ANNUAL ACCOUNTABILITY REPORT

FOR THE FISCAL YEAR 2013-2014

NOVA SCOTIA

Health and Wellness

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Annual Accountability Report for the Year 2013 - 2014

Department of Health and Wellness

Accountability Statement

The Accountability Report of the Department of Health and Wellness (DHW) for the year ended March 31, 2014, 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 2013-2014. 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 2013-2014 Statement of Mandate.

The Honourable Leo A. Glavine
Minister of Health and Wellness

Peter W. Vaughan, CD, MA, MD, MPH
Deputy Minister of Health and Wellness

Message from the Minister of Health and Wellness

I am pleased to present the 2013-14 Accountability Report for the Department of Health and Wellness.

Over the course of the last year, our department continued to work closely with our partners to develop and implement programs that help Nova Scotians access healthcare services, promote wellness and activity, strengthen healthcare policies and keep people healthy.

This past year also marked the beginning of change for the department and our partners in the District Health Authorities, as we began to work together on the DHA restructuring that will help us achieve province-wide solutions that put patients first. We have begun the work toward a more streamlined health care system that breaks down silos, increases collaboration and establishes consistency in the delivery of health care services from one end of the province to the other.

Most importantly, we are moving toward a system that will be more responsive and sustainable for Nova Scotians. We are doing this work in collaboration with our partners. Earlier this year, I toured the District Health Authorities to gain insight from board members, senior leadership teams, community health board chairs, physicians and other health care workers on how to improve provincial services. Their input will help shape our way forward, so that we can provide the best health care to Nova Scotians.

Knowing that our population will age rapidly over the next 10 to 20 years, more needs to be done to strengthen health care for our seniors. That is why our department committed to developing the province's first Dementia Strategy, and began work on the review and refocus of the Continuing Care Strategy.

This year, we also helped increase access to health care through pharmacists' extended scope of practice, which allowed them to help thousands of Nova Scotians get their annual influenza vaccines quicker at their local pharmacy. We also worked with other Canadian provinces and territories to lower the cost of four more common generic drugs.

But the work of our department is not *only* focused on getting people healthy – it's also about *keeping* people healthy. Our efforts to promote healthy, active lifestyles will become increasingly important as our population ages, and if we are to reverse the high levels of obesity and diabetes so many Nova Scotians face. This year, we promoted wellness through grants to upgrade and build recreational facilities across the province, and hope to do much more in the years to come.

None of this work could have happened without the expertise and dedication of our staff, and I am proud of the work they do that benefits Nova Scotians. The department continues to be committed and focused on increasing access to health care services, and promoting healthy, active lifestyles.

Thank you,

Minister, Health and Wellness
Leo A. Glavine

2013-2014 DHW Variance Analysis - Actuals vs. Estimate (Updated June 4th, 2014)

Item	*2013/2014 Estimate ($ thousands)*	*2013/2014 Actuals ($ thousands)*	*Variance Estimate/Actuals ($ thousands)*
Executive Administration	62,621.0	60,847.5	(1,773.5)
Physician Services	740,713.0	746,494.5	5,781.5
Pharmaceutical Services	264,178.0	266,022.6	1,844.6
Insured Services	31,214.0	36,380.8	5,166.8
Emergency Health Services	119,235.0	119,135.7	(99.3)
Continuing Care	2,957.0	2,928.8	(28.2)
Home Care Services	196,146.0	212,412.2	16,266.2
Long Term Care Program	537,729.0	537,098.6	(630.4)
Addiction & Mental Health Programs	10,358.0	9,048.7	(1,309.3)
Physical Activity Sport and Recreation	10,625.0	11,641.3	1,016.3
Primary Care Programs	16,148.0	14,612.8	(1,535.2)
Public Health Programs	17,306.0	15,085.0	(2,221.0)
Provincial Programs and Initiatives	127,957.0	123,927.1	(4,029.9)
Other Programs	28,194.0	21,659.1	(6,534.9)
Other District Health Authorities Initiatives	-	-	-
District Health Authorities	1,660,596.0	1,679,289.6	18,693.6
Capital Grants & Healthcare Amortization	84,842.0	56,885.8	(27,956.2)
Total	3,910,819.0	3,913,470.0	2,651.0
Funded Staff	489.3	441.9	(47.4)
Staff Funded by External Agencies	(22.0)	(16.2)	5.8
Total FTE net	467.3	425.7	(41.6)

Variance Analysis – 2013-14 – Actual compared to Estimate

Department of Health and Wellness expenses were $2.7 million or 0.07 per cent higher than estimate primarily due to spending being over in the following areas: District Health Authorities were over spent by $18.7 million due operational pressures. Home Care was over budget by $16.3 million due to increased utilization. Physician Services was over budget by $5.8 million due to delays in cost savings initiatives. Insured Services was over budget by $5.2 million due to increased utilization of out-of-province services. Pharmaceutical Services was over spent by $1.8 million due to increase in family pharmacare.

These over expenditures were partially offset by savings of $28.0 million in Capital Grants as a result of construction delays. Other Programs were under spent by $6.5 million due to lower uptake in the expanded children's dental age criteria and lower utilization in insulin and supplies. Provincial Programs and initiatives were underspent by $4.0 million due to IT project delays. Public Health was underspent by $2.2 million as a result of decreased drug costs and delays in *Thrive*! related projects. Administration was under spent by $1.8 million due to vacancies and operational efficiencies. Primary Care was under spent by $1.5 million due to various projects related to the Primary Health Information Management system that could not be completed in 13-14, as well as other operational efficiencies of $1.1 million.

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

2013-2014 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.

Each year, outcome measures are reviewed during the Statement of Mandate process for the upcoming year. Complete reports on the measures for the 2013-2014 fiscal year can be found on the pages that follow.

No measures have been modified in this fiscal year. A few measures have errors related to data or timeframe and/or changes in wording to align with current strategies. Correction notes are provided *in italics* in the narrative section for each measure in this report, for which there were errors, explaining the reasons for the error and how it was addressed.

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

- Wait times are measured for new referrals to out-patient clinics. Wait times exclude Emergency priority clients and clients who choose to be seen outside the wait time target.
- For all DHAs & the IWK, other than Capital Health, wait times are tracked in terms of their compliance with the provincial standards mentioned below.

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

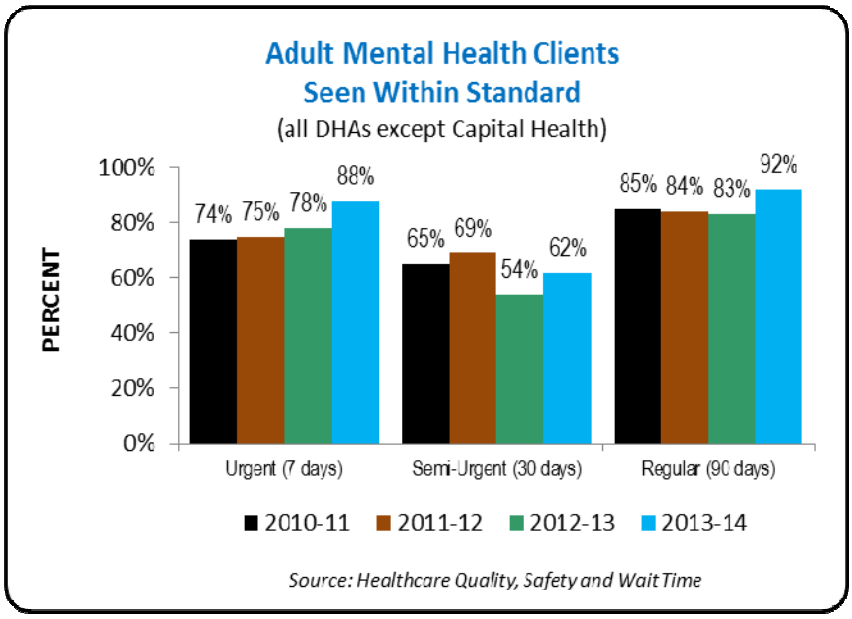
- Capital Health measures wait times differently than other DHAs & the IWK. For Capital Health, wait times are measured using the median and 90th percentile wait time.
    - The median wait time shows the number of days by which half the patients had their appointment.
    - The 90th percentile wait time shows the number of days by which 90% of patients had their appointment. It does not mean that 90% of the people waited that many days. Most patients will have received treatment much earlier.

