# 2012-13 Statement of Mandate

April 2012

NOVA SCOTIA
Health and Wellness

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## 1.0 Message from the Minister and Deputy Minister

The year ahead will present many opportunities for innovation and change in the health care system as we move toward a more efficient and responsive delivery of care. At a time when the federal government is looking for leadership from the provinces, Nova Scotia is being recognized for several initiatives that our staff and health care partners in the District Health Authorities have implemented to make life better for families.

We believe it is worth highlighting some of the successful changes underway so that together we can continue to make improvements in health care delivery in 2012-13. Nova Scotia's innovative Extended Care Paramedic nursing home program that allows seniors to be treated at home instead of at the emergency department is now a national award winning service. With help from our partners in Capital Health and the Emergency Management Centre, 17 nursing homes in Halifax Regional Municipality are using the highly trained services of our paramedics to reduce trips to the emergency department.

This past year, the program won a Public Sector Leadership Award from the Institute of Public Administration of Canada and Deloitte for outstanding collaboration and innovation by taking bold steps to improve Canada through advancements in public policy and management. We believe this program exemplifies how we can improve the experience of seniors in Nova Scotia by being open to change.

In 2012-13, we will continue to implement our emergency care plan, Better Care Sooner, with other significant improvements. We will open Collaborative Emergency Centres in communities that have faced chronic Emergency Room (ER) closures so Nova Scotians can receive same day or next day appointments with health care professionals, including doctors and nurses, when and where they need it. We will also enhance the quality of care to all hospitals with new Emergency Department standards.

We also recognize the importance that prevention and protection play in relation to good health. That is why we have a deliberate focus on wellness and health promotion, areas where our department is working hard. Placing greater emphasis on the prevention of disease and injury, the promotion of health, and healthy eating is a vital part of a sustainable health care system. In 2012-13, the department will announce a Childhood Obesity Prevention Strategy to create environments that promote active lifestyles and healthy eating. We will also continue with the important work underway to prevent tobacco use.

We recognize that health inequities exist and some Nova Scotians must cope with disadvantages and even higher rates of disease than others. To address this, we will work with our health system partners to respond effectively to patient needs, understanding factors such as age, education, income, race, disability, geography, language, sexual orientation, gender, gender identity and faith. One of the most vulnerable groups we will focus on is those with addictions and mental health illness as we release Nova Scotia's Mental Health and Addictions Strategy.

We look forward to your support as we work together to help make our health care system innovative and sustainable.

Honourable Minister Maureen MacDonald

Deputy Minister Kevin McNamara

## 2.0 Mandate, Vision, and Mission of the Department of Health and Wellness

### 2.1 Mandate

The health and wellness system includes the delivery of health care as well as the prevention of disease and injury and the promotion of health and healthy living.

The department is committed to the ongoing improvement of the health and wellness system through setting strategic direction and provincial policy to ensure services are accessible and timely; developing standards; monitoring, measuring and evaluating quality; conducting financial and human resources planning; administering the allocation of resources; and establishing requirements for information systems.

The Department is responsible for the following core program areas: mental health and addiction services, physician services, pharmaceutical programs, primary health care services, emergency health services, continuing care services, public health, physical activity, sport, and recreation.

The department also provides funding to the District Health Authorities (DHAs) and the Izaak Walton Killam (IWK) Health Centre who are responsible for service delivery and resource management of the health and wellness system.

### 2.2 Vision

An innovative and sustainable health system for generations of healthy Nova Scotians.

### 2.3 Mission

Providing leadership to the health system for the delivery of care and treatment, prevention of illness and injury, promotion of health and healthy living.

## 3.0 Priorities of the Department of Health and Wellness (DHW)

This section describes how the priorities of DHW fit within government's three priorities:

1. Make health care better for you and your family
2. Create good jobs and grow the economy
3. Get back to balance and ensure government lives within its means

## 3.1 Make health care better for you and your family

#### *3.1.1 An Emphasis on Prevention*

Placing greater emphasis on the prevention of disease and injury and the promotion of health is a vital part of creating a sustainable health system. While there is a role for providing the public information about healthy lifestyles and for clinical prevention interventions such as screening, the greatest impact on improving health will come from working across government and across

society to develop environments and policies that promote health and support healthier choices.

