Annual Accountability Report for the Fiscal Year 2005-2006

NOVA SCOTIA
Health

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Annual Accountability Report for the Year 2005-2006

Department of Health

Accountability Statement

The accountability report of the Department of Health for the year ended March 31, 2006, is prepared pursuant to the Provincial Financial Act and government policy and guidelines. These authorities require the reporting of outcomes against the Department of Health's business plan information for the fiscal year 2005-2006. The reporting of Department outcomes necessarily includes estimates, judgments and opinions by Department management.

Due to organizational changes resulting from the establishment of the Department of Health Promotion and Protection, priorities related to Health Protection and Public Health Services contained in the 2005-2006 Department of Health Business Plan are reported on in the 2005-2006 Department of Health Promotion and Protection Accountability Report. Both departments will report on the priority "Emergency Preparedness and Response". The Department of Health will report on the all hazards approach being undertaken under "Emergency Health Services" and the Department of Health Promotion and Protection will report on Pandemic Influenza initiatives.

We acknowledge that this accountability report is the responsibility of Department management. The report is, to the extent possible, a complete and accurate representation of outcomes relative to the goals and priorities set out in the Department's business plan for the year.

The Honourable Chris d'Entremont	Cheryl Doiron
Minister of Health	Deputy Minister of Health

Message from the Minister of Health

It gives me great pleasure to present the Accountability Report for the Department of Health for 2005-2006.

In my time at the Department, I have been consistently impressed with the skill and the spirit the staff brings to their jobs everyday. I appreciate that the work required to support and run the health care sector in Nova Scotia is tremendous, especially given the significant pressures we all now face. Everyday, difficult decisions must be made and we must work within limits that we wish we did not have to face.

Yet, despite all these challenges, in 2005-2006 the Department of Health was able to continue its considerable work, and even move forward with some important new initiatives as outlined in our 2005-2006 business plan.

The following are a few of the Department of Health's major achievements for 2005-2006.

Continuing Care - The Department completed consultations with over 1,400 Nova Scotians to collect their ideas and better understand the needs for long-term care and home care, both for now and in the future. This work formed the foundation for a 10-year plan for the expansion and improvement of these services.

Addressing Wait Times - In October 2005, Nova Scotia became one of the first provinces in Canada to launch a wait times web site. The site provides patients and their families with important information on treatment and services that can help them to make important decisions on where to access health care services. In December 2005 we participated with other provinces and territories in the announcement of evidence-based wait time benchmarks, another important milestone in our journey to improving access to care. These, together with investments in equipment and services, such as four new MRIs, are helping to ensure Nova Scotians get access to appropriate care sooner.

Primary Health Care - The year 2005-2006 saw the culmination of two years of planning, investment, and implementation of primary health care initiatives. With the help of Federal funding, Nova Scotia was able to initiate many significant projects, including the development and expansion of new information management systems for providers and patients, professional education opportunities for primary health care professionals, and the continuation of coordinator positions in the District Health Authorities to plan and implement community initiatives.

Expanding Information Systems - The Department continued to work with District Health Authorities to expand health information systems. We completed the implementation of the Nova Scotia Hospital Information System in 34 hospitals across the province this year. We also completed the implementation of the Picture Archiving and Communications System (PACS). Through PACS, Nova Scotia became the first jurisdiction in Canada to establish a province-wide digital network for diagnostic images like x-rays and CT scans. These projects are an important step toward achieving a fully electronic health records management system in the province.

In going through this report, I'm sure you will notice how this year's achievements build upon the good work of previous years, and lay the foundation for future initiatives. It is accomplishments such as these - where we are providing services in new ways - that will help us to continue to provide Nova Scotians with the health care they need.

Introduction

This Annual Accountability Report for the Department of Health is based on the goals and priorities set out in the Department's Business Plan for the 2005-2006 fiscal year. This report should be read in conjunction with the 2005-2006 Business Plan (available on the Department of Health web site at http://www.gov.ns.ca/health/).

The report is structured in tandem with the Business Plan and details key departmental and health system accomplishments for 2005-2006, financial performance, and health system performance measures and outcomes.