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. 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 in 2013-14 was 86% for adult, and 62% for child/adolescent patients.

Adults

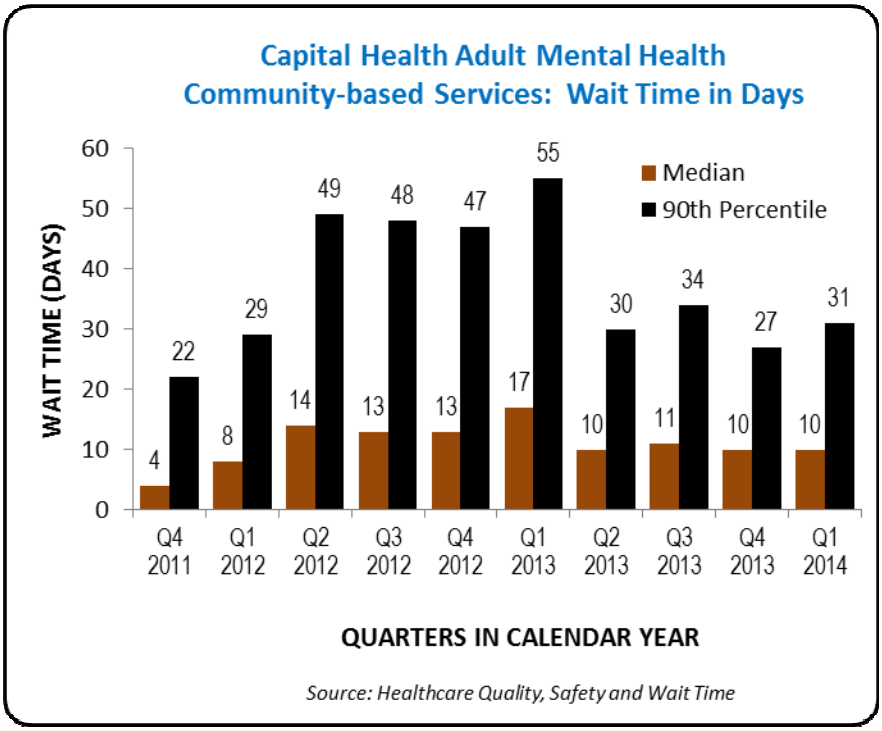
For adult clients, the percentage of clients seen within standard is on an upward trend for all priority levels.



**Correction: Please note that the base year date provided in the 2013-14 Statement of Mandate (SOM) for the adult measures should be 2010-11 and not 2011-12. This means more clients were seen within the standard times. Also, the base year data in the 2013-14 SOM included DHA9, therefore, it is different from what is reflected in the first graph for adult clients seen within standard.*

Capital Health

Beginning in 2011 in response to the Standard approval process, Capital Health introduced a new model of care and process to meet service demands and reduce wait times. DHW recognized that Capital Health's pilot changes, and the implementation of a new model of care called Choices And Partnership Approach (CAPA) across all DHAs might result in further revision to Mental Health Standards for the province.

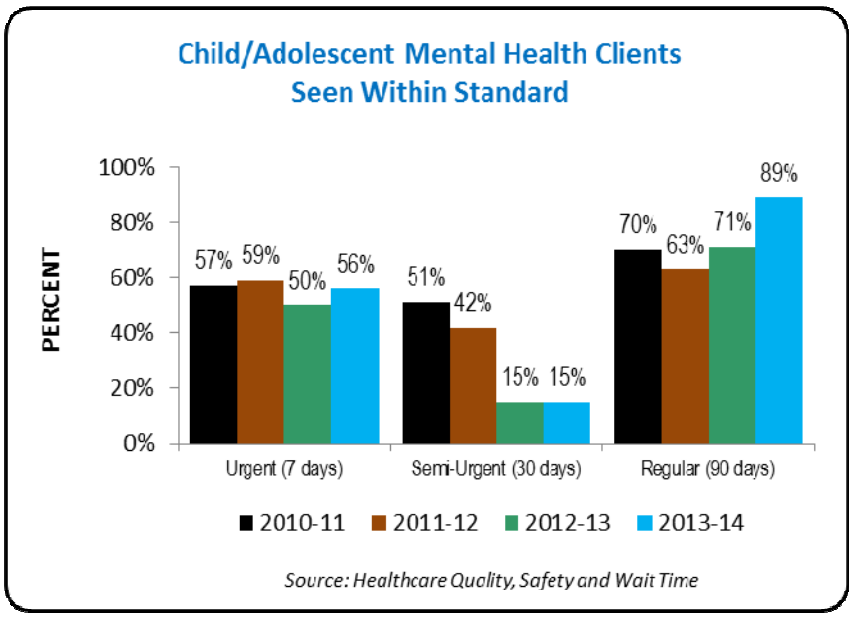


Under the new model patients are not triaged into three priority levels. As such, wait times for Capital Health are measured using median and 90th percentile wait time. To reflect this, the Adult Mental Health Clients Seen Within Standard graph excludes Capital Health from all years. Wait times for Capital Health from October 2011 to March 2014 are shown in the Capital Health Adult Mental Health

graph. Wait times through 2013-14 have been stable and lower than 2012-13. For the full 2013-14 fiscal year, the median wait time was 10 days, consistent with previous year, and the 90th percentile wait time was 31 days, which is slightly higher than 2012-13. Child/adolescent mental health services are not offered at Capital Health.

Children/Adolescents

For child/adolescent clients, the percentage of clients seen within standard is on an upward trend for Urgent and Regular priorities, and remains the same for Semi-Urgent priority.



**Correction: Please note that the base year date provided in the 2013-14 Statement of Mandate (SOM) for the child/adolescent measures should be 2010-11 and not 2011-12. This means more clients were seen within the standard times.*

In 2013-14, 56% of Urgent child/adolescent patients were seen within the standard wait time, this is consistent with an average of 55% seen within standard over the four year period.

Most Urgent referrals were for patients who received services through local emergency departments / crisis services. Demand for appointments for Urgent referrals at times exceeds available appointments, leading to wait times of up to two weeks. In addition, a high rate of no-shows for the service contributes to longer wait times.

For Semi-Urgent child/adolescent patients, only 15% were seen within the wait time standard in 2013-14.

Where Do We Want To Be In the Future?

The goal is to increase the percentage of clients seen within the provincial standard. Public wait time reporting for Mental Health through the Wait Time website was launched in 2013-14. However, data analysis is not yet complete at this time. From the analysis, the wait time standards will be reviewed and updated to reflect the new service delivery models introduced through the Mental Health and Addictions Strategy, *"Together We Can"*.

