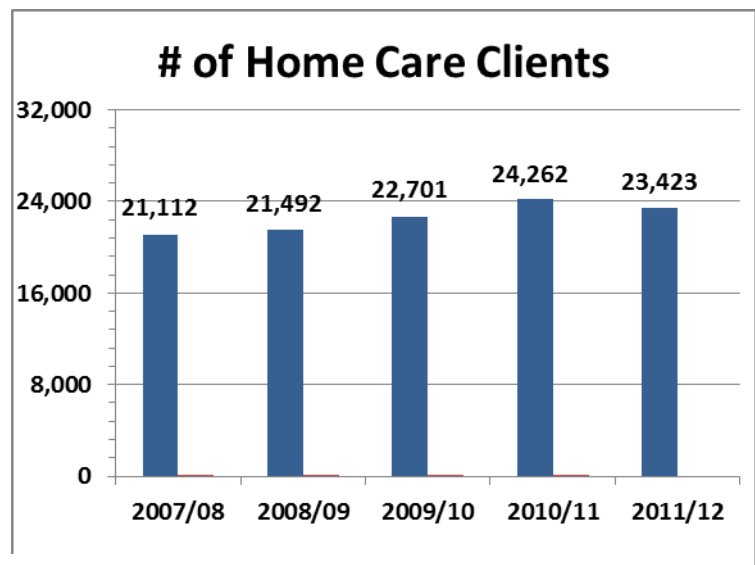
What Does the Measure Tell Us?

This measure tells us the number of discrete clients receiving services in a given fiscal year. This measure does not provide us with the number of authorized services which is the total number of home support hours and/or nursing visits that a Care Coordinator has authorized as part of a client's plan of care

Where Are We Now?

- 2007-08 to 2008-09: increase of 1.8%, up to 21,492 clients
- 2008-09 to 2009-10: increase of 5.6%, up to 22,701 clients
- 2009-10 to 2010-11: increase of 6.9% up to 24,262
- 2010-11 to 2011-12: decrease of 3.5%, down to 23,423

Note: The methodology for determining the number of active Home Care clients changed in 2011-12 to include only those clients who were authorized to receive services delivered by RNs, LPNs, and HSWs (i.e. nursing and home support services). Prior to this, self-managed care clients and clients receiving home oxygen services were also included. Due to this change in methodology, the percentage of Home Care clients for 2011-12 is showing a decrease. However, we still met our target of 23,150 – a 2% increase from the 2009-10 figure of 22,701. Additionally, clients receiving the Caregiver Benefit, Personal Alert Assistance Program, Supportive Care Program, etc. are not included as home care clients.



Source: SEAScape Database, NS Dept of Health and Wellness

Where Do We Want to Be in the Future?

The reality is that with an aging population, more people are seeking access to LTC beds which contributes to wait times. Government needs to ensure all home and community supports and services are exhausted first before long term care is considered. That is why the recent budget announced an investment of approximately \$20 million which will be used to focus on providing more options for people to receive care at home.

Percentage of Individuals Waiting for Long Term Care who are Receiving Home Care

Long term care provides personal and/or skilled nursing care in a residential setting to individuals who require the availability of professional staff on-site at all times. Before being considered for placement in a long term care facility, an applicant must undergo a comprehensive assessment to determine the type and level of care required;

What Does the Measure Tell Us?

The measure indicates the percentage of people who have been assessed as requiring a long term care level of care, who are waiting, in the community for placement and, in the meantime, are receiving publicly funded home care.

Where Are We Now?

Waits for long term care are measured at a point in time. As of January 2012, 83% of people waiting for a LTC bed were waiting in the community. Of these, 59% were receiving publicly funded Home Care, exceeding our target of 32%. Continuing Care aims to increase the utilization among the 41% who are not receiving these services.

Where Do We Want to Be in the Future?

Timely access to long term care beds has been identified as a priority by the DHW, DHAs and long term care providers. DHW undertook a review of the long term care placement process to develop recommendations to improve access. As a result of the report “Removing Barriers to Access Long Term Care”, DHW identified 14 recommendations as priorities for immediate consideration and action to improve access and utilization of long term care. DHW is currently in the process of making decisions regarding policy changes and implementation dates and it is expected changes will be forthcoming in fiscal 2012-13.

The Continuing Care Branch of the Department of Health and Wellness has also undertaken a current state analysis to assess barriers for accessing home care services and to recommend strategies for action. The report includes a completed survey of DHAs and home care service providers to support improving access to home care, recommendations to expand scope and range of services and gaps in utilization of home care. It is expected that priority recommendations will be rolled out over the 2012-13 fiscal year.

Number of Health Care Providers Using Electronic Medical Record (EMR)

An Electronic Medical Record allows Primary Health Care providers to digitally manage their records in their clinic. Providers have immediate access to detailed information on each patient.

2011-12 was the second year of a three-year accelerated EMR adoption initiative. 141 newly adopted providers represent 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?

Despite a delayed start in engaging the EMR Implementation Team, the EMR funding available through the Primary Health Information Management Program, Tangible Capital Assets and the Physician Master Agreement continue to encourage physicians to adopt the EMR, and there is interest among providers to implement the Nightingale on Demand EMR.

Where Are We Now?

Securing the required human resources for the three year EMR adoption initiative was a challenge. In the absence of sufficient team resources in place, the provincial EMR Program was not positioned to optimally promote the program. As a result, the original target of 180 providers in 2011-12 was modified to 146, with the target for 2012-13 being increased.

141 licensed providers implemented the Nightingale on Demand Electronic Medical Record during fiscal year 2011-12. This represents 97% of the targeted 146 providers.

At fiscal year end 2011-12, there were 1,824 EMR users including 428 family physicians, 49 specialists, 40 Nurse Practitioners, 273 other health care providers and 1,034 other practice support.

Where Do We Want to Be in the Future?

The provincial EMR Program has targeted 216 additional EMR adoptions for the third and final fiscal year of this initiative. 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 Clinic Hardware/Infrastructure Support

Enhanced training and Peer Network supports will also be a focus of the program. EMR adoption remains a priority. However, some providers have delayed adopting the EMR while they await a decision from DHW and Doctors Nova Scotia regarding EMR Choice. While the overall target of an additional 490 health care providers over the three years continues to be the goal, achieving that goal by March 31, 2013 could be a challenge given the current environment.

Retention Rate of New Nurse Graduates

Registered nurses (RNs) are the largest group of health professionals in the health care system. In 2011 there were 10,207 RNs registered to practice in Nova Scotia. For more than a decade we have monitored the nursing workforce and established the Nursing Strategy in 2001 to ensure that Nova Scotians continue to have access to nurses and the services they provide.

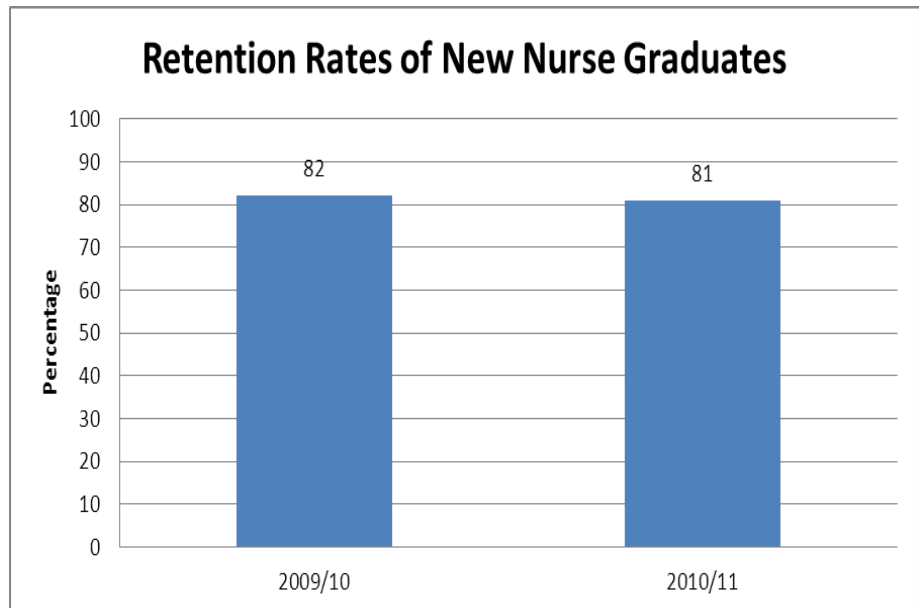
A desired outcome of the Nursing Strategy is to maintain or increase the number of Nova Scotia nursing graduates who stay in the province to work.