Through leadership and collaboration to ensure an appropriate, effective and sustainable health system that promotes, maintains and improves the health of Nova Scotians.

This is the Mission of the Department of Health. The Department is committed to the ongoing improvement of the health care system through system planning, legislation, resource allocation, policy and standards development, monitoring and evaluation, and information management. Accordingly, the Department fulfills its mission by:

- *Setting the strategic direction for the health care system and developing provincial plans, policy and standards which enable accountability and support that direction;*

- *Providing funding to health authorities, physicians and other health service providers in the provincial health system;*

- *Monitoring, evaluating and reporting on performance and outcomes across the health system; and*

- *Ensuring quality health services are available for Nova Scotians.*

The Department of Health has identified three "critical to mission" criteria against which all proposals for new and expanded programs and all existing programs and services are evaluated.

Our Mission requires that all health care and services be:

- **Integrated**
  An integrated health system ensures the coordination of services and allows providers to work together to improve the health status of the population.

- **Community-Based**
  A community-based health system assures input by communities in planning and identifying strategies and services to improve the health status of the population and ensures that teams of providers participate in carrying out these strategies and services.

- **Sustainable**
  A sustainable health system is one that is accountable for providing quality services to the population it serves and is affordable in the long term.

Core Business Areas

The Department of Health has seven key areas of care and service delivery. These are briefly outlined below:

Primary Health Care

Primary Health Care includes primary care, which is the first point of contact that individuals have with the health care system and the first element of the continuum of care. Primary health care includes prevention, diagnosis and treatment of common illness or injury, support for emotional and mental health, ongoing management of chronic conditions, advice on self-care, ensuring healthy environments and communities, and coordination for access to other services and providers.

Primary health care is about positively influencing the many factors that affect health. It includes a team-based approach to health care delivery, all-day access to essential health services, care for people of all ages and cultures in their communities, and the appropriate use of technology.

Mental Health Services

The Mental Health Services Branch is responsible for policy, standards, monitoring and funding of mental health services. Mental Health services for children, youth and adults are delivered through the province's nine DHAs and the IWK Health Centre. Delivered across the life span, core programs include:

- secondary prevention and promotion,
- outpatient and outreach services,
- acute, short stay and long-term psychiatric in-hospital treatment,
- specialty mental health services, and
- community supports.

Specialty mental health services include seniors' mental health, eating disorders, adult and youth forensic services, sex offender treatment, early psychosis and neurodevelopmental services. Services are consumer and family-focused, and community-based where possible. Some mental health services are delivered through a "shared care" approach in collaboration with primary care services.

Acute and Tertiary Care

Through collaborative relationships with the nine DHAs, the IWK Health Centre, and all approved provincial health care programs, the Acute and Tertiary Care Branch ensures that affordable, appropriate, and effective acute care services are available to Nova Scotians. The Branch also liaises with, and supports the operations of provincial and ancillary programs (dentistry, optometry, prosthesis) ensuring that provincial standards for clinical care are developed and maintained across the province.

Acute care services are delivered in 39 facilities throughout Nova Scotia. These include the 37 under governance and operation of the DHAs as well as the St. Anne's Community and Nursing Care Centre in Arichat and the IWK Health Centre in Halifax. Funding is provided by the

Department of Health in accordance with the Canada Health Act and the Nova Scotia Health Services and Insurance Act.

The Queen Elizabeth II Health Sciences Centre and the IWK Health Centre in Halifax are the province's two Provincial Health Care Centres (PHCCs). In addition to providing primary and secondary care services to metro area residents, they provide specialized services such as neurosurgery, secondary and tertiary care pediatrics, high risk obstetrics, burn intensive care, cardiac surgery, transplantation programs, cardio-thoracic surgery, immunology, hematology, as well as all the services available in the community and district facilities. The PHCCs also provide the highest level of emergency services.