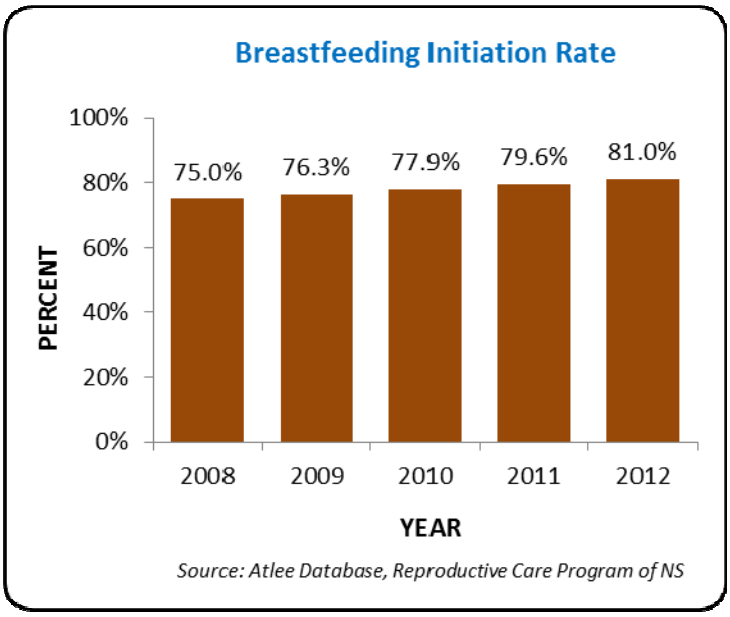
Breastfeeding Initiation Rate: Percentage of Infants Receiving Breastmilk and/or Who Had Early Breast Contact

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 data, from the Atlee Database with the Reproductive Care Program of NS (a provincial program of DHW), shows the percentage of infants receiving breast milk and/or who had early breast contact.



Where Are We Now?

The baseline percentage of breast-feeding initiation for NS in 2006 was 72.7% and has shown a continuous rise to 81.0% in 2012. The 2013 data is expected to be complete and available in fall of 2014.

Where Do We Want to Be in the Future?

By 2015-16, 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*! related to breastfeeding are implemented.
- Complementing work underway at the national level for promotion, protection and support for breastfeeding and the *Baby Friendly Initiative*.

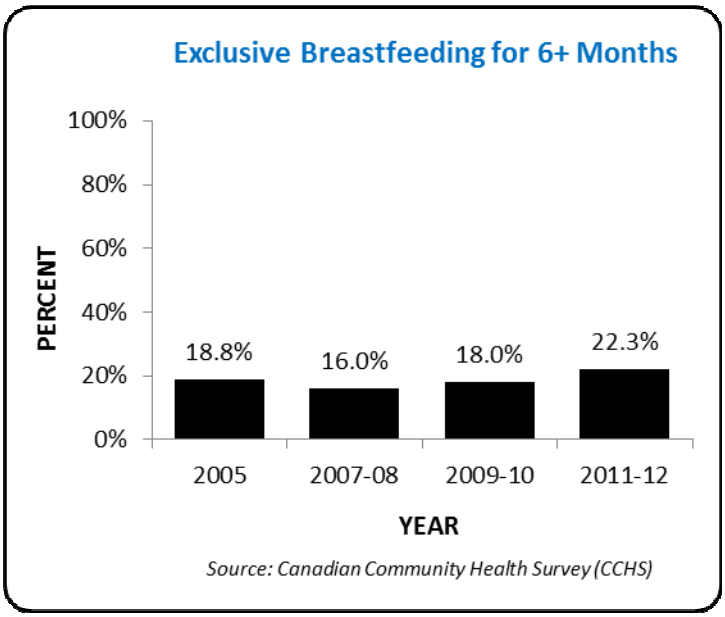
Breastfeeding Duration Rate: Percentage of Infants Who Exclusively Breastfed for At Least 6 Months

DHW aims to improve the health status of mothers and babies by increasing the breastfeeding duration 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 data is from the Canadian Community Health Survey (CCHS). This measure is the percentage of infants who exclusively breastfed for at least 6 months of age.



Where Are We Now?

The percentage of exclusive breast-feeding mothers for 6 months or longer for NS is on an upward trend. The rate in 2005 was 18.8% and in 2011-12 was 22.3%. Data from 2011 and 2012 combined was the latest statistically reliable data available.

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 exclusive breastfeeding at 6 months of age rate. Strategies to achieve this target include:

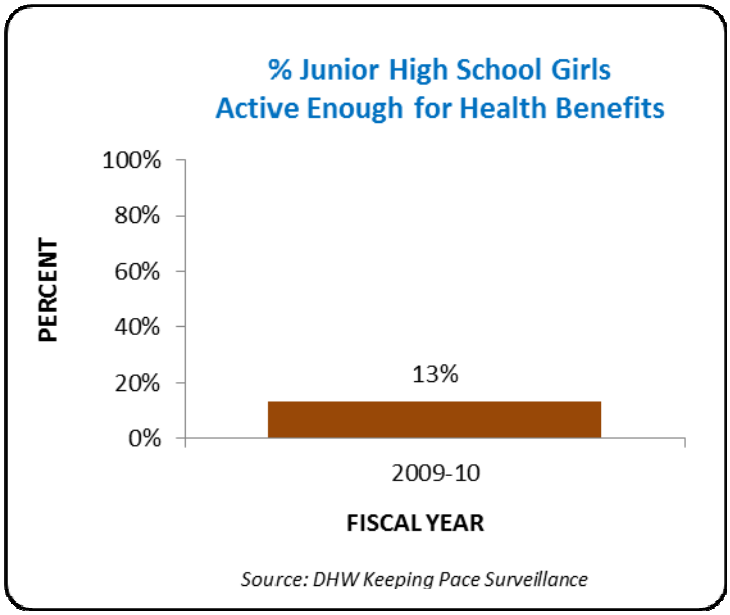
- Implementation and monitoring of the Provincial Breastfeeding Policy.
- Capacity building for the promotion, support and protection of breastfeeding through the DHAs, the IWK, family resource centres and other community organizations.
- Work to ensure the components of *Thrive*! related to breastfeeding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

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 activity between girls and boys. The decrease in physical activity for girls occurs between Grades 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 surveillance 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?

In 2009-10, 13% of junior high girls were active enough for health benefits. 2009-10 is the baseline for *Keeping PACE*. However, data was not collected in 2013-14 because DHW is currently reviewing the best way to collect data in cooperation with the *Thrive!* Strategy.

Where Do We Want to Be in the Future?

Nova Scotia aims to increase this percentage.

As part of the *Thrive!* Strategy, several actions aimed at junior high girls have begun:

- A new after school program began in 2012-13 and has expanded in 2013-14.
- A social marketing campaign aimed at this target group will continue.
- Municipal government physical activity plans will target female youth as a priority.
- Funding to build policies and organizational practices that support participation of girls and women.

Prevalence of Adolescents Aged 13-18 Years Who Engage in Organized Forms of Gambling

Early involvement gambling, in addition to other risk factors, has been associated with increased risk of developing gambling-related harms later in life[1]. These include, but are not limited to:

- family dysfunction and domestic violence;
- alcohol, tobacco, and other drug problems;
- mental health problems;
- employment issues and job loss;
- financial struggles; and
- risk for suicide.

The province has a high rate of youth involved in gambling. Population level gambling policies in the areas of access and advertising combined with targeted interventions, have the greatest impact on reducing gambling-related harms.

What Does the Measure Tell Us?

The 2011 Adolescent Gambling Survey was conducted to assess levels of involvement in organized and informal forms of gambling as well as risky and harmful involvement in gambling. Involvement of adolescents in organized forms of gambling refers to commercial forms of gambling, such as bingo, lottery, raffles, sports betting, Video Lottery Terminals, etc. This measure refers to involvement in the past year.