In 2012-13, the department will focus on:

Implementing, along with other government departments, initiatives that support physical activity and healthy eating as identified in the Childhood Obesity Prevention Strategy; implementing the revised Tobacco Control Strategy, including making appropriate changes in legislation and continuing to work with DHAs and the community to prevent tobacco use and help people stop using tobacco; continuing to raise awareness of our high rates of problem drinking and problem gambling and identifying effective solutions; and investing in Public Health by building capacity in epidemiologists and public health inspectors.

### *3.1.2 Better Care Sooner (BCS)*

Better Care Sooner is the province's plan to improve primary and emergency health care services across Nova Scotia. The plan contains 32 action items to be implemented from 2011 to 2014. Since January 2011, much progress has been made in implementing some of the actions in the plan.

In 2012-13, the department will focus on the following:

Opening additional Collaborative Emergency Centres (CECs), introducing Emergency Department (ED) standards, identifying "system level" barriers that impact emergency access and flow; improving the coordination of the movement of patients between health facilities; providing more options for shuttle services for select hospital transfers; providing senior friendly care in emergency departments; testing new funding models for the health system; and using IT to track and improve patient experience.

The department will also focus on building the awareness, knowledge and skills to better understand the communities it serves and how to address their diverse clinical and cultural health and wellness needs. We will work with First Nations communities to support culturally safe and acceptable care. Specifically, we will begin to implement ED and CEC standards, including cultural competence components, and evaluate their impact on improving emergency and primary health care throughout the province.

### *3.1.3 Wait Times*

In 2012-13, DHW will collaborate with DHAs to validate the provincial surgical wait list in Nova Scotia and establish ongoing wait list validation practices to ensure the surgical queue is appropriate and reflective of system demand.

Using the provincial Patient Access Registry Nova Scotia (PAR NS), DHW will work with DHA clinical and administrative leadership to implement strategies for optimizing surgical queue management practices to reduce the number of long waiting patients in Nova Scotia with a focus on hip and knee replacement wait lists.

Health care providers and district health authorities will continue to use wait list data from PAR NS to manage surgical wait lists and operating room resources.

### *3.1.4 Mental Health and Addictions Strategy including Concurrent Disorders*

In the Spring 2010 Throne Speech, the intention to create a mental health and addictions strategy was announced. The strategy will help ensure timely access to quality services. In July 2010, the Nova Scotia Health Research Foundation was enlisted to oversee the research and project management of the strategy. Stakeholder and public consultations were completed in the Spring of 2011-12. The Advisory Committee continues to work on their report and recommendations. The Minister of Health and Wellness is anticipating receiving the report in the spring of 2012-13. This work will inform government's Mental Health and Addictions Strategy, which will be released shortly after the Advisory Committee's report has been received.

### *3.1.5 Quality and Patient Safety*

In 2012-13, DHW will investigate the potential for a provincial adverse event reporting system. The Quality and Patient Safety (QPS) Division will draft a health indicator framework to measure, track and evaluate provincial health services. It will also assist in implementing the strategic activities of the Quality Patient Safety Advisory Committee.

The Infection Prevention and Control Center of Nova Scotia (IPCNS) will expand its service provider networks in 2012-13; examine the potential for a provincial surveillance system for hospital acquired infections; and make recommendations regarding certification of medical device reprocessing technicians in Nova Scotia. In addition, IPCNS will develop infection prevention and control guidelines for provincial long term care facilities and guidelines for the management of *C. Difficile* infection in health care facilities.

### *3.1.6 E-Health Technology Solutions*

1. Electronic Health Record (EHR) - Share (Secure Health Access Record) is a secure and private lifetime record of an individual's health and care history. The plan for 2012-13 is to accelerate the adoption of SHARE in the acute care, long term care and other sectors in NS. Over the next year we will be adding 552 new providers.

2. Electronic Medical Record (EMR) Adoption (2010 – 2013) will implement service delivery improvements and accelerate adoption of the provincial Electronic Medical Record (EMR) among primary healthcare providers across Nova Scotia. Over three years, 490 new providers will be added to the provincial EMR. The plan for 2012-13 is to implement the remaining 216 of the planned 490 providers.

3. Drug Information System (DIS) allows providers access to a comprehensive medication history which will assist in the clinical decision making process and ultimately improve patient safety. In 2012-13, the department will continue to develop the provincial DIS with a focus on community pharmacies.