Acute and Tertiary Care is responsible for the policy development, program content, tariff negotiations with the professional provider associations and day-to-day management of a group ancillary health services. Dental programs/services include children's oral health, cleft palate/craniofacial surgery, dental surgery, and services for mentally challenged clients. Prosthetic services include arm and leg, ocular, and mastectomy prostheses, and maxillofacial prosthodontics. Optometry and Interpreter Services for the Deaf and Hard of Hearing are also included. These programs and services are not mandated as insured services under the Canada Health Act but are provided by the Province to assist those individuals who most require assistance.

Working with the Department's Financial Services Branch, Acute and Tertiary Care plays a key role in the development and priority-based approval of DHA role studies, master programs and functional programs.

Acute and Tertiary Care also includes provincial programs that address health issues across sectors of the health system and which are beyond the mandate of any single DHA or health organization. Provincial Programs develop service standards, monitor their achievement, and provide advice to the Department of Health based on best practices, stakeholder input and research-based evidence. Current Provincial Programs include:

- Cancer Care Nova Scotia
- Nova Scotia Diabetes Care Program
- Reproductive Care of Nova Scotia
- Nova Scotia Breast Screening Program
- Cardiovascular Health Nova Scotia
- Nova Scotia Provincial Blood Coordinating Program
- Nova Scotia Hearing and Speech Program

Physician Services

In addition to hospital services, the Department of Health also funds medical or physician services for Nova Scotians under the terms of the Canada Health Act and the Health Services and Insurance Act. Under the legislation, insured physician services include those services that a qualified and licensed physician deems are medically necessary to diagnose, treat, rehabilitate or otherwise alter a disease pattern.

Pharmaceutical Services

Pharmaceutical Services provides programs, drug policy advice and research to promote, maintain and improve the health of Nova Scotians through appropriate drug use. The main program area is the Nova Scotia Seniors' Pharmacare Program. The Seniors' Pharmacare Program provides prescription drug insurance to 100,000 seniors in the province.

Continuing Care Services

Continuing Care contributes to the integrated continuum of health services by providing a range of home, community and residentially-based services to support individuals with identified health and supportive care needs. Care is provided in a manner that enables the individual to live as independently as possible in the community or in a residentially-based service. In most cases, the need for care and support is for the longer term (continuing care). However, both home care and residentially-based programs also address short-term needs. While the majority of clients are seniors, services are also provided to younger adults.

Continuing Care services include home care, long term care, adult protection and care coordination. Services are coordinated through single entry access that ensures care needs are identified through the use of a consistent assessment process. Referrals are made to the appropriate care providers. Assessment, care coordination and ongoing case management are a responsibility of the Continuing Care Branch. Continuing Care collaborates with approximately 140 provider organizations, including non-profit home support agencies, VON[1], and Nursing Homes/Homes for the Aged. Nursing Homes and Homes for the Aged are variously owned and operated by municipalities, private-for-profit owners, and non-profit organizations.

Home Care programs provide support to approximately 23,000 Nova Scotians. Services include both short term (acute) and longer term professional nursing care provided by registered nurses (RNs) and licensed practical nurses (LPNs). Home support services include personal care, nutritional care, essential housekeeping, and home oxygen. Community supports include adult day and volunteer programs, meals-on-wheels, and limited community rehabilitation services.

Residentially-based programs, providing support to approximately 8,500 Nova Scotians, include licensed Nursing Homes and Homes for the Aged, licensed Residential Care Facilities and a number of Community-Based Options that provide services to up to three clients, and operate within interim guidelines.

Adult protection support services are extended to adults 16 years of age or older who live independently in the community and are abused or neglected (including self-neglect). Provided under the authority of the Adult Protection Act, these services are currently provided to approximately 1,300 clients annually. Of those, 75% are over the age of 65.

Emergency Health Services

Emergency Health Services (EHS) is the division of the Department of Health that is responsible for the continual development, implementation, monitoring and evaluation of pre-hospital

[1]Victorian Order of Nurses

emergency health services for the province. Since 1995, the ambulance system has undergone a transformation from primarily a transportation system to a pre-hospital medical system with a province-wide fleet of well-equipped ambulances. As part of a performance-based contract, the ambulances are staffed by registered paramedics who perform life saving procedures and can administer a wide range of medications.