Where Are We Now?

The 2011 Nova Scotia Responsible Gaming Strategy identified several key priority areas and goals to address gambling-related risks and harms associated with adolescent gambling. As a result, this measure was added to the 2012-13 Statement of Mandate to reflect work undertaken to achieve these goals.

2011 is the base year for this measure. Based on the 2011 prevalence rates, 54.4% of adolescents between the ages of 13 and 18 years engaged in organized (commercial) forms of gambling. This is the latest data available.

1 Jacobs, D. F. (2004). Youth gambling in North America: Long-term trends and future prospects. In J. Derevensky and R. Gupta (Eds.).*Gambling problems in youth: Theoretical and applied perspectives* (pp. 1-24). New York: Kluwer Academic/Plenum Publishers.

Where Do We Want To Be In the Future?

This measure will no longer be used because there are no plans to collect this data in the future. The two gambling measures (for ages13-18yrs and 19+), in the 2013-14 Statement of Mandate, have been replaced by a single gambling measure, in the 2014-15 Statement of Mandate.

The goals outlined under the 2011 NS Responsible Gaming Strategy to address youth gambling is for DHW to work in partnership with the DHAs and IWK to build on strategies and approaches aimed at increasing awareness of youth gambling and youth problem gambling and implementing measures designed to mitigate the impacts on youth. The actions in the strategy are aimed at addressing the root causes of gambling related problems.

Activities under the 2011 NS Responsible Gaming Strategy to achieve this goal include:

- Working with DHAs, IWK and the Department of Education to develop and implement supportive guidelines and procedures to promote school health in the areas of mental health, substance use and gambling.
- Working with the Department of Education on the development and implementation of the Learning Outcomes Framework for Healthy Living Grades P-9.
- Working with the DHAs and IWK to increase the use of screening tools and assessment for gambling-related issues in adolescents.
- Developing a prevention and health promotion grants program to support community organizations, DHAs/IWK related to addressing gambling-related risk and harms.

Prevalence of Adults 19 Years and Older Who are at Risk For, or Experiencing Gambling Related Harms and Seek Treatment Service

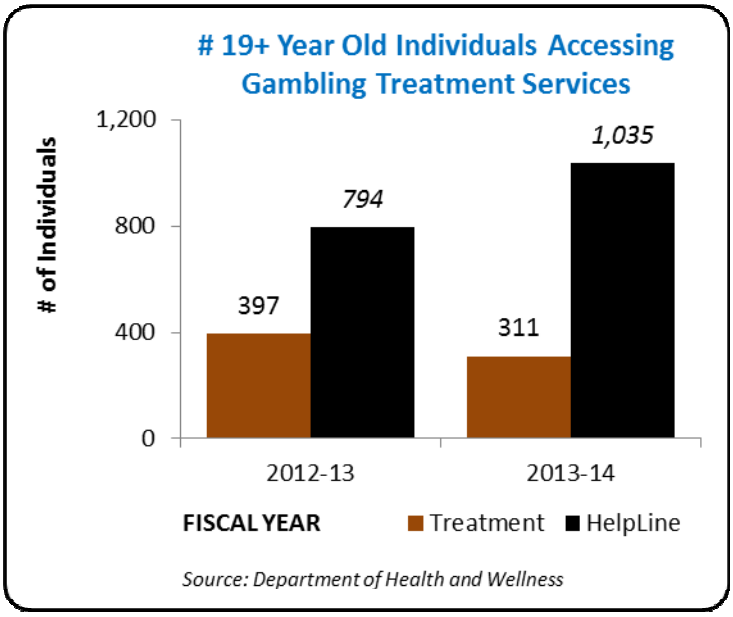
At-risk and problem gambling are associated with adverse consequences, such as, but not limited to:

- family dysfunction and domestic violence;
- alcohol, tobacco, and other drug problems;
- mental health problems;
- employment issues and job loss;
- financial struggles; and
- risk for suicide.

Population level gambling policies in the areas of access and advertising combined with targeted interventions, have the greatest impact on reducing harmful involvement in gambling.

What Does the Measure Tell Us?

DHW tracks the percentage of the Nova Scotia population aged 19 and older* identified as at-risk for problem gambling using the Canadian Problem Gambling Index (CPGI). The CPGI is used in most prevalence studies conducted by the Provinces across Canada. It is considered the most reliable and valid instrument available today for measuring gambling prevalence in the general adult population.



** Correction: Please note that this measure was incorrectly listed in2013-14 SoM as "18 years and older", when it should have been "19 years and older".*

In 2013, the diagnosis of "problem gambling" was changed to "gambling disorder" in the Diagnostic and Statistical Manual V (classification system used in diagnosing mental health disorders, developed by the American Psychiatric Association). This change has been adopted by all jurisdictions in Canada to identify gambling-related harms. As a result, the measures previously used for gambling need to be revised to reflect these changes. It will also require modifications to screening and assessment tools currently used in Nova Scotia.

DHW also tracks the number of individuals who seek professional treatment services in the DHAs and IWK for substance use and gambling-related issues through the Addiction Services Statistical Information System Technology (ASsist). The Problem Gambling Helpline provides professional gambling-related treatment services and tracks the number of individuals calling the helpline.

Where Are We Now?

In 2007, it was estimated that there were 6.1% or about 47,000 adults (19 years or older) experienced gambling-related harms. A new data collection cycle was recently completed, and the data is being validated for analysis. This measure will require revisions in the future due to the above mentioned changes.

The 2011 Nova Scotia Responsible Gaming Strategy identified several key priority areas and goals to address gambling-related harms. These goals were reflected in the 2012-13 Statement of Mandate through indicators to track prevalence of those experiencing harms who are seeking assistance.

In 2012-13, 397 individuals 19 years and older accessed treatment service for gambling-related harms in the DHAs, while 794 individuals 19 years and older did so through the Problem Gambling Helpline.

In 2013-14, 311 individuals accessed treatment service for gambling-related harms in the DHAs, and 1,035 individuals called the Problem Gambling Helpline.

Where Do We Want to Be in the Future?

The current measure used to identify harms is no longer valid. The two Gambling measures (for ages13-18yrs and 19+yrs), in the 2013-14 Statement of Mandate, have been replaced by a single Gambling measure, in the 2014-15 Statement of Mandate. The actions in the 2011 NS Responsible gaming Strategy are aimed at addressing the root causes of gambling related harms and removing barriers to accessing help.

By 2015, Nova Scotia is aiming for an upward trend in individuals seeking professional treatment from the base year 2012. The degree to which there is large-scale success in increasing the number of individuals with gambling-related issues depends on a range of factors. Greatest impact will be realized when barriers to accessing services are removed for individuals who need help and root causes of gambling-related harms are addressed. This will include working closely with the DHAs, IWK and other community stakeholders.