What Does the Measure Tell Us?

This measure is one way of showing how many new nurse graduates remain in Nova Scotia and are working in the nursing profession. Increasing the retention rate will ideally lead to a sustainable nursing workforce for the province's health care system.

Where Are We Now?

The target of an 80% retention rate was exceeded in 2011² with 81% of new RN graduates working in Nova Scotia. The retention rate was 82% in the previous year. Each year a proportion of RN graduates choose to leave the province to work or remain in the province, but have not yet found work in nursing. In recent years, the proportion has remained relatively stable, averaging around 80%.



Source: Health System Workforce Branch, NS Dept of Health and Wellness

Where Do We Want to Be in the Future?

The target for 2012-13 remains at an 80% retention rate for RN graduates remaining to work in Nova Scotia.

²The fiscal year started on November 1, 2010 and ended on October 31, 2011.

Percentage of Adult and Child/Adolescent Mental Health Clients Seen Within the Provincial Wait Time Standard

By having the department monitor how long patients have to wait to be seen for mental health services, in terms of urgency, it gives us a better indication of where we need to focus our efforts. Timely access to service is important in supporting people living with mental illness in their communities.

What Does the Measure Tell Us?

The wait time standards are the same for both adult and child/adolescent clients:

Mental Health Wait Time Standards	
Urgent	Within 7 days
Semi-Urgent	Within 30 days
Regular	Within 90 days

Wait times are measured for new referrals to out-patient clinics and exclude Emergency priority clients, clients who choose to be seen outside the wait time target, and clients who change priority level while waiting for their first appointment.

Where Are We Now?

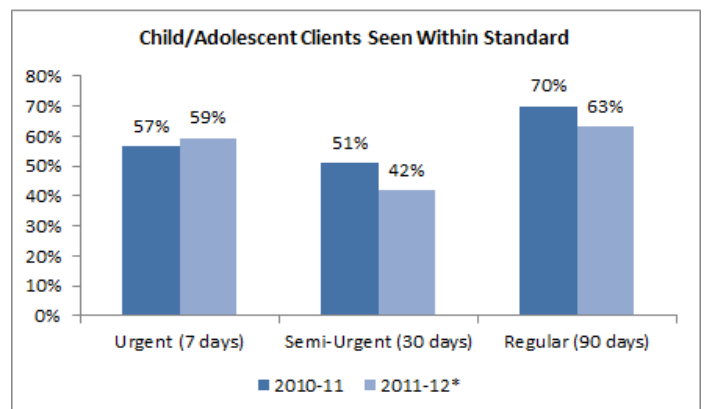
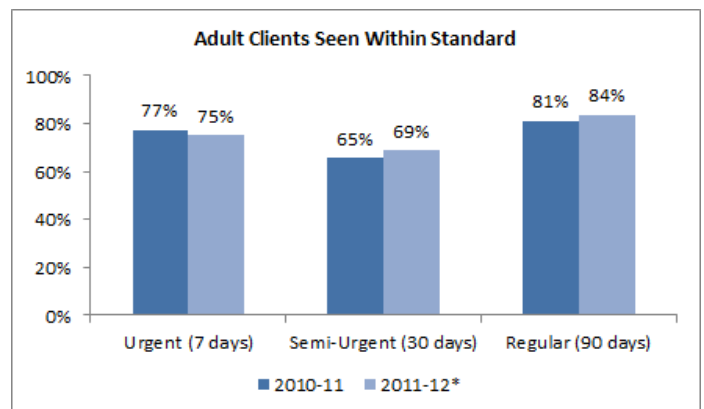
Wait time reporting was established province-wide effective October 2010. Wait times are monitored by the Department on a quarterly basis. For adult clients, percent in standard shows a downward trend for Urgent priority and upward trend for Semi-Urgent and Regular. For child/adolescent clients, percent in standard shows an upward trend for Urgent priority and a downward trend for Semi-Urgent and Regular.

In 2011, Capital Health (DHA 9) made significant changes to their service delivery model to improve wait times for patients. As a result of these changes, DHA 9 no longer conforms to the provincial standards because patients are not triaged into three priority levels. Therefore, the data reported for 2011-12 excludes Capital Health clients, which means that information for approximately 40% of adult Mental Health outpatients in Nova Scotia is not represented. Wait times for DHA 9 are monitored quarterly by the Department using median and 90th percentile measures instead of percentage within standard.

If the priority levels are removed, and all wait times are combined into one measure, then the percent of clients seen within the standard wait time is 80% for adult, and 56% for child/adolescent patients.

Where Do We Want To Be In the Future?

The goal is to increase the percentage of clients seen within the provincial standard. In addition, public wait time reporting for Mental Health through the Wait Times website is planned for launch in 2012-13.



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

Number of Recommendations in the Auditor General's Special Report on Pandemic Preparedness to which the Department of Health and Wellness has Responded

In 2010-11 the department responded to recommendations in the Auditor General Report on Pandemic Planning and H1N1 lessons learned. A review was completed, which included health system stakeholder engagement. Implementation of the recommendations of the Auditor General's Special Report was begun and progress was tracked.

What Does the Measure Tell Us?

This measure represents the number of recommendations that we have agreed are the responsibility of the department to address.

The Auditor General listed 33 recommendations for the department to address, however, only 29 were applicable to DHW. The remaining four recommendations are attributed to either the Department of Justice or the Executive Council Office of Central Government.

Where are We Now?

The department has submitted a response to the Auditor General for all 29 recommendations.

Where Do We Want to Be in the Future?

While we have responded to all 29 recommendations from the Auditor General's Special Report on Pandemic Preparedness that are applicable to DHW, there is still work to be done in order to complete the necessary actions to address all 29 recommendations. 23 out of 29 (79%) of the recommendations have been completed.

DHW is committed to addressing all 29 recommendations and continues to make progress on work to finalize the remaining six outstanding recommendations.

Number of Recommendations from the H1N1 Lessons Learned Report To Which the Department of Health and Wellness has Responded

Following the Auditor General Report on Pandemic Planning, the H1N1 Lessons Learned findings report was published. An H1N1 Lessons Learned tracking tool was developed and progress on implementing the recommendations is currently being tracked.

What Does the Measure Tell Us?

This measure represents the number of recommendations from the H1N1 Lessons Learned tracking tool that the department has begun to address.

Where are We Now?

There are 68 recommendations in the H1N1 Lessons Learned tracking tool, and work has begun on all 68.

Where Do We Want to Be in the Future?

We are on track to complete the implementation of all 68 recommendations by 2012-2013. Completing these recommendations enhances the provinces capability to respond to any threat that has the potential to impact the provincial health system.

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

Electronic Health Record (EHR) - Share (Secure Health Access Record) is a secure and private lifetime record of an individual's health and care history. Access to this information by health care providers will allow for better care and faster treatment for patients in Nova Scotia.

Nova Scotia continues to collaborate with Canada Health Infoway on the implementation and roll-out of the SHARE Provider Viewer and Clinical Repository. The number of clinicians who are using SHARE is a good measure of the success of the EHR.