The main components of EHS are a communications centre, a ground ambulance service, an air medical transport program (EHS Life Flight), a provincial trauma program, a medical first responders program, and the Atlantic Health Training and Simulation Centre. All system components are monitored by physicians with expertise and training in the provision of emergency medical care.

Priorities and Departmental Accomplishments for the Year 2005-2006

Primary Health Care

Priority	Accomplishments
Collaborative Practice Teams ***Primary Health Care Nurse Practitioner Positions*** Beginning in 2003 with four, Nova Scotia now has sixteen primary health care nurse practitioner positions across the province. They are filling a longstanding service gap in communities. DHAs will continue development of innovative primary health care initiatives. New funding in 2005-2006 will support the formation of new multi-disciplinary teams (family physicians, nurse practitioners, family practice nurses and other community partners) using a variety of collaborative practice models.	Funding for nineteen Primary Health Nurse Practitioners is now secure. District Health Authorities continued to develop innovative primary care initiatives including the planning and implementation of an enhanced model of service delivery for the former Duffus Street Medical practice (a traditional fee-for-service group family practice). The recent relocation of the Duffus Health Centre in Halifax to accommodate an expanded team and services that expanded its services to include health promotion and chronic disease management activities through an interdisciplinary team. In addition, physician remuneration through an alternative payment plan (APP) and an electronic patient record has been implemented. Together, these initiatives will result in improved and increased access to primary health care.
Primary Maternity Care In response to recommendations of the Nova Scotia Advisory Committee on Primary Health Care Renewal, a Primary Maternity Working Group was established in 2004 to develop an approach to team based primary maternity care and a regulatory framework for the inclusion of midwives in collaborative teams delivering primary maternity care in Nova Scotia. Issues being explored include scope of practice, legislation/regulation, integration with DHAs, collaborative teams, and payment strategies. The Working Group is expected to report to the Department of Health in June 2005 with recommendations aimed at developing the legislation and infrastructure needed to support collaborative primary maternity care models.	Responding to the recommendations of the Nova Scotia Advisory Committee on Primary Health Care Renewal, the Primary Maternity Working Group produced a report and related recommendations in June 2005. In response, the Department of Health agreed to put a regulatory framework for midwives into place. A Legislation Committee was formed in 2005 to enable work on midwifery legislation to proceed. Based on that ongoing work, the Department of Health will be introducing legislation in Fall 2006 that will regulate the practice of midwifery in Nova Scotia. The implementation of a regulatory framework for midwives combined with the inclusion of midwives in collaborative practice teams delivering primary maternity care in Nova Scotia will result in a comprehensive range of care provided at the right time, in the right place.

Priority	Accomplishments
Diversity and Social Inclusion Awareness in Primary Health Care Nova Scotia's vision for primary health care recognizes the need for primary health care services that value and respond to the "cultural, racial and spiritual experiences of individuals, families and communities." It requires that equity of access be established for those who have historically faced barriers for reasons including race, ethnicity, language and culture, understanding that these and related factors affect health. Diversity and Social Inclusion in Primary Health Care is an initiative to raise awareness of diversity and social inclusion issues across a broad range of stakeholders within the primary health care system. Ongoing activities in 2005-2006 will include involvement of primary health care leaders and culturally diverse populations in the development of guidelines and policies that address diversity and social inclusion issues in primary health care.	Outcomes of the Diversity and Social Inclusion in Primary Health Care Initiative have included educational resources to assist stakeholders, including providers, DHAs, CHBs, primary health care organizations and the public to understand diversity, inclusion and exclusion and the need for the development of cultural competence in the primary health care system. Resources include: • *The Cultural Competence Guide for Primary Health Care Professionals*; and • *Cultural Competence for Primary Health Care in Nova Scotia: A DVD and Discussion Guide* The Cultural Competence Guidelines address issues that include under-screening in high-risk populations; race, ethnic and linguistic specific data gaps; the need for cultural health interpretation; and the promotion of system-wide, cultural competence. They are the first provincial guidelines of their kind in Canada.
Continuing Professional Education for Primary Health Care Providers Nova Scotia is the lead province in the Atlantic Region collaborative initiative *Building a Better Tomorrow*. The core of the initiative is the development and delivery of continuing professional education modules to primary health care providers in all four Atlantic Provinces in an effort to facilitate change. It will support providers' transition to a renewed primary health care system and complement renewal activities currently underway in the Atlantic Provinces. Priority activities for 2005-2006 include the design and pilot testing of education modules, delivery of modules to 270 providers in Nova Scotia (675 across Atlantic Canada) and program evaluation.	**Building A Better Tomorrow** To follow through on the commitment to facilitate change and build capacity within the system to sustain Primary Health Care, the Department of Health initiated an Atlantic Regional Project on Inter-professional Education for health professionals working in Atlantic Canada in 2003. Twelve inter-professional education modules were developed, pilot tested and implemented to over 5000 inter-disciplinary health professionals. Training modules included team building, conflict resolution, understanding primary health care, etc. On-line modules were developed and delivered via the Nova Scotia Telehealth Network.. The training modules were accredited and certification processed through Dalhousie University and Memorial University in Newfoundland. Over 65 facilitators in Nova Scotia delivered modules in all DHAs and the IWK. The success of this initiative will support providers during the transition to a renewed primary health care system and complement renewal activities currently underway in the Atlantic Provinces.