Activities under the 2011 NS Responsible Gaming Strategy to achieve this target include:

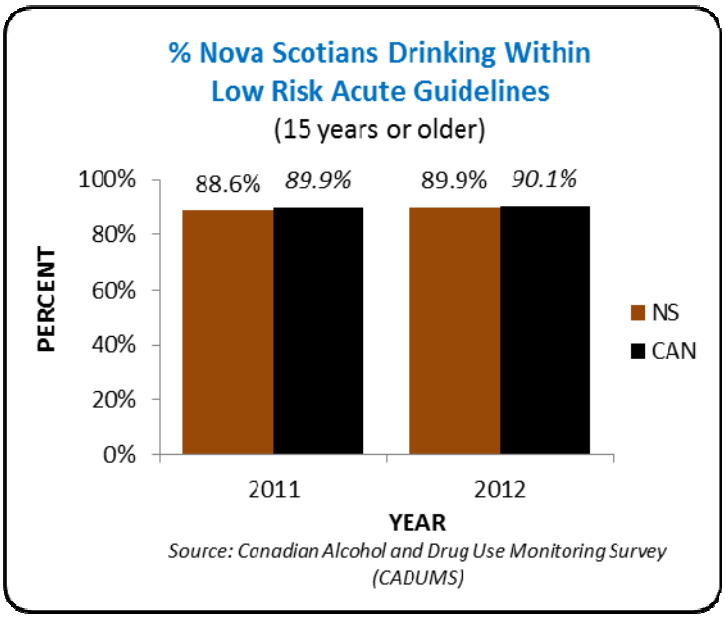
- Addressing stigma related to gambling–related harms;
- Improving the quality, accessibility and range of options to assist individuals and their families who experience gambling-related harms;
- Establishing stronger linkages between treatment services and other health and community services;
- Enhancing health promotion and prevention initiatives to enhance consumer protection in order to prevent gambling-related harms.

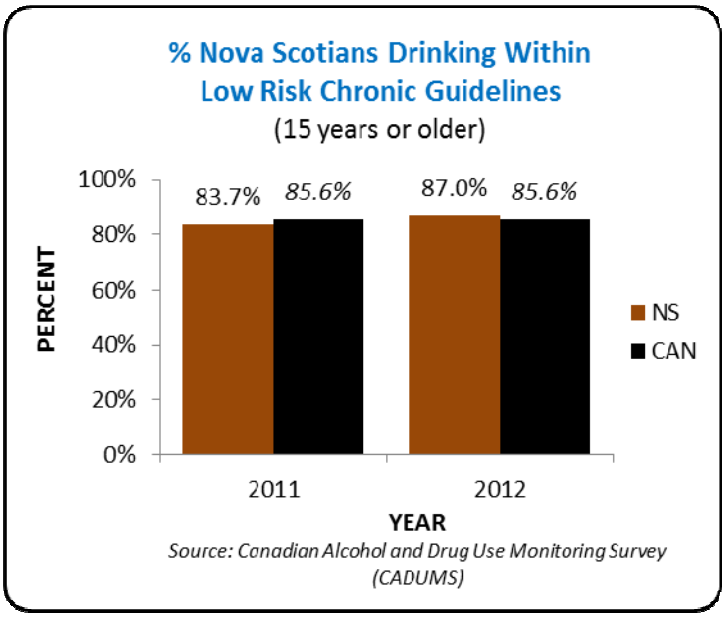
Percentage of the Nova Scotia Population Aged 15 years and Older Who Drink Within Low Risk Chronic and Low Risk Acute Guidelines

Harmful alcohol consumption is linked to a growing number of short and long term health and social harms. Alcohol is also currently the second leading causal risk factor (after tobacco) for burden of disease. These harms and risks can be reduced if the population, in general, consume alcohol ("drink") within limits of the National Low Risk Alcohol Drinking Guidelines.

What Does this Measure Tell Us?

The Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) is an annual survey that, since 2011, has included the prevalence of those consuming alcohol in excess of the National Low Risk Alcohol Drinking Guidelines (the "Guidelines"). Within these Guidelines are two risk groups, acute and chronic. Acute risk refers to the risk for immediate injury such as, but not limited to, sexual violence, motor vehicle collisions, and physical violence, while chronic risk refers to risk for chronic disease such as, but not limited to, various types of cancers and heart disease. The graphs reflect the targets from the 2013-14 DHW Statement of Mandate (SoM) that focused on increasing the prevalence of those drinking within the Guidelines. However, the targets were changed in the 2014-15 SoM to focus on decreasing the prevalence of those drinking in excess of the Guidelines, to match CADUMS' survey.





Where Are We Now?

2011 was the first year for which CADUMS had the indicator for drinking in excess of the Guidelines, so it is the baseline year. According to the 2012 CADUMS data collection cycle, 87.0% of Nova Scotians aged 15 years and older consumed alcohol within the low risk chronic parameters, and 89.9% within the low risk acute parameters in the Guidelines. Both were

increases from 2011, as desired. The chronic rate was better than the national rate, but the acute rate was slightly below.

Where Do We Want to Be in the Future?

By 2015, Nova Scotia aims to have the percentage of the Nova Scotia population aged 15 years and older who consume alcohol within chronic and acute risk levels to be greater than the national rate (to be measured as those consuming alcohol in excess of the National Low Risk Alcohol Drinking Guidelines to be lower than the national rate). There will be a continued focus on reducing the percentage of heavy drinkers in NS.

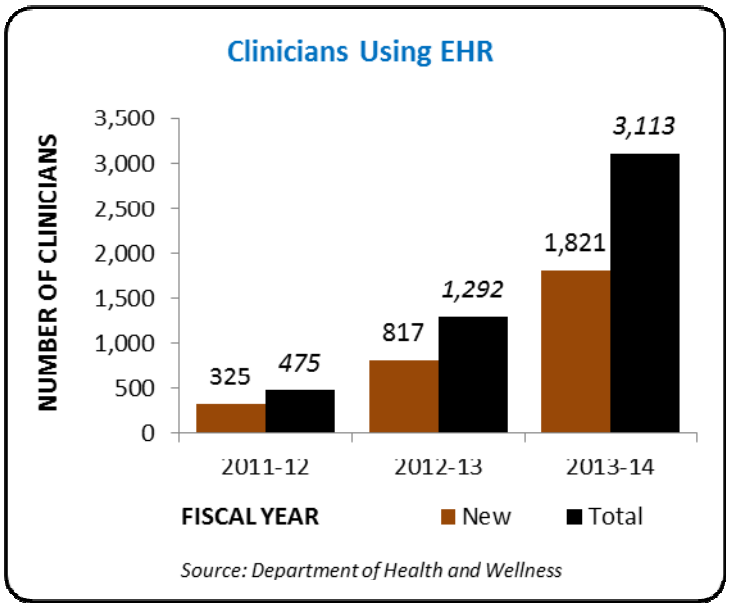
Electronic Health Record (EHR) Initiative – Number of Clinical Users of Secure Health Access Record (SHARE)

Electronic Health Record – SHARE 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.

The Department of Health and Wellness continues to collaborate with the District Health Authorities and the IWK on the continued adoption 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.

What Does the Measure Tell Us?

These numbers represent the number of clinical users (e.g. physicians, nurse practitioners) using the SHARE Provider Viewer and Clinical Repository. There was continued uptake with SHARE throughout the year.



Where Are We Now?

As of March 31, 2014 we have 3,113 clinical users on SHARE, which is an increase of 1,821 clinical users from March 31, 2013.

Where Do We Want to Be in the Future?

Although SHARE could be used by all clinical users in Nova Scotia, it provides value to clinicians depending on geographic location and nature of clinical practice. As a result, DHW will continue to roll-out SHARE to as many providers as possible in our healthcare system who would benefit most from the available data in the Clinical Repository.

In collaboration with the SHARE Adoption Team in the District Health Authorities and the IWK, we will continue to focus on the roll-out and adoption in the clinical community.