Year	Number of New Clinicians Using SHARE	Total Clinicians Using SHARE
ACTUAL (2010-11)	150	150
TARGET (2011-12)	1,850	2,000
ACTUAL (2011-12)	325	475

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 (eg., physicians, nurse practitioners) using the SHARE Provider Viewer and Clinical Repository. There is continued uptake with SHARE while waiting for the Lab Interfaces.

Where Are We Now?

We are continuing to roll-out SHARE to those Providers in our Healthcare System who find value in the current data in the Clinical Repository.

Due to continued technical issues with vendor software, the two lab interfaces are still outstanding for the Clinical Repository, and therefore, the target of 2,000 users of SHARE was not met. In 2011-12, 325 new clinicians started to use, and continue to use SHARE, bringing the total number of clinicians using SHARE up to 475.

The SHARE technical team (HITS-NS) will continue to focus on delivery of two outstanding lab interfaces to the Clinical Repository. The SHARE adoption team will continue to 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 will be a focus for 2012-13. DHW aims to have 1,000 clinicians using SHARE by 2012-13.

Number of Serviced Patient Calls received by HealthLink 811

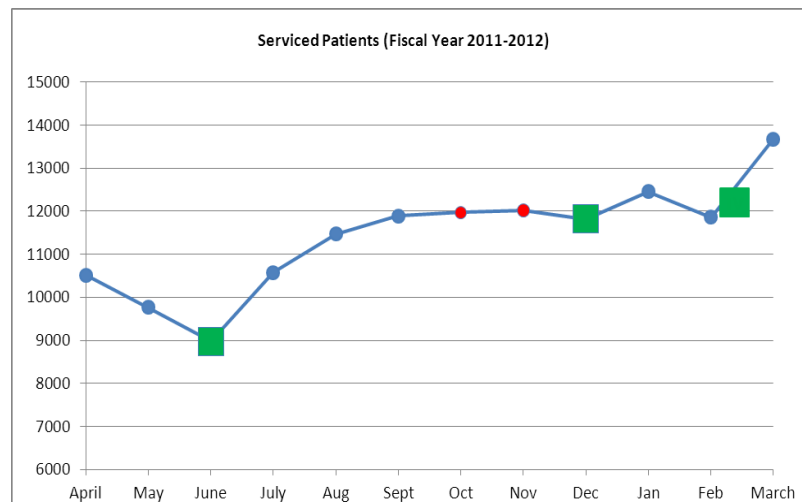
A Telecare service called HealthLink 811 provides Nova Scotians with access to Registered Nurses 24 hours a day, 7 days a week. Nurses provide health advice and health information over the phone including information about health services available in the caller's community. The benefits of HealthLink 811 include: helping individuals with self-care advice; being prepared with information during outbreaks and events; access to population health data and most importantly, enhancing access to health-care services. This service also increases 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 health care services in Nova Scotia. The measure demonstrates the success of the HealthLink 811 promotional approach and will support future health care planning processes.

Where Are We Now?

The Department of Health and Wellness conducted promotional activities during the reporting period including television, radio and a provincial mailer that was sent to households throughout the province. In addition, 811 supported and was promoted in conjunction with the Prescription Drug/Alcohol campaign launched by Addiction Services in Fall 2011.



□ Tv Advertising began in these months.

● Commercial regarding mixing prescription drugs and alcohol ran on TV.

The Statement of Mandate projected 168,670 calls received by HealthLink 811 in 2011-12. The actual number of patients served by HealthLink 811 in 2011-12 was 136,974. As the service matures, we are better able to project the expected call volumes to 811. Future volumes would be anticipated to be approximately 140,000 serviced patient calls per year.

Where Do We Want to Be in the Future?

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 sources of health information.

Number of Primary Health Care Providers Who Have Undergone Advanced Self Management Support Training

Across Canada and globally, there is a growing understanding that patients with chronic conditions benefit from being actively engaged in their own care. Chronic Disease self-management and self-management support is an area of focus within primary health care that supports patients to become more empowered with respect to their health.

Self-management support entails a health care provider working with patients who are living with chronic disease to become a partner in their healthcare. Increasing the capacity for health care providers across the system with the awareness and tools required to engage in this work with individuals living with chronic diseases is aligned with the Expanded Chronic Care Model and “best practice” literature.

What Does the Measure Tell Us?

This measure is an indicator of the progress made in building capacity amongst primary care providers to enable them to support their patients with self-management skills.

Where Are We Now?

Our target was achieved. The self-management support education module was successfully offered in two DHAs to a total of 30 participants. In addition, an abbreviated version of the training was delivered to 90 health care providers who support individuals who are living with chronic pain. A province wide implementation plan is currently being developed.

Where Do We Want To Be in the Future?

In future, through a continued partnership between the Department of Health and Wellness and the DHAs, programs and initiatives will be offered to providers to promote sustainability and increase their capacity to support patients with self-management.

Number of Primary Health Care Teams in Nova Scotia

One of the Department of Health and Wellness' strategies is to improve the health of Nova Scotians through greater access to collaborative primary health care teams. Collaborative primary health care teams consist of family physicians and one or more professionals from the following groups: nurse practitioners, family practice nurses, dietitians, social workers, mental health workers, other allied health providers and support staff. The composition of a collaborative primary health care teams varies depending on the needs of the population.

What Does the Measure Tell Us?

Studies indicate that collaborative primary health care teams lead to improved patient safety, quality of life and health outcomes for the elderly and for individuals with chronic conditions including mental health conditions. According to the Health Council of Canada, Canadians are in favor of collaborative team-based care. Providers benefit from improved job satisfaction and decreased job stress. In addition, collaborative team-based care has a positive impact on recruitment and retention of healthcare professionals.

Where Are We Now?

The overall target of 10-20 new teams has been reached during fiscal 2011-12. Over the past number of years, building collaborative 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:⁹

- An additional 19 registered nurses completed or are in the process of completing the family practice nursing (FPN) program. An additional feature of the FPN program is Team Collaboration Days. Collaborative primary health care teams from across the province participated in a one-day workshop on Geriatrics. Total attendance was 108.
- The government committed to adding nine new nurse practitioners (NP) - one in each DHA. Hiring of these NPs is almost complete with five in practice, two recruiting, and two being planned in conjunction with CECs.
- A recruitment and retention strategy that aligns with the Physician Resource Plan will be developed.
- There has been substantial investment in the role of paramedics in CECs.

Where Do We Want to Be in the Future?

The Department plans to implement four new collaborative primary health care teams and support existing collaborative primary health care teams in conjunction with the Physician Resource Plan during 2012-13. During the past year, the Department has developed a provincial planning tool for implementing and augmenting collaborative PHC teams through better understanding of population needs and service levels. Using a population-based planning approach, additional providers will be added to enhance access to collaborative primary health care teams.

Two midwives will be added to provide primary maternity care to priority and underserved populations in the HRM area in 2012-13.

Number of Chronic Disease Self-Management Program Sessions

Across Canada and globally, there is a growing understanding that patients with chronic conditions benefit from being actively engaged in their own health care. Increasing access to self-management programs for individuals living with chronic diseases across the province is aligned with the Expanded Chronic Care Model and “best practice” literature.

What Does the Measure Tell Us?

Increased access to self-management programs is an area of focus that has potential to support patients to become more empowered with respect to their health. This reflects both the components of the Expanded Chronic Care Model and the evaluation data available for standardized self-management programs (i.e. the Stanford Model).

Since implementation in 2008, support and resources for provincial chronic disease self-management programs has expanded in both provincial access and uptake by individuals. A targeted marketing campaign was done in March/April 2012 which resulted in a significant increase in the number of inquiries about the program.

Where Are We Now?

In 2010-11 there were 64 *Your Way To Wellness* self-management programs delivered across the province, exceeding the target of 50 self management session being offered. 65 sessions were delivered in 2011-12. In addition the *Nova Scotia Chronic Pain Initiative* clinic teams delivered 38 chronic pain self-management programs in 2010-11, while offering 42 programs in 2011-12.