Priority	Accomplishments
Electronic Patient Records The implementation of the Nova Scotia Primary Health Care Information System Program (PHCISP) is a first step in the development of shared electronic health records across levels of care. In 2005-2006, the program's immediate goal is to increase the number of primary health care providers using electronic patient record (EPR) systems. PHCISP will launch an application hosting service to provide EPR application delivery and helpdesk support. Health Canada's Primary Health Care Transition Fund is providing funding for the initial two years of this project, including the development of extensive change management tools and training in support of provider engagement. They are also providing funding for an interoperability pilot for electronic delivery of laboratory and diagnostic image reporting.	Launched the PHIM Program to provide a provincial primary health care information management program in which providers can participate. Established the hosting environment and provincial help desk to make this an operational service for participating clinics. Held stakeholder engagement activities to inform primary health care providers about the program. Health transition funds were made available to encourage participation in the program. In 2005-2006, 25 per cent of the province's primary healthcare providers registered in the program. By March 2006, six clinics were actively using the system with 51 other clinics in varying degrees of preparing to participate in the program. Developed change management tools and education services to enhance the effectiveness of the program for participating clinics. Launched the priority initiative to provide electronic transfer of laboratory and Diagnostic Imaging results from Nova Scotia's three acute care systems to the PHIM program. This complex development eliminates the paper transfer of these reports to family practices and requires the input of the lab and diagnostic imaging team from all Nova Scotia acute care information system program areas. The testing and rollout of the initiative are scheduled for 2006-2007. Defined streamlined implementation processes for clinics participating in the PHIM Program to facilitate a smooth transition. Developed a data governance policy to define the rules around data access for the provincially hosted information management program. These initiatives will result in the provision of coordinated, efficient and safer health care through the timely sharing of critical health information through primary health information management.