4. Personal Health Records (PHR) Demonstration A PHR is a complete or partial health record under the custodianship of a person(s) (e.g. a patient or family member) that holds all or a portion of the relevant health information about that person over their lifetime. A PHR allows an individual access to his/her personal health information from all health care providers. In addition, health care providers also have access to this record. The patient can share this

information electronically with his/her health care providers if he/she wishes. The plan for 2012-13 is to demonstrate the benefits of PHRs in two to five family physician practices.

### *3.1.7 Childhood Obesity Prevention Strategy (COPS)*

In the 2010 and 2011 Throne speeches, Government committed to develop a childhood obesity prevention strategy. Currently, 61% of adults and 32% of children are overweight or obese in Nova Scotia, increasing their risk for chronic disease and putting additional pressure on an overburdened health system. All levels of government and sectors of society must work together to create environments that support people, particularly children and families, to be healthier. DHW conducted a comprehensive evidence based review and consulted broadly to develop a whole-of-government strategy. It will focus on enhancing support in the early years; increasing skills, knowledge and opportunities to eat healthy and be active; and building healthier communities. The strategy will be launched in the spring of 2012-13.

### *3.1.8 Nurse Practitioners*

Government committed $1,500,000 to add a nurse practitioner in each District Health Authority. Significant progress has been made to establish these positions. Nurse practitioners have already been hired and are working to support residents in a number of Districts with recruitment efforts underway in others. All nurse practitioners to be hired through this commitment are anticipated to be in place in early 2012-13.

### *3.1.9 Establish Acute and Chronic Disease Targets*

The Chronic Disease Management Advisory Committee (CDMAC) provides leadership in advising system wide change to strengthen chronic disease prevention and management across the continuum. In 2012-13, through the work of its members and partners, CDMAC will respond to the Acute and Chronic Disease Target Setting Report and work with system stakeholders to identify the required system supports needed to achieve reduction targets for diabetes, hypertension and osteoporosis.

### *3.1.10 Continuing Care*

Continuing Care provides a range of home/community based services and residential care options for individuals needing short and long term care. The focus for 2012-13 will be to continue growing home care services to ensure more individuals are able to stay at home longer and to support family and friend caregivers in caring for them. DHW will work with the Department of Community Services to increase funding available to seniors for home adaptations to ensure their home environment is safe and enables the care they require. In addition, DHW will develop more restorative care to address mobility concerns and medication issues for seniors in the community.

In 2012-13, the final phase of integrating Continuing Care into the district health authority structures will be completed with the transfer of service delivery relationships with home care

agencies and long term care facilities from DHW to the DHAs. DHW will remain responsible for funding, regulation, monitoring and evaluation and licensing of service providers.

## 3.2 Create good jobs and grow the economy

### *3.2.1 Provincial Workforce and Immigration Strategies*

DHW will work with other departments and stakeholders to support the implementation of the provincial Workforce Strategy, as well as the provincial Immigration Strategy. This includes integrating internationally educated health professionals into the workforce, and projects related to foreign qualifications recognition. Attention will focus on improving health human resources information and planning to better identify the right number and mix of health care providers to meet the needs of different populations in Nova Scotia.

## 3.3 Get back to balance and ensure government lives within its means

### *3.3.1 Expenditure Management Initiative*

DHW, working with the DHAs and IWK have started several expenditure management initiatives. These initiatives were chosen because they not only address cost reductions but also support better patient care by ensuring staff are scheduled effectively and efficiently, improve the buying power of supplies and equipment, increase timely access to patient information by reducing paper, and improve access and management of beds. These initiatives are listed below:

Staff scheduling will provide the opportunity to schedule staff efficiently as well as provide a tool to improve managing overtime costs. Cumberland DHA, Capital DHA and the IWK will implement staff scheduling in 2012-13.

Group Purchasing enables DHAs/IWK to bulk purchase and standardize the supplies purchased in all the hospitals across the province. In 2012-13, this procurement initiative will build collaboration across the purchasing groups within the DHAs/IWK, drive standardization of supplies and services across the DHAs/IWK and, achieve cost savings that will be used to enable targeted budget reductions and be reinvested by the DHAs/IWK.

Merged Services is examining opportunities to deliver administrative services. The six areas that have been identified as having the greatest opportunity for collaboration and cost savings are: Human Resources; General Administration; IT & Telecommunications; Laundry; Finance/Payroll; and Supply Chain. In 2012-13, work will move forward on key areas of merged services.