Self-management programs in Nova Scotia recently expanded, in collaboration with the IWK, to include a program for youth living with chronic conditions. This program was offered on a limited basis and evaluated with positive results. The *You're In Charge Program* will now be offered in multiple locations annually across Nova Scotia.

In total through 2011-12, more than 2,500 Nova Scotians participated in a chronic condition/pain self-management program.

Where Do We Want To Be in the Future?

Through continued programs and initiatives by the Department of Health and Wellness in partnership with the DHAs, the goal is to sustain and increase access to self-management support for patients living with chronic conditions and their families.

An evaluation of Your Way to Wellness has commenced. Results from the evaluation will inform future programming for those living with chronic disease across Nova Scotia.

Number of Primary Health Care Teams Offering Advanced Access – Same Day or Next Day Access

Increasing access to Primary Health Care for all Nova Scotians is a key priority for the Department of Health and Wellness. Timeliness is one component of access and the ability to have same day/next day access to a Primary Health Care (PHC) team is one indicator of timeliness. It is an expectation of PHC that new teams plan to achieve same day/next day access. The availability of same day/next day appointments is part of the new Collaborative Emergency Centres (CEC) being implemented across the province under the Better Care Sooner plan.

What Does the Measure Tell Us?

The potential benefits of same day/next day access to Primary Health Care can include reduced wait times, a decrease in emergency room visits and increased patient and provider satisfaction.

Where Are We Now?

In 2011-12 the province opened its first Collaborative Emergency Centre (CEC) in Parrsboro. In addition, Primary Health Care added new providers to teams to enhance access. Timeliness of access to medical appointments in all communities is a priority of the Department of Health and Wellness. The Department works with DHAs to support Primary Health Care teams as they seek to improve access to patient-centred care.

Where Do We Want to Be in the Future?

In addition to CECs providing same day/next day access, the Department's plan is to focus on increased access to Collaborative Primary Health Care teams across the province. The Department plans to implement four new collaborative primary health care teams and support existing collaborative primary health care teams in conjunction with the Physician Resource Plan during 2012-13. During the past year, the Department has developed a provincial planning tool for implementing and augmenting collaborative PHC teams through better understanding of population needs and service levels. Using a population-based planning approach, additional providers will be added to enhance access to collaborative primary health care teams.

Two midwives will be added to provide primary maternity care to priority and underserved populations in the HRM area in 2012-13.

Participation Rates in the Colon Cancer Prevention Program (CCPP)

Nova Scotia (NS) 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. The aim of the CCPP is to increase the number of eligible Nova Scotians who participate in routine, biennial screening, and to find and safely remove precancerous and cancerous colonic growths. As of December 31, 2011, 923 Nova Scotians have been found to have cancerous or precancerous colonic growths through participation in the CCPP.

Currently, the CCPP measures and monitors several operational and outcome measures. The Participation Rate is a key, internationally recognized indicator of program impact.

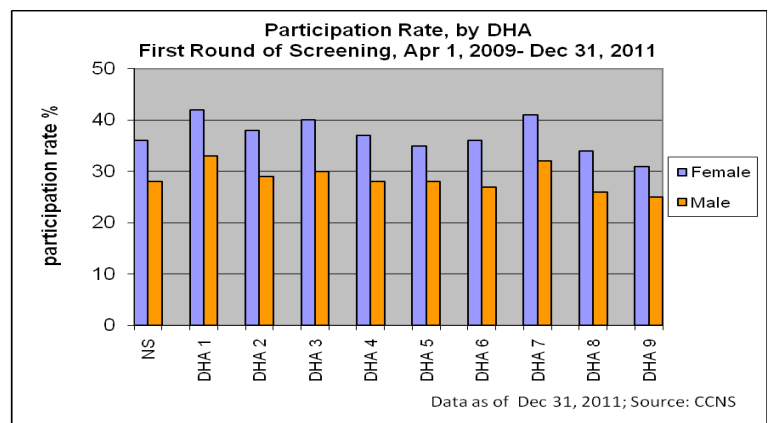
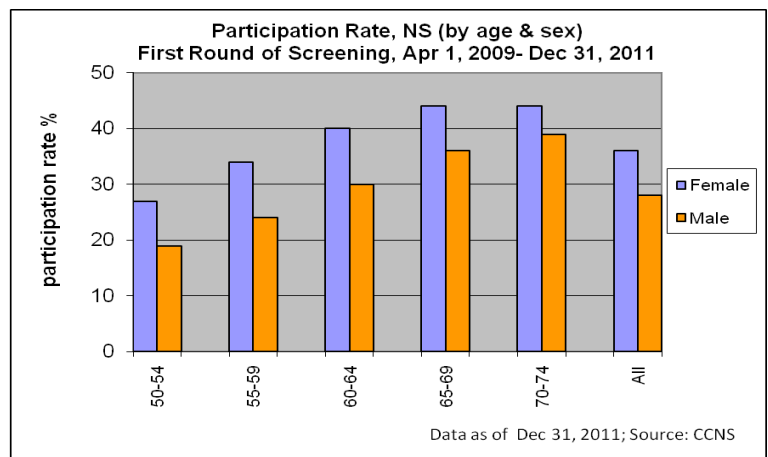
What Does the Measure Tell Us?

Participation Rate is defined as the number of Nova Scotians who complete the screening test out of those who are invited to do so. It takes a full two years after introducing the program in a DHA for all members of the target population (aged 50 – 74 years) to be invited for screening. 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.

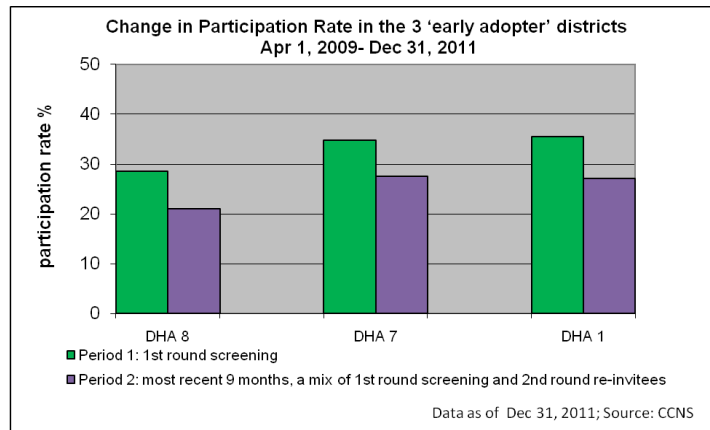
Where Are We Now?

Initially launched in three “early adopter” districts in March 2009 (Cape Breton DHA, Guysborough Antigonish Strait DHA and South Shore Health), the program has been gradually phased-in across the province. Capital Health, the largest health district with approximately 40% of the provincial population, implemented the program on March 25, 2011. To date, over 238,000 Nova Scotians have been sent a Home Screening Test (FIT – Fecal Immunochemical Test).

For first round screening during the period of April 1, 2009 - December 31, 2011, overall participation has been 32% - in line with the initial target of 30%. Participation rates are much higher for females (36%) than males (28%) and tend to increase with age. We also see emerging variation in participation rates between DHAs.



Furthermore, our early adopter districts have now completed their initial two year “prevalence round” of screening and are moving into a more mature state when most of the target population are receiving their second invitation for screening – this is also referred to as “retention” within the program. As expected, based on experience from other organized screening programs, we are seeing a decreased participation rate in this subsequent round of screening for these districts.



Where Do We Want to Be in the Future?

The target for 2012-13 is to maintain a minimum participation rate in the CCPP of 30%. Using data from the Program and in collaboration with the DHAs and other key stakeholders, *Cancer Care Nova Scotia* is working to identify and implement strategies to increase participation overall and to support strong repeated participation (retention) on subsequent rounds of screening.

Given the immaturity of organized screening programs for colon cancer both nationally and internationally, there is very little data or experience available on which to base participation targets going forward. Therefore, CCNS will explore the use of available modeling tools to inform target setting for participation rates and other performance indicators.