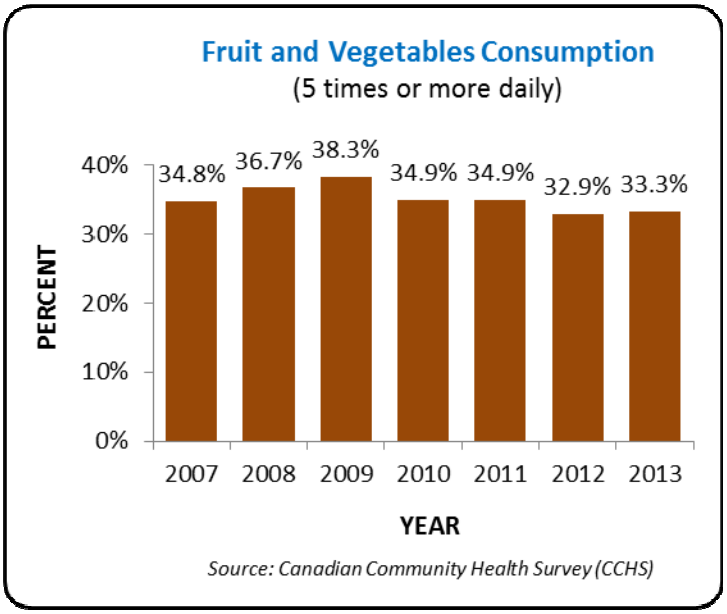
DHW aims to have an additional 1000 Clinical Users on SHARE by the end of fiscal 2014-2015 resulting in a target of 4,113 clinical users on SHARE by March 2015.

Percentage of Nova Scotia Population (12 years +) Who Report Eating Fruit/Vegetables 5 or More Times 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 that fruits and vegetables play a protective role 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 fruits and vegetables 5 or more times per day. The data includes those that met and exceeded the recommended servings. The data is drawn from self-reported data from the Canadian Community Health Survey (CCHS)[2].



Where Are We Now?

Between 2001[3] and 2013, the percentage of Nova Scotians (12 years and older) that consumed fruits and vegetables 5 or more times per day generally stayed the same at 32.6% and 33.3%, respectively.

**Correction: Please note that the wording of this measure has changed since the 2013-14 Statement of Mandate to better match the CCHS definition. Annual data is also being presented instead of bi-annual data previously due to sufficient single year data being available now for trend analysis.*

Where Do We Want to Be in the Future?

For 2014, DHW aims to increase from 2013, the percentage of the population (12 years +) who report eating fruits and vegetables 5 or more times per day. DHW aims to see a consistently increasing trend in this percentage; over the long term. The following strategies are in place to improve the outcomes for this measure over the long term:

- Continued implementation of the *Healthy Eating Nova Scotia Strategy* (*HENS*) and *Thrive! Strategy*;

2 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.

3 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.

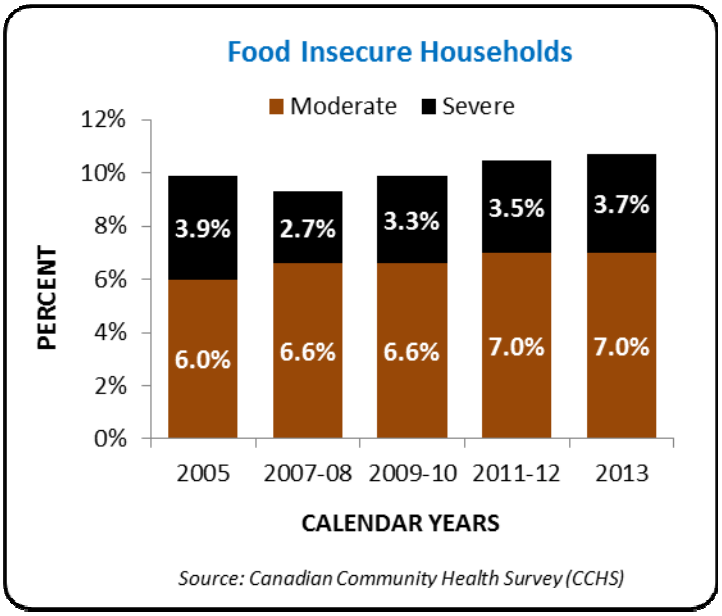
- Ensuring that any food policies produced for government funded or regulated food service operations include efforts to increase access to fruit and vegetables;
- Supporting the development of community based initiatives that increase knowledge and skills related to preparing fruit and vegetables;
- Supporting the development of policy to ensure access to affordable fruit and vegetables by all Nova Scotians.

Percentage of Food Insecure Households

Food security[4] 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 Nova Scotia's Healthy Eating Strategy, *Healthy Eating Nova Scotia (HENS)* 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.



** Correction: Please note the 2005 percentage value was incorrectly reported in the 2013-14 Statement of Mandate as a combined 7.7%. The 2007-08 percentage value had also been incorrectly reported as 7.7%.*

Where Are We Now?

In 2005[5], there were 9.9% (6.0 % moderately and 3.9% severely) households in Nova Scotia which were food insecure. In 2013[6], the CCHS reported household food insecurity in NS at 10.7% (7.0% of these households were moderately food insecure, 3.7% were severely food insecure). More extensive information regarding food insecurity can be found here:

http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/insecurit/prov_ter-eng.php

4 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.

5 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.

6 Survey cycles and ability to obtain statistically reliable results from sample size are responsible for inconsistent reporting periods. Lack of access to appropriate statistical methodology required of the data does not allow DHW to choose other reporting periods.

Where Do We Want To Be In The Future?

By 2014-15, Nova Scotia aims for a downward trend from the base year in the percentage of food insecure households[7]. 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 actions in the strategy are aimed at addressing the root causes of food insecurity related problems.

Strategies to achieve this target include:

- Continuing to support implementation of the provincial *HENS* and *Thrive!* strategies;
- 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.

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

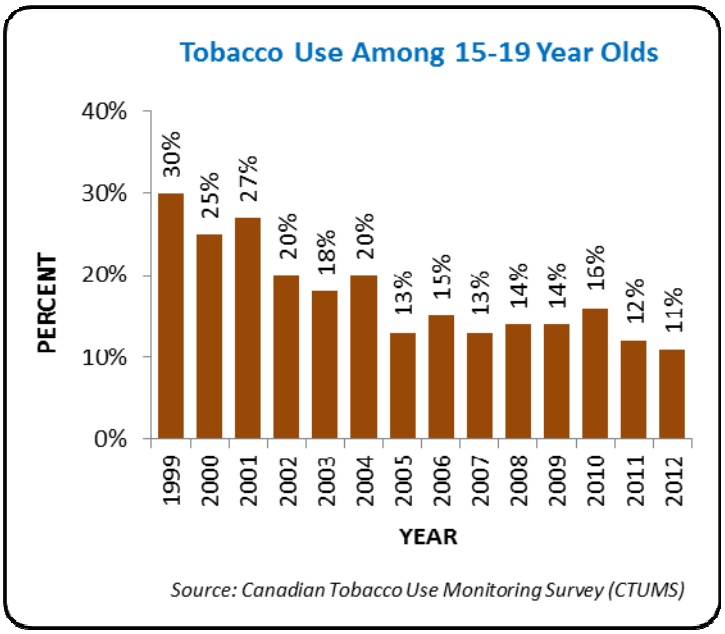
Percentage of Young Adults Aged 15 to 19 Who Smoke

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. Ensuring that we prevent tobacco use among children and youth is critically important. Experimentation and use at a young age increases the risk that tobacco use may continue into adult years.

The Canadian Tobacco Use Monitoring Survey (CTUMS), which is a telephone self-report survey based on the calendar year, divides smoking rates into various age ranges. One of those ranges is the 15 to 19 year olds.

What Does the Measure Tell Us?

This measure describes the Nova Scotia population aged 15 to 19 years who reported daily and non-daily smoking at the time of CTUMS as a percentage of the total provincial population aged 15 to 19 years.