Scanning supports better patient information flow. Scanning and archiving: this is another step towards electronic health records. Colchester and Capital DHAs have already implemented scanning, and the IWK has completed the first phase of scanning (electronic forms) and will fully implement the software solution by the end of 2011-12. The remaining DHAs will implement scanning throughout 2012-13 and 2013-14.

Bed Utilization will ensure the right number of beds are being used appropriately. Bed utilization is funded by the Change and Innovation Fund ($1.5m). Implementation started in 2011-12 and the full system will be implemented in all DHAs/IWK in 2012-13.

## 4.0 Performance Measures

The Department is currently reviewing the full suite of performance measure to select the best measures for Business Planning purposes. This involves identifying strategic outcomes and the sources of related data; selecting annual and ultimate target years where possible; and establishing trends.

Recognizing that this is only one forum for reporting on the Department's work, other performance measures will be considered for branch operational plans. The resulting performance measures should remain consistent over specific time periods.

The following performance measures align with the priorities of the department as they have been presented in this Statement of Mandate.

## 4.1. Performance Measures for the Department of Health and Wellness

| OUTCOME | MEASURE | DATA Base Year | TARGET YEAR 2012-13 | TREND | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Better Access to Emergency Care in Tertiary, Regional and community EDs | Percentage of CTAS[1],[2]1-3 patients with total length of stay from triage to ED departure for patients within 8 hours<br><br>Percentage of CTAS 4-5 patients with total length of stay from triage to ED for patients within 4 hours<br><br>Source: MediTech (DHAs 1-8, IWK, EDIS (IWK), NACRS[3] (IWK) | Base year: 2011<br><br>Base year: 2011 | NS aims to have an upward trend in the percentage of patients<br><br>NS aims to have an upward trend in the percentage of patients | 2011: 86%<br><br>2011: 83% | Identify system level barriers to flow of patients through EDs<br><br>**Develop provincial requirements of Emergency Department Information Systems and select a vendor**<br><br>**Implement e-triage in EDs**<br><br>**Promote 811 and 911 use**<br><br>**Enhance access to primary care** |

| OUTCOME | MEASURE | DATA Base Year | TARGET YEAR 2012-13 | TREND | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| 24/7 access to primary health care and emergency care 100% of the time | Number of hours that CECs are closed<br><br>Source: Acute and Tertiary Care Accountability Report | Base year: 2012-13: | 0 hours of closures | NS aims to maintain 0 hours of closures | Open CECs to increase access to primary health care and emergency care |

[1] CTAS: Canadian Triage and Acuity Scale; 1=Life-or- Limb- threatening; 2=severe pain or unstable vital signs; 3=Moderate Illness that may require some tests; 4=possible bone fracture or large cuts; 5=minor injury

[2] This measure represents only facilities were CTAS information is collected

[3] National Ambulatory Care Reporting system

| OUTCOME | MEASURE | DATA<br>Base Year | TARGET YEAR<br>2012-13 | TREND | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Timely access to better care sooner | Percentage of CTAS 4-5 patients in ED<br><br>Source: MediTech (DHas 1-8, IWK, EDIS (IWK), NACRS[4] (IWK) | Base year: 2011<br><br>*Note: Data will not be available until the fiscal 2012-13 year* | NS aims to have a downward trend in the % of CTAS 4-5 patients | 2011: 57% | Assess ER processes and plan to streamline flow of patients<br><br>Undertake a gap analysis re the ED Standards<br><br>Conduct a feasibility study for an EDIS<br><br>Implement NACRS into DHA<br><br>Promote use of 811 & 911<br><br>Enhance access to primary care |

[4] National Ambulatory Care Reporting system

| OUTCOME | MEASURE | DATA<br>Base Year | TARGET YEAR<br>2012-13 | TREND | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Improve quality and appropriateness of patient care through reduction in long waiting patients and optimizing surgical wait list management practices.<br>Reduce wait times for patients *still* waiting for surgery in Nova Scotia. | Percentage change in number of long waiting (1+ years) patients waiting for surgery.<br><br>Wait times for patients *still waiting* for surgery. (**Note** that this is a different measure than the wait times for *completed* surgeries, which is reported publically)<br><br>Source: Patient Access Registry NS (PAR NS) | 2010-11:<br><br>54% increase from April 1, 2010 to March 31, 2011<br><br>2010-11:<br><br>90th percentile: 536 days as of March 31, 2011 | NS aims to reduce the number of long waiting patients.<br><br>NS aims to improve 90th percentile[5] wait times for patients still waiting for surgery | 2010/11 baseline: 54%<br><br>2010/11: 536 days | Validate surgical queue to remove cases not requiring surgery. Establish ongoing wait list validation practices in District Health Authorities.<br><br>Work with DHA clinical and administrative leadership on initiatives to prioritize booking of long waiting patients. |