Percentage of Applicable Response Time Standards Met or Exceeded

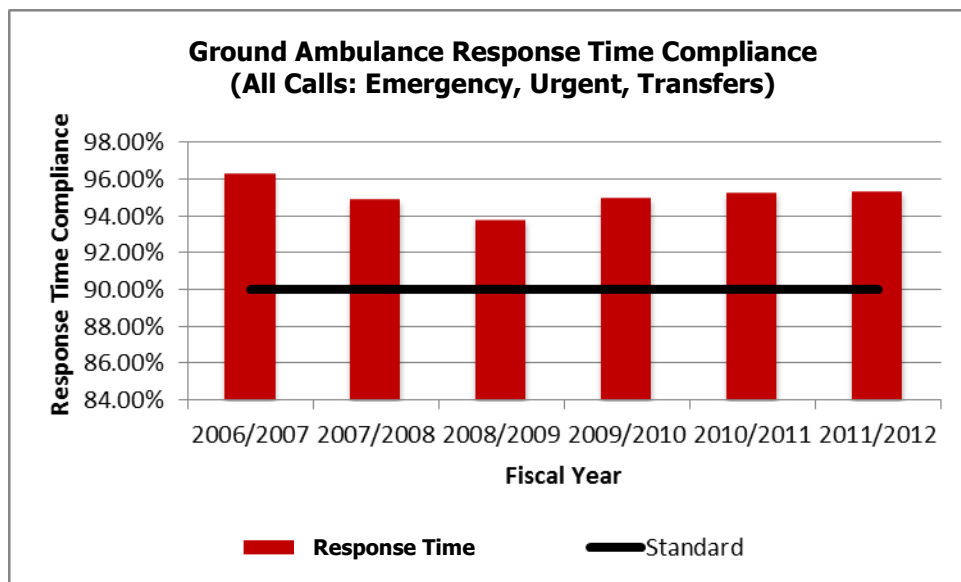
This is a measure of response time compliance for all calls in the ground ambulance categories: emergency, and urgent. An example of the importance of response time compliance is the response of paramedics to cardiac arrests. When an individual sustains a cardiac arrest, for each minute that passes the 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, the response time compliance



Source: Emergency Health Services, NS Dept of Health and Wellness

improved from 93.8% in 2008-09 to 95.3% by 2010-11 and remained stable in 2011-12 at 95.4%. EHS continues to collaborate with the districts to work through 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 and Wellness 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.

Percentage of Service Inquiries Investigated and Closed Within 20 Days

This is a measure of service inquiry responsiveness for all formal inquiries made to EHS. EHS is an evidence based organization that relies on feedback to improve quality and enhance efficiencies.

EHS is a patient focused system that requires a method for stakeholders to easily inquire about system operations. As a result, the EHS system has a service inquiry process that provides anyone, who has come in contact with the system, an opportunity to inquire about processes.

This process is designed to be client friendly and provide prompt and appropriate responses. All inquiries received by EHS, are viewed as an opportunity to validate the system, and enhance client satisfaction, as well as to drive system improvements and efficiencies. In this service inquiry process, all inquiries are logged and categorized in order to establish trends in issues identified so the system can use this information to improve upon itself.

What Does the Measure Tell Us?

The measure shows the percentage of times that service inquiries were opened and investigated within the standard. The standard is measured in days. The Nova Scotia standard was set using industry best practices. Due to a policy change in 2011-12, the requirement to investigate and close 90% of inquiries within 10 days was extended to 20 days to allow for a more robust review of any issues that came forward. Therefore the measure is now the “Percentage of Service Inquiries investigated and closed within *20 days*”.

Where Are We Now?

The service inquiry standard to investigate and close inquiries within 20 days was met 92% of the time in 2011-12.

Where Do We Want to Be in the Future?

The Department of Health and Wellness is dedicated to working with partners to continually improve our responsiveness to the public and to resolve any issues or concerns brought to our attention.

Number of Cultural Competency Guidelines Implemented

Cultural competence can work to reduce disparities and inequities in health status and health services. It can support the detection of population-specific diseases and conditions. It can also address inequitable access to health care and respond to Nova Scotia's existing and changing demographics.

The Cultural Competence Guidelines are a tool that supports health equity, diversity, social inclusion and cultural competence. The diversity of Nova Scotians includes such factors as race, ethnicity, language, sex, sexual orientation, gender identity, (dis)ability, spirituality, age, geography, literacy, education, income, faith perspectives and more.

What Does the Measure Tell Us?

Looking at what has been accomplished under the Cultural Competence Guidelines tells us about progress made in terms of planning, developing and delivering a culturally competent health care system. An example of this is educating health care providers and administration about: cultural competence, the Guidelines, and building on better and best practices currently in place. This gives us indications of areas that require specific focus.

Where Are We Now?

There are 15 Cultural Competency Guidelines and work has begun in each. The main areas of focus have been: ensuring health care is respectfully delivered and responsive to cultural health beliefs, practices, lived experience and linguistic difference; data with diversity identifiers; working collaboratively with diverse populations; building a diverse and representative health staff; making cultural competence training available on an ongoing basis; providing cultural and language interpretation services; providing written material for all literacy levels; accountability for cultural competence and culturally appropriate services at the highest level of the organization; and appropriate screening for diseases and conditions that disproportionately affect specific populations.

Where Do We Want to Be in the Future?

While aspects of the Cultural Competence Guidelines have been implemented throughout the health system, the ultimate goal is integrate and entrench cultural competence in health system planning, policy and service delivery.

Breastfeeding Initiation Rate: Percentage of Infants Receiving Breastmilk and/or Who Had Early Breast Contact

DHW aims to improve the health status of mothers and babies by increasing the breastfeeding initiation rate in Nova Scotia.

Breastfeeding supports the healthy development of newborns by: contributing to healthy brain and nervous system development; protecting babies against infectious diseases; and enhancing emotional development. Beyond infancy, the benefits continue to contribute to protection against childhood cancers, obesity, diabetes, allergy, and Crohn's disease.

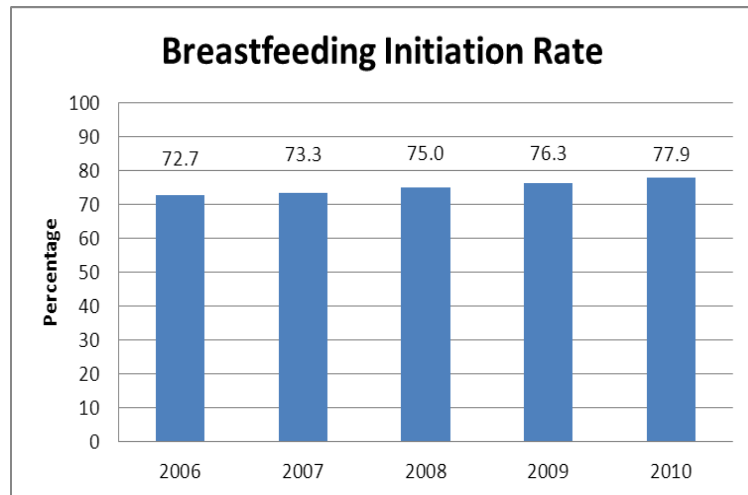
What Does the Measure Tell Us?

This measure is the percentage of infants receiving breastmilk and/or who had early breast contact.

Where Are We Now?

The percentage of breastfeeding initiation for NS in 2006 was 72.7% and has shown a continuous rise to 77.9% in 2010.

This rate is similar to the CCHS data, which shows the rate for NS at 77.7% while the national rate is at 87.2% for 2010.



Source: Atlee Database, Reproductive Care Program of NS

Where Do We Want to Be in the Future?

By 2014-15, Nova Scotia aims to continue its upward trend from the base year for the breastfeeding initiation rate.