Where Are We Now?

According to CTUMS, in 1999, 30% of Nova Scotia's young adults (aged 15 to 19 years) smoked. That rate has dropped to 11% in 2012, the latest CTUMS data available. The continuing implementation of Nova Scotia's comprehensive tobacco control strategy has been, in part, responsible for decreasing tobacco use rates, including the use of policy and legislation, community-based programs, nicotine treatment support and social marketing campaigns.

Where Do We Want to Be in the Future?

By 2015, Nova Scotia aims to achieve a 10% smoking prevalence rate for the population of young adults aged 15 to 19 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; and
- Improving and broadening smoke-free places legislation.

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.

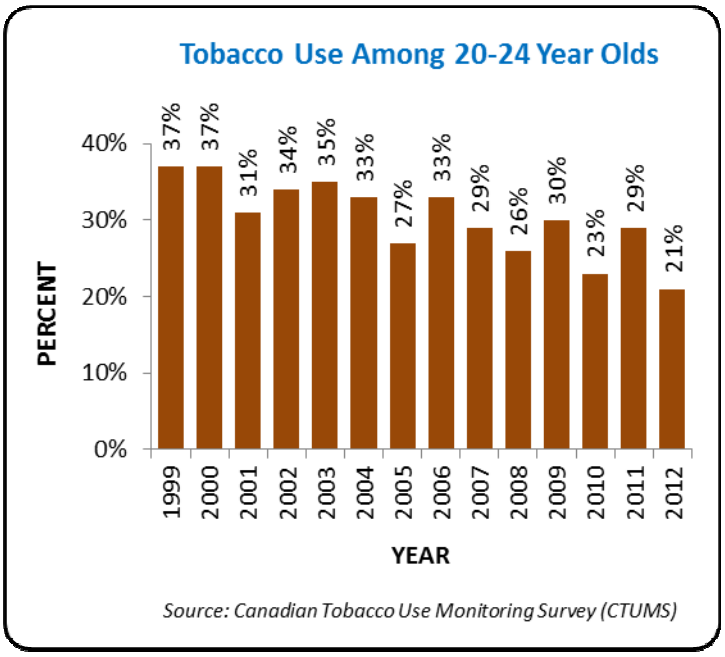
The Canadian Tobacco Use Monitoring Survey (CTUMS), which is a telephone self-report survey based on the calendar year, divides smoking rates into various age ranges. One of those ranges is the 20 to 24 year olds.

What Does the Measure Tell Us?

This measure describes the Nova Scotia 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 1999, 37% of Nova Scotia's young adults (aged 20 to 24 years) smoked. That rate has dropped to 21% in 2012, the latest CTUMS data available.



** Correction: Please note the 2010 percentage value was incorrectly reported in the 2013-14 Statement of Mandate as 28%.*

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:

- Continuing social marketing campaigns;
- Retaining high tobacco taxes and prices;
- Preventing the tobacco industry from advertising; and
- Improving and broadening smoke-free places legislation.

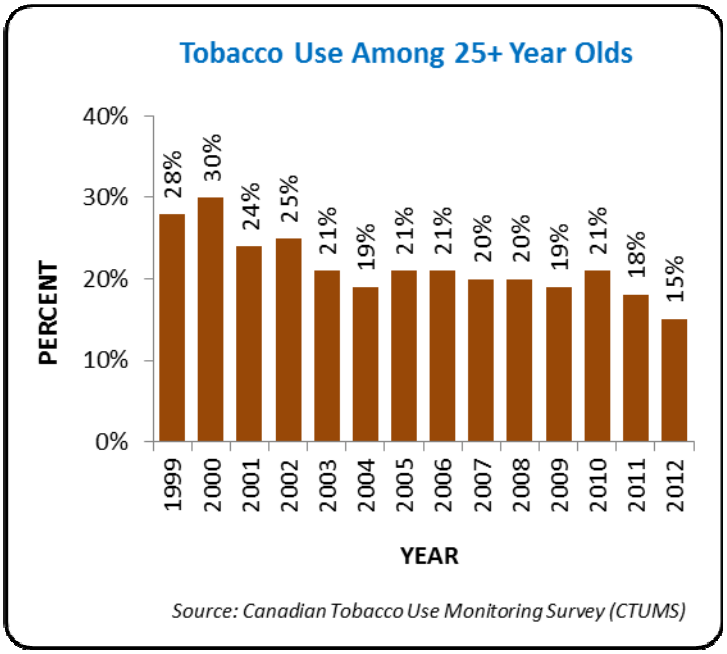
Percentage of Population Aged 25 and Over Who Smoke

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), which is a telephone self-report survey based on the calendar year, divides smoking rates into various age ranges. One of those ranges is the 25 plus year 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 CTUMS as a percentage of the total provincial population aged 25 years and older.



Where Are We Now?

According to CTUMS, in 1999, 28% of Nova Scotians 25 years of age and older smoked. That rate dropped to 15% for 2012. The 2012 data is the latest CTUMS data available.

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:

- Continuing social marketing campaigns;
- Retaining high tobacco taxes and prices;
- Preventing the tobacco industry from advertising; and
- Improving and broadening smoke-free places legislation.

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

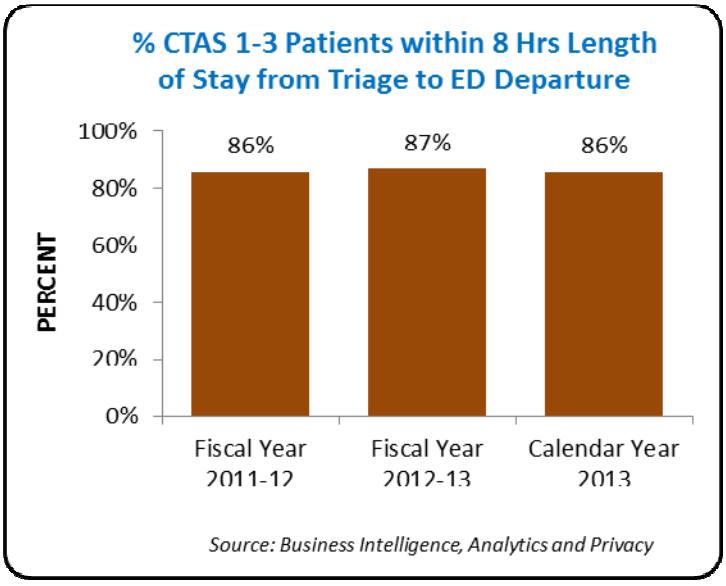
Nova Scotia adopted emergency care standards in 2014. Dr. John Ross, who was appointed as the first provincial advisor on emergency care, developed these standards. These standards address minimum requirements for patient access, triage, patient transfer, staffing qualifications, equipment, and site performance. The following two measures are part of the site performance standards. The department is currently working with the DHAs and IWK to ensure compliance with these standards.

A. Percentage of Canadian Triage and Acuity Scale (CTAS) 1-3 Patients with Total Length of Stay from Triage to Emergency Department Departure 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?

At the time of reporting, data for the calendar year of 2013 was the latest annual cycle of data available that had been validated, instead of the 2013-14 fiscal year. Please note that the calendar year data has a three month overlap with the 2012-13 fiscal year data (Jan-Mar 2013).

For the calendar year of 2013, 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, a marginal change from the previous year. The range across all EDs, provincial, regional, community is from 76% - 99%.

Where Do We Want To Be In the Future?

By 2015, 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 90% of the time. The DHW, DHAs and IWK are working collaboratively to improve the flow of patients through the Nova Scotia emergency care system.