[5] 90 % of people fall below this figure

| OUTCOME | MEASURE | DATA<br>Base Year | TARGET YEAR<br>2012-13 | TREND | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Public resources will be more effective and efficient by enhancing access to mental health services | Percentage of adult clients seen within the provincial standard[6]<br><br>Percentage of child/adolescent clients seen within the provincial standard<br><br>Source: Meditech (DHAs 1-8), PHS[7] (DHA 9), Meditech Magic (IWK) | Base year: 2011-12<br><br>Urgent: 77%<br>Semi-Urgent: 65%<br>Regular: 81%<br><br>Base year: 2011-12<br><br>Urgent: 57%<br>Semi-Urgent: 51%<br>Regular: 70% | NS aims to increase the percentage of adult clients seen within the provincial standard<br><br>NS aims to increase the percentage of child/ adolescent clients seen within the provincial standard | Base year: 2011-12<br><br>Urgent: 77%<br>Semi-Urgent: 65%<br>Regular: 81%<br><br>Urgent: 57%<br>Semi-Urgent: 51%<br>Regular: 70% | Utilization of "Stronger Families" program at IWK and CBDHA<br><br>Providing parenting groups where appropriate for regular referrals to determine the need for individual treatment.<br><br>Participate in the Development of the Mental Health Strategy |

| OUTCOME | MEASURE | DATA<br>Base Year | TARGET<br>2012-13 | TREND | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Enhanced provision of effective and efficient primary health care | Number of NEW health care providers implementing EMR in their daily practice<br><br>Source: PHIM[8] | Base Year:<br>2011-12<br><br>146' | 216 | 2011-12:<br>146 ytd | Continue to promote the implementation of the EMR |

[6] This is the year-to-date figure. It may change by year-end.
[7] Pathways Healthcare Scheduling
[8] Primary Healthcare Information Management

| OUTCOME | MEASURE | DATA Base Year | TARGET 2012-13 | TREND | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Comprehensive patient information is accessible to health care providers. | Number of clinicians using the EHR<br><br>Source: HITS-NS[9] | Base year: 2010-11: 104 | 1000 | 2010-11: 104<br><br>2011-12: 448 | Continue to collaborate with Canada Health Infoway on EHR Project<br><br>Continue enhanced active integration to the Client Registry<br><br>Continue roll out of SHARE Provider Viewer and Clinical Repository |

| OUTCOME | MEASURE | DATA Base Year | TARGET YEAR 2014-15 | TRENDS | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Increased affordability, accessibility, availability and consumption of fruits and vegetables for all Nova Scotians. | Percentage of NS population (12 years +) who report eating at least the recommended 5-10 servings of fruit/ vegetables per day<br><br>Source: CCHS[10] | Baseline 2001[11]: 32.6% | NS aims to continue an upward trend | 2003: 33.3%<br><br>2005: 35.0%<br><br>2007-08: 35.7%<br><br>2009-10: 36.3% | Implementation of the Healthy Eating Strategy<br><br>Support implementation of the Childhood Obesity Prevention Strategy pending approval and funding. |

[9] Health Informatio Technology Services Nova Scotia

[10] CCHS data are based on the calendar year. Prior to 2007, CCHS core content data was collected every two years. Beginning in 2007, these data are now collected annually. In order to be comparable to previous CCHS cycles, the yearly data are combined every two years. The latest combined year cycle is 2007-08.