Strategies to achieve this target include:

- Implementation and monitoring of the Provincial Breastfeeding Policy
- Capacity building for the promotion, support and protection of breastfeeding through the DHAs, the IWK, family resource centres and other community organizations.
- Work to ensure the components of THRIVE
- Complementing work underway at the national level for promotion, protection and support for breastfeeding and the Baby Friendly Initiative.

Percentage of Nova Scotia Population (12 yrs +) Who Report Eating at Least 5-10 Servings of Fruit/Vegetables Per Day

Consumption of fruits and vegetables remains a key public health message, and therefore one of the department's goals is to increase affordability, accessibility, availability and consumption of fruits and vegetables for all Nova Scotians. Studies have shown the protective role that fruits and vegetables play in preventing chronic disease, including heart disease, stroke, type 2 diabetes, hypertension and many cancers.

What Does the Measure Tell Us?

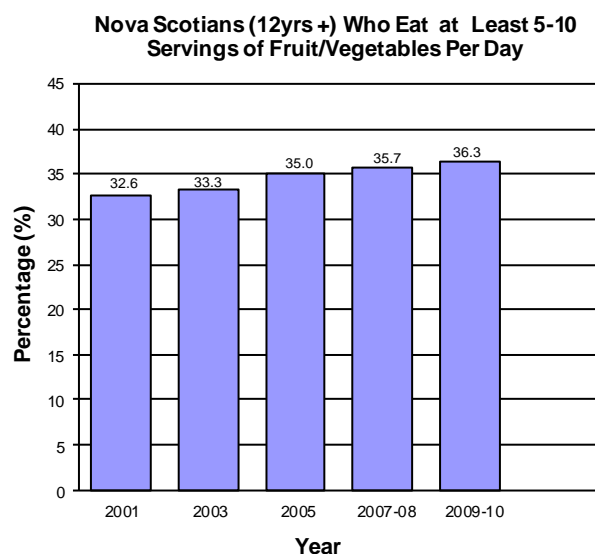
This measure is the percentage of the Nova Scotian population (12 years and older) who report eating at least the recommended 5-10 servings of fruits and vegetables per day. These data include those that met and exceeded the recommended servings. The data is drawn from self-reported data from CCHS3.

Where Are We Now?

Between 2001⁴ and 2010, the percentage of Nova Scotians (12 years and older) that consumed at least 5-10 servings of fruits and vegetables per day rose from 32.6% to 36.3%.

Where Do We Want to Be in the Future?

By 2014-15, Nova Scotia aims to continue an upward trend from its base year in the percentage of the population (12 years and older) who report eating at least 5-10 servings of fruits and vegetables per day.



Source: Community Counts Health Survey (CCHS)

Strategies to achieve this target include:

- § Continued implementation of the Healthy Eating Nova Scotia Strategy (*HENS*)
- § Ensuring that any nutrition guidelines produced for government funded or regulated food service operations include efforts to increase access to fruit and vegetables
- § Supporting the development of community based initiatives that increase knowledge and skills related to preparing fruit and vegetables
- § Complementing work underway at the national level for fruit and vegetable promotion with activities at the local level
- § Developing policy to ensure access to affordable fruit and vegetables by all Nova Scotians
- § Working with the provincial Fruit and Vegetable Working Group and the *HENS* Strategy Steering Committee on identified priorities for fruit and vegetable consumption
- § Working to ensure the components of THRIVE! that focus on improving healthy eating, which includes increases to fruit and vegetable consumption, are moving forward

³ CCHS self-reported data were initially collected every two years then yearly in 2007 using a smaller sample size. In order to be comparable to previous CCHS cycles, the yearly data are combined every two years.

⁴ The base year was set at 2001 because this is a population outcome that will take time to see significant shifts and it predates the release of the Healthy Eating Nova Scotia Strategy.

Percentage of Food Insecure Households

Food security⁵ is a prerequisite for and fundamental determinant of health. Income-related access to food is the largest contributor to food insecurity and Nova Scotia has among the highest rates of income-related household food insecurity in the country. Therefore, measuring the percentage of food insecure households is a method we can use to monitor how we are doing in the area of income related access to food.

What Does the Measure Tell Us?

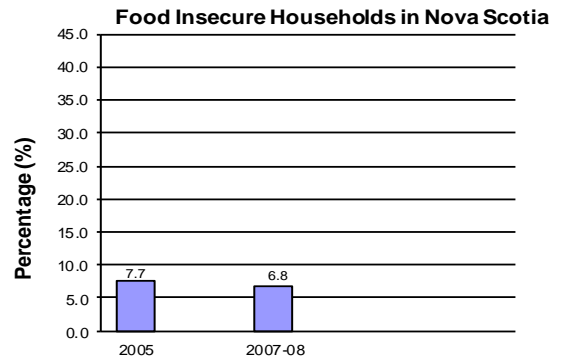
This measure is the percentage of food insecure households in Nova Scotia. Food security is one of the priority action areas in the Nova Scotia's Healthy Eating strategy, *Healthy Eating Nova Scotia* and a core component of THRIVE!. Food insecurity is a barrier to healthy eating and can lead to a variety of health and social challenges. Food security is influenced by and also impacts social determinants of health including literacy, early childhood development and education. Food insecurity impacts on chronic diseases, mental health and emotional well-being, maternal health/birth outcomes, and child development.

Where Are We Now?

In 2005⁶, there were 7.7% insecure households in Nova Scotia. There was a slight decline to 6.8% in 2007-08⁷.

Where Do We Want To Be In The Future?

By 2014-15, Nova Scotia aims to continue a downward trend from the base year in the percentage of food insecure households⁸. The degree to which there is large scale success in reducing the percentage of food insecure households depends on a wide range of factors. The greatest impact will be realized when the root causes of food insecurity including income-related access to nutritious food are addressed.



Source: Community Counts Health Survey (CCHS)

Strategies to achieve this target include:

- § Continuing to support implementation of the provincial HENS strategy
- § Continuing to work in partnership with the Nova Scotia Food Security Network and others interested in promoting and supporting food security, such as support provincial efforts to increase access to a nutritious diet to support healthy eating.
- § Continuing to monitor income-related food insecurity
- § Working to inform THRIVE! to include policy and initiatives to improve healthy eating including increases to fruit and vegetable consumption

⁵ Food security is identified in the provincial Healthy Eating Strategy as one of its four priority areas for action. Food security means that all people, at all times, have access to nutritious, safe, personally acceptable and culturally appropriate foods that are produced, procured and distributed in ways that are sustainable, environmentally sound and socially just.

⁶ Baseline is established at 2005 because in the 2005 CCHS 3.1 survey, the food insecurity questions were changed and therefore not comparable with previous data.

⁷ In 2009-10, CCHS introduced a modified food insecurity variable different from the 2005 and 2007-08 variable used in this report, therefore 2009-10 data cannot be compared to the previous years' data. This change in the performance measure will be examined to determine future use.

⁸ This performance measures target will also need to be examined.

Percentage of Young Adults Aged 20 to 24 Who Smoke

High smoking rates translate into high rates of chronic disease. Reducing youth smoking is a key to the prevention of smoking related illnesses and to the promotion of a healthy population. This is especially important when considering that habits during young adult years tend to be maintained well into adult life.

The Canadian Tobacco Use Monitoring Survey (CTUMS) divides smoking rates into various ranges. One of those ranges is the 20 – 24 yr olds.

What Does the Measure Tell Us?

This measure describes the percentage of the Nova Scotian population aged 20 to 24 years who reported daily and non-daily smoking at the time of CTUMS as a percentage of the total provincial population aged 20 to 24 years.

Where Are We Now?

According to CTUMS, in 2009, 30% of Nova Scotia's young adults (aged 20 to 24 years) smoked. That rate dropped to 29% in 2010.

Where Do We Want to Be in the Future?

By 2015, Nova Scotia aims to achieve a 20% smoking prevalence rate for the population of young adults aged 20 to 24 years.