Priority	Accomplishments
Health Literacy Awareness In 2005-2006, the Primary Health Care Section will continue with work that was initiated in 2004-2005 to implement a health literacy awareness initiative, in partnership with the Department of Education and other stakeholders. This initiative involves the development of tools to help raise awareness that literacy is a determinant of health. These tools will facilitate awareness building among primary health care providers of literacy issues, as well as strategies to improve the understanding and use of health information by patients.	Held two stakeholder consultation sessions to raise awareness and provide tools to address health literacy. In April 2005, the launching workshop engaged participants in the identification of strategies to implement health literacy resources that had been developed and compiled. These resources are available at:http://www.gov.ns.ca/health/primaryhealthcare/healthlit.htm. They include: • Health Literacy Making the Connection DVD • Health Literacy Awareness Initiative • Health Literacy and Older Nova Scotian Facts • Identifying Clients with Limited Literacy Skills Commenced discussion on developing a framework for a provincial health literacy strategy. This framework will provide clear and consistent strategic goals for health literacy improvement. Through improved and increased health literacy awareness, clinicians and patients will be better positioned to work together to improve the understanding and use of health information by patients.
Primary Health Care Transition Fund The Primary Health Care Transition Fund supports the DHAs as they develop and implement enhancement to primary health care services throughout the province. Priorities include the creation of new ways to develop sustainable primary health care networks/organizations; increased emphasis on health promotion, injury prevention and population health; and transitioning the primary health care system to an electronic patient record. These activities continue to be informed by the Report of the Nova Scotia Advisory Committee on Primary Health Care Renewal.	Supported a number of other priority areas identified in the 2005-2006 Business Plan and reported on in this document through the Primary Health Care Transition Fund. The Primary Health Care Transition Fund deadline was extended to September 30, 2006 offering an extension to a number of these initiatives. The draft Report the Nova Scotia Advisory Committee on Primary Health Care Renewal was completed and sent to Health Canada in May 2006. Key accomplishments and outcomes will be available for the next accountability report. The Primary Health Care Transition Fund was established to encourage innovative ways to provide and improve access to Primary Health Care in Nova Scotia communities.
Primary Health Care Evaluation Nova Scotia is building upon its existing capacity for primary health care evaluation and research to evaluate the impact of changes made as a result of renewal activities. Enhancing primary health care evaluation and research capacity throughout the	In 2005-2006, the Department of Health continued to develop a framework for Primary Health Care Evaluation. The framework includes goals, objectives, activities, outputs and outcomes. Completed a logic model and the identification of primary health care

Priority	Accomplishments
province will strengthen Nova Scotia's ability to continue to improve the primary health care system beyond the transition phase. In February 2004, the Primary Health Care Section of the Department of Health invited a broad range of stakeholders to a consultation on the development of an evaluation framework for primary health care in Nova Scotia. A contract subsequently developed a logic model and a catalogue of possible indicators to support future evaluation plans. A subsequent RFP will engage consultants to work with stakeholders to refine the approach to evaluation and build capacity. A workshop on primary health care research and knowledge translation will be planned for the 2005-2006 year.	indicators. Measurement tools are being field-tested. Surveys are being developed to test the instruments. Results as well as a final report for primary health care evaluation for Nova Scotia are expected in Fall 2006. Results will be disseminated to the Primary Health Care Evaluation Working Group. As a result of this initiative, tools and indicators will be available to monitor, evaluate and improve access to, and the delivery of, Primary Health Care in Nova Scotia.

Mental Health Services

Priority	Accomplishments
Mental Health Strategic Directions Throughout 2004-2005, the Department of Health worked with teams of mental health clinicians and consumers to continue the implementation of core service standards and to begin the process of implementation of specialty service standards for eating disorders, neurodevelopmental disorders and services to seniors. During 2005-2006, the Department will focus on the continued implementation of service standards while addressing 'waiting lists', human resource needs, collaboration with the primary care sector and the development of expanded home based services (assertive treatment, intensive case management).	**Standards** Completed the development of core service standards for neurodevelopmental conditions affecting adults. Initiated forensic standards development in 2005-2006, which will be completed in 2006-2007. Established a process for routine five-year reviews of the Mental Health Standards. Clients/patients benefit from the development of these standards because they provide the preferred conditions relevant in mental health services and define the key service components. They also act as a guide for service delivery and reduce service variation across the province so people receive a similar service regardless where they access it within the province. **Depression Strategy** Launched phase one of the Depression Strategy for adolescents and seniors in December 2005. The Strategy will help raise awareness and encourage early identification and intervention to produce the most positive outcomes for those experiencing depression. One goal is to help reduce stigma and decrease barriers for accessing treatment. Another goal is to reduce long-term disability due to depression. **Mental Health Wait times** Initiated contact with Capital District Health Authority and the IWK to discuss their wait times projects. In Winter 2006, the IWK agreed to become a pilot site for the Department of Health Wait Times Project. Developed a project plan for monitoring Mental Heath Provincial Wait times in March 2006. This represents the Mental Health component of the DOH Provincial Wait Times Project. These activities will provide meaningful and reliable information to decrease wait lists and eliminate backlogs for service. This will improve access for Nova Scotians experiencing a mental health issue. This information will also allow for investment in appropriate resources and increase the accountability of service providers.