[11] The base year is 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.

| OUTCOME | MEASURE | DATA<br>Base Year | TARGET YEAR<br>2014-15 | TREND | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Improve access to healthy foods for all Nova Scotians by reducing the number of food insecure households. | Percentage of food insecure households<br><br>Source: CCHS[12] | Base Year: 2005[13]: 7.7% | NS aims to have a downward trend | 2007/08: 6.8%<br><br>2009/10: 9.4% | Continue to support implementation of the provincial *Healthy Eating Nova Scotia* strategy<br><br>Continue to work in partnership with the Nova Scotia Food Security Network and others interested in promoting and supporting food security<br><br>Continue to monitor income-related food insecurity<br><br>Support implementation of the Childhood Obesity Prevention Strategy pending approval and funding. |

[12] CCHS data are based on the calendar year. Prior to 2007, CCHS core content data was collected every two years. Beginning in 2007, these data are now collected annually. In order to be comparable to previous CCHS cycles, the yearly data are combined every two years. The latest combined year cycle is 2007-08.
[13] CCHS questions related to food insecurity changed in 2005, therefore, 2005 is the base year.

| OUTCOME | MEASURE | DATA Base Year | TARGET YEAR 2014-15 | TRENDS | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Healthy, active youth in the female population | Percentage of junior high school girls active enough for health benefits<br><br>Source: HPP: Keeping Pace surveillance[14] | Base year: 2009-10[15]<br><br>13.2% | Ns aims to have an upward trend | 2009-10: 13.2% | Continue to support Active Kids Healthy Kids Strategy<br><br>Implement physical activity interventions within COPS |

| OUTCOME | MEASURE | DATA Base Year | TARGET YEAR 2015 | TRENDS | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Increase the number of adults with gambling problems who seek professional gambling treatment services in NS | Prevalence of 18 years and older who are at risk for or have gambling problems and seek treatment services<br><br>Source: 2007 NS Adult Gambling Surveillance[16] | 2007: 7% | Prevalence of 10% of individuals at risk for or with gambling problems will seek professional gambling treatment services | 2007: 7%<br><br>(data will not be available until end of 12-13 fiscal) | Implementation of the 2011 NS Responsible Gaming Strategy |

[14] Data are only collected by HPP every four years.

[15] 2009-10 was selected as base year as it will be year with most current data from which to develop a realistic target.

[16] This is the latest surveillance data available (from the 2007 NS Adult Gambling Prevalence Study) before the implementation of the 2011 NS Responsible Gaming Strategy and is selected as a base

| OUTCOME | MEASURE | DATA BASE YEAR | TARGET YEAR 2015 | TRENDS | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Improve the health status of mothers and babies by increasing breastfeeding initiation and duration in Nova Scotia. | Breastfeeding initiation rate: percentage of infants receiving breast milk and / or who had early breast contact.<br><br>Source: Nova Scotia Atlee Perinatal Database[17] | Base year: 2006: 72.7% | NS aims to continue an upward trend | 2007: 73.3%<br>2008: 75.0%<br>2009: 76.3%<br>2010: 77.9% | Implementation and monitoring of the Provincial Breastfeeding Policy directives<br><br>Support implementation of the Baby-Friendly Initiative<br><br>Capacity building for promotion, support and protection of breastfeeding through the DHAs, the IWK Health Centre, family resource centres and other community organizations<br><br>Support implementation of the recommendations related to Breastfeeding in the Childhood Obesity Strategy pending approval and funding to support the strategy |
| | Breastfeeding duration rate: Percentage of Women Who Exclusively Breastfeed For At Least Six Months (Duration)<br><br>Source: Canadian Community Health Survey | Base year: 2003: 16.3% | NS aims to continue an upward trend | 2005:- 18.8%<br>2007/08: 16%<br>2009/10:- 18.0% [18] | |

[17] Nova Scotia Atlee Perinatal Database is a provincial database administered by the Reproductive Care Program, DHW. It is selected as it captures information on almost 100% of births in NS whereas CCHS looks only at a sample of Nova Scotian women.

[18] Data related to this measure were collected every two years until 2007 when the data were collected annually. In order to be comparable to previous CCHS cycles, the yearly data were combined over two years. The latest CCHS data for breastfeeding duration are for 2009-10; and according to Statistics Canada Guidelines, these data have a high degree of sampling variability, and although they can be used, they should be used with caution.

| OUTCOME | MEASURE | DATA<br>Base Year | TARGET YEAR<br>2015 | TRENDS | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Decrease the number of adolescents between the ages of 13-18 who are currently engaging in organized forms of gambling | Prevalence of adolescents aged 13-18 years who engage in organized forms of gambling<br><br>**Source:** 2011 Adolescent Gambling Surveillance Report [19] | 2011: 54.4% | NS aims to achieve a 50% prevalence rate of adolescents between the ages of 13 and 18 years who engage in organized forms of gambling | 2011: 54.4% | Implementation of the 2011 NS Responsible Gaming Strategy |