The implementation of the renewed Comprehensive Tobacco Control Strategy, which was released in the spring of 2011, will help to achieve our targets through the following actions:

- Improving sales to minors compliance rates
- Continuing social marketing campaigns
- Retaining high tobacco taxes and prices
- Preventing the tobacco industry from advertising
- Improving and broadening smoke-free places legislation

Percentage of Population Aged 25 and Over Who Smoke

High smoking rates translate into high rates of chronic disease. Reducing the smoking rate is a key to the prevention of the number of smoking related illnesses and to the promotion of a healthy population.

The Canadian Tobacco Use Monitoring Survey (CTUMS) divides smoking rates into various ranges. One of those ranges is the 25 + yr olds.

What Does the Measure Tell Us?

This measure describes the percentage of the Nova Scotian population aged 25 years and over who reported daily and non-daily smoking at the time of CTUMS⁹ as a percentage of the total provincial population aged 25 years and older.

Where Are We Now?

According to CTUMS, in 2009, 20% of Nova Scotians 25 years of age and older smoked. In 2010, that rate remained relatively the same at 21%.

Where Do We Want to Be in the Future?

By 2015, Nova Scotia aims to achieve a 15% smoking prevalence rate for the population of Nova Scotians aged 25 and older.

The implementation of the renewed Comprehensive Tobacco Control Strategy, which was released in the spring of 2011, will help to achieve our targets through the following actions:

- Improving sales to minors compliance rates
- Continuing social marketing campaigns
- Retaining high tobacco taxes and prices
- Preventing the tobacco industry from advertising
- Improving and broadening smoke-free places legislation

⁹ Canadian Tobacco Use Monitoring Survey is a telephone self-report survey based on the calendar year. 2009 data were not available at the time this report was completed.

Injury-related Mortality Rate

Injury is the leading cause of death and disability during the first 45 years of life. It kills 425 Nova Scotians every year and costs our economy \$518 million annually. It is a significant public health issue in Nova Scotia. In 2004, Nova Scotia became the first province in Canada to establish a government led and funded injury prevention strategy, released in 2009.

What Does This Measure Tell Us?

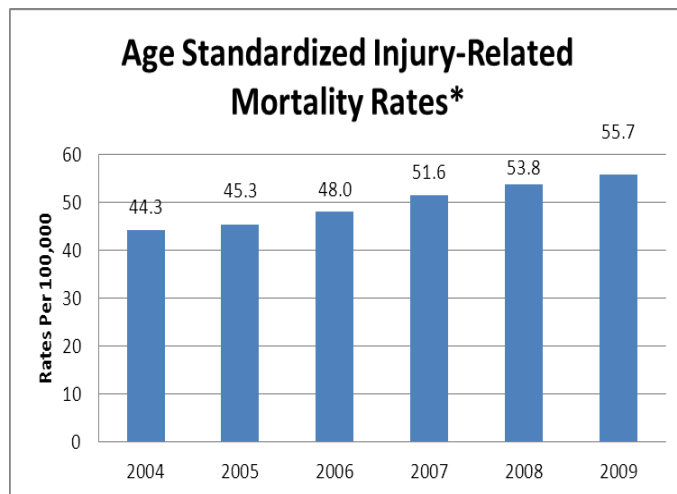
This measure describes the age-standardized injury related mortality rate per 100,000 of Nova Scotians.

Where Are We Now?

The base year of 2004 was selected because it was the year that the first Nova Scotia Injury Prevention Strategy was released. In 2004, the rate per 100,000 of injury related mortality in Nova Scotia was 44.3¹⁰. This rate has risen to 53.8 in 2008¹¹.

Where Do We Want To Be in the Future?

By 2015, Nova Scotia is aiming for a downward trend from its base year. The degree to which there is large scale success in reducing injuries depends on a wide range of factors. The greatest impact will be realized when the root causes of injuries such as poverty, social exclusion, and harmful use of alcohol are addressed.



*Data for 2010 and 2011 under review thus not included

Source: Vital Statistics

Nova Scotia's Renewed Injury Prevention Strategy, released in 2011, specifically acknowledges the role of poverty, social exclusion, and alcohol in Nova Scotia's injury rates. Projects and programs supported by the Strategy take into account the barriers created by poverty and social exclusion, ensuring that initiatives target those most in need of support and in no way increase disparities. The injury prevention coordinator partners with other sectors such as Healthy Development and Addictions Prevention and Treatment Services on the issue of alcohol. It is also identified as a risk factor and addressed in the work of projects and programs supported by the Strategy.

¹⁰ The data are slightly different than those presented in 2010-11 Statement of Mandate as a small proportion of the related population were inadvertently double-counted in the Statement of Mandate.

¹¹ Data collection can be more than a year behind the reporting period as data are dependent on cleaning and analysis by Vital Statistics. The most current data are included.

Percentage of adults (20 years of age and older) Active Enough for Health Benefits

A goal of the department is to improve physical activity levels for the adult population. Physical inactivity is a significant factor in the onset of chronic diseases and a major risk factor for heart disease, type 2 diabetes and depression.

What Does the Measure Tell Us?

Active enough for health benefits is defined as accumulating 150 minutes of moderate to vigorous physical activity per week, preferably at least 30 minutes on 5 days per week. The percentage of adults active enough for health benefits is a self-reported figure.

Where Are We Now?

2007-08 46 % of adults were active enough for health benefits. In 2009-10, this rate increased to 50%.

Where Do We Want to Be in the Future?

In 2005 the Integrated Pan Canadian Healthy Living Strategy was approved by FPT Ministers. The strategy sets new targets for 2014-15. Nova Scotia aims to have 54% of its adult population active enough for health benefits.

Strategies to achieve this target include:

- Maintaining and expanding the number of municipalities with a comprehensive physical activity plan
- Developing a provincial plan to improve walking and biking on a daily basis
- Implementing the Physical activity Components of the THRIVE! strategy

Percentage of Junior High Girls Active Enough for Health Benefits

Physical activity is essential to the healthy development of all children and youth. There is a significant disparity between the levels of physical activities between girls and boys. The decrease in physical activity for girls occurs between Grade 3 and 7. More research is required to identify the factors contributing to this disparity. One way to measure this is the percentage of junior high girls active enough for health benefits.

What Does the Measure Tell Us?

Active enough for health benefits is defined as accumulating at least 60 minutes of moderate to vigorous physical activity on 5 days per week. The percentage of junior high girls active enough for health benefits is calculated from the Keeping PACE (formerly PACY) surveillance initiative. *Keeping Pace* is a research initiative that identifies the physical activity and dietary intake of children and youth in Nova Scotia. Physical activity data is collected, using accelerometers, (motion detectors) every four years (2001-02, 2005-06, 2009-10), in a random sample of schools for Grades 3, 7 and 11.

Where Are We Now?

2009-10, 13.2 % of junior high girls were active enough for health benefits. 2009-10 is the baseline year for the data.

Where Do We Want to Be in the Future?

Nova Scotia aims to increase this percentage.

Strategies to achieve this are to implement the physical activity components of the THRIVE! Strategy.

Percentage of Adults with a Gambling Problem

As of 2007, there were 19,000 problem gamblers in Nova Scotia. Problem gambling is associated with higher rates of financial problems, marital discord, and mental health concerns.

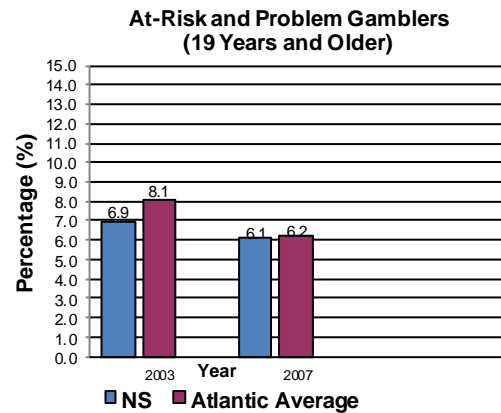
DHW tracks the percentage of the Nova Scotia population aged 19 and older identified as at-risk and problem gamblers.