Priority	Accomplishments
Improving the Quality of Mental Health Services' 2005-2006 will see the introduction of a plan to monitor the quality, appropriateness and effectiveness of mental health services using DHA/IWK Mental Health Profiles, performance indicators for in-patient services, and expanded technology to support the local analysis of ambulatory health care information. A one-year demonstration of a new approach to outcome measurement will also be initiated as part of this plan. The Health of the Nations Outcome Scale (HoNOS) will provide the Department of Health and the DHAs/IWK with outcome measures and indicators for monitoring mental health services. The HoNOS is now a standard component of clinical practice in many parts of the United Kingdom, Europe, and Australia.	**Mental Health Profiles** Capital District Health Authority created the profile format and template to be utilized for the remaining DHAs/IWK. The data provided by Capital District Health Authority was accepted in the Winter 2006. The remaining DHAs and the IWK will complete their profiles in 2006-2007. The HoNOS Demonstration Project was initiated in the South Shore District Health Authority. These profiles provide the Department of Health, DHAs and IWK with an overview of mental health indicators that identify the greatest pressures for service. This will identify high-risk populations and service priorities and enable service providers to optimize resources and services for Nova Scotians. HoNOS provides an outcome measure for clinicians to determine if their interventions are making a positive change in their client's/patient's condition. **Provincial Performance Indicators for Inpatient Services** Identified, validated and analyzed inpatient data sources for performance indicators with recommendations to follow in 2006-2007. This information will ensure that inpatient services are delivered in the appropriate geographic locations.
Autism – Early Intensive Behavioural Intervention (EIBI) Treatment Program The implementation of the Early Intensive Behavioural Intervention Treatment program for children with autism spectrum disorder will begin in 2005-2006. The overall goal is to provide treatment to young children with autism through the DHAs/IWK. Recruitment and training of therapists will be a priority in order to maintain standards and ensure evidence-based practices.	Implemented the EIBI Program in five DHAs and IWK in the 2005-2006 fiscal year. Increasing numbers of children and families will continue to receive treatment as EIBI treatment teams are trained in the remainder of the province. The second component of the treatment model was introduced to clinical teams, partners/stakeholders and families in March 2006. Advanced training will be provided in 2006-2007. Prior to implementation of the EIBI program, no publicly funded treatment programs were available for children with autism. Research evidence suggests providing treatment at an early age produces the most promising results. This service was developed to enhance outcomes for these children.

Priority	Accomplishments
Mental Health Legislation A new Mental Health Act (Bill 109) was introduced during the Fall 2004 session of the House of Assembly. It received first reading. Extensive stakeholder consultation and analysis followed in late 2004 and early 2005. Further development of the legislation is anticipated in 2005-2006.	Bill 203 (formerly Bill 109), *The Involuntary Psychiatric Treatment Act*, passed third reading in October 2005 and received royal assent on December 8, 2005. Isued a Request For Proposals in March 2006 to obtain a Patient Rights Advisor Service as required by the regulations of the Bill. Initiated development of regulations with education sessions in 2005-2006, which will continue into 2006-2007 in preparation for the proclamation of the Bill. This legislation will ensure that patients who are declared incompetent will receive mental health services as required and will have access to a Patient Rights Advisor.
Labour Market Agreement for Persons with Disabilities The impact of addictions treatment on employability is well documented. The evaluation of the effectiveness of Addictions Services in addressing vocational crisis and client employability will be continued.	A consultant undertook an evaluation of the impact of addiction services on the employability of clients. A review of the literature demonstrates addictions as a disability that requires access to treatment programs and protection from discrimination. The literature review also found evidence that addiction treatment had positive effects on employability. The second phase of the evaluation included an analysis of outcome monitoring data. Based on this data, slightly more than half of the adult clients were working for at least minimum wage when they first accessed Addiction Services 12 months prior to the current reporting period. At the end of the reporting period, 72.3 per cent of adult clients were working for at least minimum wage. Among the 27.7 per cent of adult clients who reported not working in this reporting period, 53 percent had at some point in the last 12 months worked for at least minimum wage. In total, 41 per cent of adults reported benefits to their employability as a result of addiction treatment. This indicates that addictions services helped clients maintain employment and/or obtain employment. The final report is to be released in September 2006. The report documents the impact of addiction service treatment on a key health determinant. It also supports ongoing federal recovery for service delivery.