[19] This is selected as the base year as the impact of the 2011 NS Responsible Gaming Strategy will begin when implemented in 2012

| OUTCOME | MEASURE | DATA<br>Base Year | TARGET YEAR<br>2015 | TRENDS | STRATEGIC ACTIONS TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| A reduction in the percentage of the Nova Scotia population aged 15 years and older currently experiencing harm from their drinking | Percentage of the Nova Scotia population aged 15 years and older currently experiencing harm from their drinking<br><br>Source: CADUMS[20] | Base year: 2008:<br>NS: 7.0%<br>Canada: 6.8% | NS aims to decrease 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 of the population aged 15 years and older | 2009:<br>NS: 6.8%<br>Canada: 6.5% | Conduct/participate in research related to social and economic costs of alcohol use especially for high risk or hazardous drinkers<br><br>Heighten profile of alcohol as critical public health/safety issue<br><br>Develop/implement programs that address high-risk drinking behaviours and contexts<br><br>Continue to conduct/monitor research on links between supply of alcohol and alcohol-related problems |

[20] Canadian Alcohol and Drug Use Monitoring Survey is produced annually with data collection in June/July and data availability in June/July the following year.

| OUTCOME | MEASURE | DATA<br>Base Year | TARGET YEAR<br>2015 | TRENDS | STRATEGIC ACTIONS<br>TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Reduce tobacco use among young adults | By Age :<br>Percentage of 15- 19 year olds who smoke<br><br>Percentage of 20-24 year olds who smoke<br><br>Percentage of 25 + year olds who smoke<br><br>Source: CTUMS[21] | <br>14%<br><br>30%<br><br>19% | <br>10%<br><br>20%<br><br>15% | <br>2009: 14%<br>2010: 16%<br><br>2009: 30%<br>2010: 29%<br><br>2009: 19%<br>2010: 21% | Implementation of the renewed comprehensive tobacco control strategy |

| OUTCOME | MEASURE | DATA<br>Base Year | TARGET<br>2012-13 | TREND | STRATEGIC ACTIONS<br>TO ACHIEVE TARGET |
|---|---|---|---|---|---|
| Sustainable, high performing nursing workforce | Retention rate for nurses graduating from Nova Scotia universities<br><br>Source: College of Registered Nurses of Nova Scotia | Base year: 2010-11<br><br>80% | 80% retention of new nursing graduates | 2010-11: 80% | Work with DHAs/IWK and relevant partners to enhance retention through initiatives outlined in the provincial Nursing Strategy |

[21] Canadian Tobacco Use Monitoring Survey

## 5.0 Budget Context

## Department of Health and Wellness 2012-13

| | *2011/2012 Budget ($ thousands)* | *2011/2012 Forecast ($ thousands)* | *2012/2013 Budget ($ thousands)* |
|---|---|---|---|
| *Executive Administration* | 67,925 | 63,298 | 65,851 |
| *Medical Payments* | 721,872 | 723,727 | 727,661 |
| *Pharmaceutical Services* | 258,620 | 262,555 | 265,905 |
| *Insured Services* | 31,133 | 33,833 | 31,254 |
| *Emergency Health Services* | 108,515 | 110,478 | 116,317 |
| *Continuing Care* | 2,966 | 2,816 | 2,949 |
| *Home Care Services* | 174,153 | 179,364 | 194,153 |
| *Long Term Care Program* | 514,886 | 499,338 | 529,430 |
| *Addiction Services* | 835 | 1,526 | 1,472 |
| *Physical Activity, Sport and Recreation* | 16,408 | 16,530 | 27,263 |
| *Public Health Programs* | 14,119 | 13,365 | 15,285 |
| *Provincial Programs and Initiatives* | 128,649 | 119,403 | 128,096 |
| *Other Programs* | 19,494 | 19,385 | 20,172 |
| *Other District Health Authority Initiatives* | 24,927 | 19,933 | 26,595 |
| *District Health Authorities* | 1,591,136 | 1,593,846 | 1,606,920 |
| *Capital Grants & Healthcare Amortization* | 92,620 | 99,403 | 102,190 |
| ***Total*** | **3,768,259** | **3,758,800** | **3,861,513** |

| | | | |
|---|---|---|---|
| *Funded Staff (FTEs)* | 526 | 448 | 494 |
| *Staff Funded by External Agencies* | (21) | (24) | (29) |
| *Total FTE Net* | **505** | **424** | **465** |