What Does the Measure Tell Us?

The Canadian Problem Gambling Index (CPGI)¹² is used in all prevalence studies. It is the only instrument that is reliable and valid for measuring gambling prevalence in the general population. Based on the CPGI, Nova Scotia classifies people as “non gamblers,” “non problem gamblers,” “at-risk gamblers” or “problem gamblers”.¹³ At-risk and problem gamblers are experiencing adverse consequences from their gambling and reported in the prevalence studies.

Where are We Now?

2003 was selected as the base year as it was the first year that Nova Scotia used the CPGI for measuring prevalence of problem gambling. In 2003, 6.9% of Nova Scotians 19 years and older were classified as at-risk and problem gamblers as compared to 2007, where 6.1% classified as at-risk and problem gamblers. When compared to the Atlantic averages, Nova Scotia had fewer at-risk and problem gamblers compared to the Atlantic average of 8.1%¹⁴ in 2003. In 2007, Nova Scotia was again only slightly lower at 6.1% compared to 6.2%¹⁵.



Where Do We Want to Be in the Future?

Nova Scotia aims to be at or below the four year floating average of the percentages of all the Atlantic provinces by 2015 (excluding Nova Scotia). Strategies to achieve this target include:

- Continuing to raise the profile of gambling as a public health issue
- Social market campaigning to reduce the stigma associated with gambling
- Strengthening the relationship with the Nova Scotia Health Research Foundation to contribute to the research agenda on health promotion, prevention and treatment collaborating with key departmental and community stakeholders in an effort to address at-risk and problem gambling
- Researching links between the supply of gambling opportunities, associated gambling problems and the impact of existing provincial supply reduction measures
- Exploring factors that contribute to gambling problems in populations at greater risk
- Increasing awareness of youth gambling and youth problem gambling consumer protection initiatives/player choices

¹² CPGI is a self-report survey used in prevalence studies to determine non-gamblers, non-problem gamblers, at-risk gamblers or problem gamblers.

¹³ Those scoring 1 or higher on the scale are considered at-risk; those scoring 3 or higher are considered problem gamblers.

¹⁴ The Atlantic average in 2003 included New Brunswick as the only Atlantic province other than Nova Scotia to undertake a prevalence study.

¹⁵ The Atlantic average in 2007 included Newfoundland and Labrador and Prince Edward Island's prevalence studies.

Percentage of the Nova Scotia Population Aged 15 years and Older and Currently Experiencing Harms from their Drinking

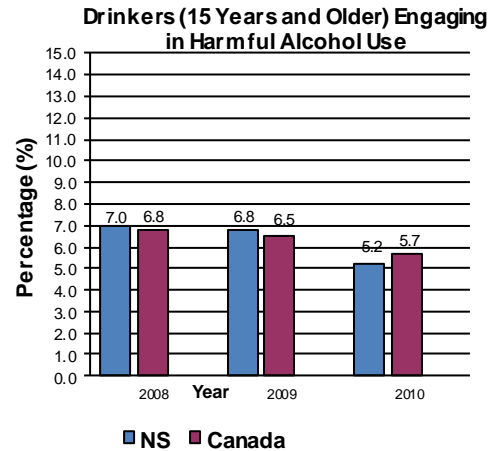
Harmful alcohol consumption is linked to a growing number of short and long term health and social harms. Alcohol is currently the second leading causal risk factor (after tobacco) for burden of disease¹⁶. The Nova Scotia per capita rate for alcohol consumption is increasing and the province has a high rate of heavy drinkers, particularly among young adults and youth. Population level alcohol policies in the areas of pricing, access, and advertising combined with targeted interventions, have the greatest impact on reducing harmful alcohol use.

What Does this Measure Tell Us?

The Canadian Alcohol and Drug Use Monitoring Survey (CADUMS)¹⁷ is an annual survey that includes the prevalence of those experiencing harms from their alcohol consumption in the past year. Harms are defined as occurring as a result of alcohol use in the following areas: physical health; friendships and social life; financial position; home life or marriage; work, studies or employment opportunities; legal problems; difficulty learning; and housing problems.

Where Are We Now?

2008 is the base year as it is the first year CADUMS was produced. Based on CADUMS, in 2008, 7.0% of Nova Scotian drinkers aged 15 years and older engaged in harmful use compared to 6.8% in 2009¹⁸. National data for 2008 and 2009 was 6.8% and 6.5% respectively. In 2010, the percentage of the Nova Scotia population aged 15 years and older engaged in harmful use was 5.2%. This is slightly below the National rate at 5.7%. Based on this data, there are currently in Nova Scotia approximately 41,929 residents 15 years of age and older are engaged in harmful alcohol use.



Where Do We Want to Be in the Future?

By 2015, Nova Scotia aims to maintain the percentage of the Nova Scotia population aged 15 years and older and currently experiencing harms from their drinking to be at or below the national percentage based on CADUMS. Strategies to achieve this target included in the *2007 Nova Scotia Alcohol Strategy: Changing the Culture of Alcohol Use*:

- Raising the profile of alcohol as a public health and safety issue
- Communicating low-risk drinking guidelines that promote moderate consumption
- Targeting prevention and early identification
- Promoting available services
- Conducting/participating in research related to social and economic costs of alcohol use
- Supporting the development and implementation of policies/legislation that address drinking behaviours in high-risk contexts

¹⁶ World Health Organization

¹⁷ CADUMS is based on the calendar year, conducted annually, and provides directly comparable national and provincial data.

¹⁸ 2010 data are not yet available.

Human Papillomavirus (HPV) Vaccine Coverage Rate for School-Based Female Population

This vaccine prevents infection from the types of Human Papilloma viruses that cause most cases of cervical cancer and genital warts. This school-based program is funded by HPP, and delivered at the DHA level. Maintaining high vaccination coverage rates not only reduces the risk of infection for vaccinated individuals but also reduces the risk of disease transmission to others within a population. High vaccination coverage will contribute to the protection of the population from this preventable disease.

What Does the Measure Tell Us?

This measure describes the percentage of the school-based female student population vaccinated with the HPV vaccine.

Where Are We Now?

In 2010-11, the vaccine coverage data for school-based immunizations was 76%.

Where Do We Want to Be in the Future?

Nova Scotia aims to maintain an HPV vaccine coverage rate at or above 80%. Immunization for prevention of HPV is a key public health intervention. Strategies to achieve this target include:

- Providing vaccine to district public health to deliver school-based vaccine programs
- Promoting the program through information delivery to the Grade 7 students' parents, physicians and other health care professionals
- Preparing vaccine coverage reports to inform school-based vaccine programs

Appendix A

Annual Report under Section 18 of the Public Interest Disclosure of Wrongdoings Act

The *Public Interest Disclosure of Wrongdoing Act* was proclaimed into law on December 20, 2011.

The Act provides for government employees to be able to come forward if they reasonably believe that a wrongdoing has been committed or is about to be committed and they are acting in good faith.

The Act also protects employees who do disclose from reprisals, by enabling them to lay a complaint of reprisal with the Labor Board.

A Wrongdoing for the purposes of the Act is:

- a) a contravention of provincial or federal laws or regulations
- b) a misuse or gross mismanagement of public funds or assets
- c) an act or omission that creates an imminent risk of a substantial and specific danger to the life, health or safety of persons or the environment, or
- d) directing or counseling someone to commit a wrongdoing

Table A.1

The following is a summary of disclosures received by the Department of Health and Wellness

Information Required under Section 18 of the Act	Fiscal Year 2011-2012
The number of disclosures received	0
The number of findings of wrongdoing	0
Details of each wrongdoing	Not Applicable
Recommendations and actions taken on each wrongdoing	Not Applicable