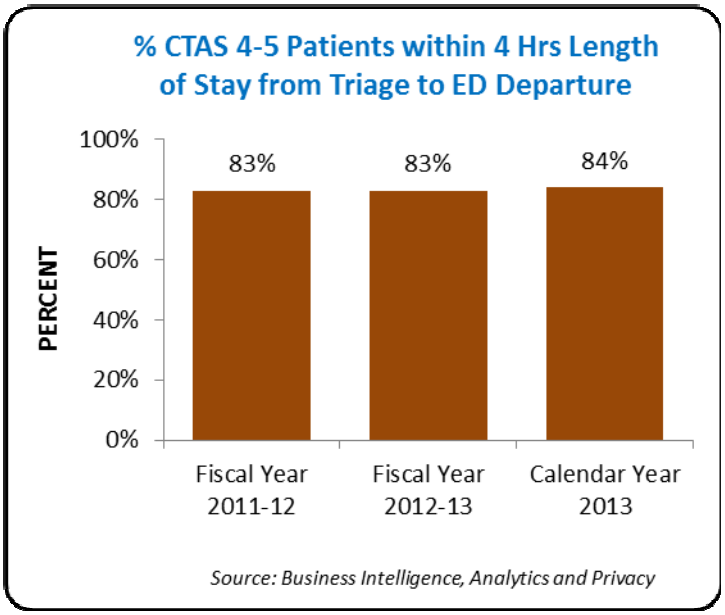
B.Percentage of CTAS 4-5 Patients with Total Length of Stay from Triage to Emergency Department Departure Within 4 Hours

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 illness or 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?

At the time of reporting, data for the calendar year of 2013 was the latest annual cycle of data available that had been validated, instead of the preferred 2013-14 fiscal year. Please note that the calendar year data has a three month overlap with the 2012-13 fiscal year data (Jan-Mar 2013).

For the calendar year of 2013, 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 84% provincially, a marginal change from the previous year. The range across all EDs, provincial, regional, community is from 70% to 100%.

Where Do We Want To Be In the Future?

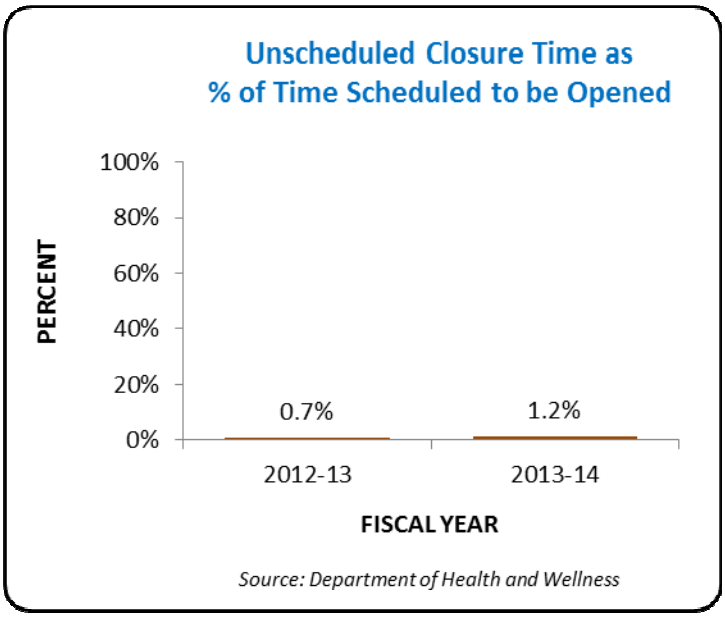
Our goal is that by the year 2015, the total length of stay in the Emergency Department from triage to departure (admission or discharge) for CTAS 4-5 patients should be 4 hours or less, at least 90% of the time. The DHW, DHAs and IWK are working collaboratively to improve the flow of patients through the Nova Scotia emergency care system.

Unscheduled closure time for Collaborative Emergency Centres (CEC)

Historically, a number of rural communities in Nova Scotia have had closures of their emergency departments leaving residents without consistent access to both primary and emergency care in their local facilities. In some of these communities, we have opened CECs. The CEC is a new model of care that integrates primary care and emergency care in a way that is predictable and sustainable. We are measuring hours of closure as an indicator of community access to both primary and emergency care.

What Does the Measure Tell Us?

This measure counts the total number of unscheduled hours that CECs were closed during 2013-14. This tells us the number of hours that residents could not access care in their local facility.



Where Are We Now?

Over the 2013-14 fiscal year, eight CECs were open for all or part of the year. During that time they experienced a cumulative total of 737 unscheduled hours of closure out of a possible 59,789 total eligible hours. In other words, CEC were closed 1.2% of their scheduled open hours.

Where Do We Want To Be In the Future?

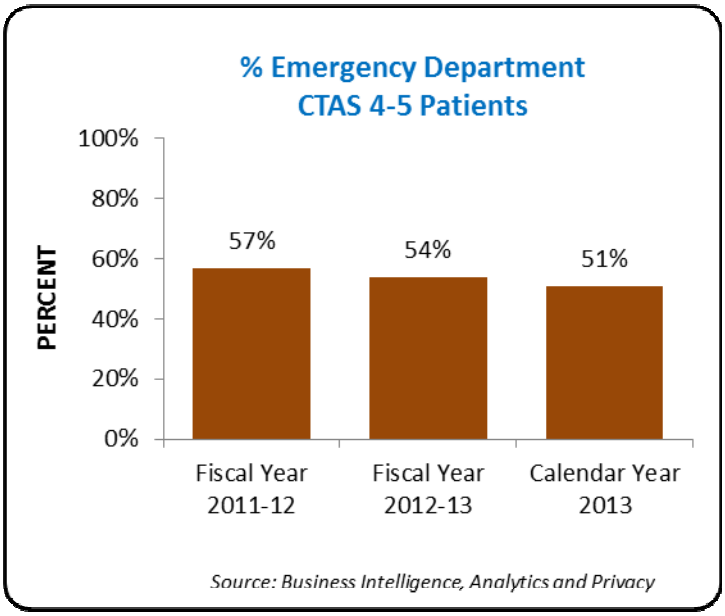
Our goal is to provide predictable and sustainable access to health care in Nova Scotia and to minimize unscheduled closures in these communities.

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

Some visits to emergency departments are for problems that can be adequately treated in a primary health care setting. Over the past year a number of initiatives have focused on improving primary and emergency care in Nova Scotia to ensure 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?

At the time of reporting, data for the calendar year of 2013 was the latest annual cycle of data available that had been validated, instead of the preferred 2013-14 fiscal year. Please note that the calendar year data has a three month overlap with the 2012-13 fiscal year data (Jan-Mar 2013).

In 2011-12, the percentage of patients with a CTAS level of 4-5 was 57% provincially. 2011-12 is the baseline year. In the 2013 calendar year, the percentage decreased to 51% provincially.

Where Do We Want To Be In the Future?

DHW wants to see 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.

A number of actions are being taken to ensure that patients receive care in the most appropriate setting. Collaborative Emergency Centres have been launched in communities across Nova Scotia and will provide access to primary, urgent and emergency care by a team of professionals. Additionally, access to primary care services is being enhanced, the Mental Health and Addictions Strategy is being rolled out, as is the Physician Resource Plan.

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;

d) danger to the life, health or safety of persons or the environment; or

e) directing or counseling someone to commit a wrongdoing.

Table A.1

The following is a summary of disclosures received by the DHW in 2013-14:

Information Required under Section 18 of the Act	Fiscal Year 2013-2014
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

NOTES

NOTES

Health and Wellness