Priority	Accomplishments
Methadone Maintenance Treatment Methadone maintenance treatment is an effective strategy for reducing harms associated with opiate dependency. In 2004, *Standards for Blood Borne Pathogens Prevention Services in Nova Scotia* were published, including standards for methadone maintenance treatment services. The impact of these standards will be analyzed. A provincial framework for evaluating methadone maintenance treatment services will be developed.	Provided resources to Addiction Prevention and Treatment Services (APTS) in Capital Health to help support an evaluation of methadone maintenance treatment services. The findings indicated that there was a considerable relationship between entering the methadone maintenance treatment services and the reduction of substance use, high-risk behaviours, criminal behaviours, and improvement in housing conditions and family support. A report was produced and is available on Capital Health's website: http://www.cdha.nshealth.ca/programsandservices/addictionprevention/EvaluationApts.pdf Provided funding to Cape Breton District Health Authority for methadone maintenance treatment services included resources for evaluation. A physician working in the program conducted on-going evaluation and research in 2005-2006. Clients demonstrated a significant decrease in opiate use and a significant increase in employability among clients (34 per cent of patients returned to full-time employment) at three months post intake. As a result of these evaluations, significant changes were introduced to both programs. These changes reflect an attempt to focus clients on treatment and lifestyle issues. The evaluation supports the continued development of best practices in Nova Scotia. The results of the evaluation will also support the development of a provincial framework for evaluating methadone maintenance treatment services.
Enhanced Addiction Services for Rural Women and Youth In 2002, the Nova Scotia government allocated $1.8 million to improve health outcomes for women and youth with substance use and/or gambling problems. The bulk of the funding was used by the DHAs to dedicate staff to provide and evaluate a range of services for women and adolescents based on provincial standards, best practice, and cost-effectiveness. A provincial report on the impact of these enhanced services will be generated.	In 2005-2006, the Department of Health directed $2.1 million to services to improve addiction outcomes for rural women and youth throughout the province. The funding was directed toward gaps in addiction prevention and treatment service and brings rural services in-line with what is currently offered in urban areas through CHOICES Adolescent Treatment (IWK Health Centre) and Matrix (women's community-based services in Capital Health).

Priority	Accomplishments
	A draft provincial report highlighted that approximately 80 per cent of the funding for Enhanced Services was directed toward prevention and treatment staffing and 12 per cent to support services. One time costs included updating computer network capabilities for Capital Health, improving reporting capabilities through the updating of the Addiction Services Statistical Information System (ASsist), and improving outreach for women and youth in rural areas of the province through a communications campaign. A tremendous uptake in programming occurred within the three years of the Enhanced Services Initiative. From 2001-2002 to 2003-2004, the number of youth participating in treatment increased by 51 per cent and the number of women participating in treatment increased by 70 per cent. The service for rural women and youth has improved tremendously and has reduced significant treatment barriers.
Client Information System for Addiction Services Addiction Services is in the process of implementing a new provincial client information system. This collaborative effort between the Department of Health and the DHAs will provide both with addiction-specific data. The added functionality of the new information system will enhance our ability to measure service standards and provide reporting for federal recoveries and other accountabilities.	Implemented Addiction Services Statistical Information System Technology (ASsist) in DHAs 4, 5, 6, 7, 8 and CHOICES (IWK). Approval for implementation in the other DHAs is being requested in the 2007-2008 budget. ASsist is a provincial web-based information system and was obtained to improve the information infrastructure for Addiction Services in Nova Scotia. This system is designed to support addiction prevention and treatment services, programming, accountabilities, and improve client care.

Acute and Tertiary Care

Priority	Accomplishments
MRI Access and Utilization Magnetic Resonance Imaging (MRI) scanners are used to detect and diagnose soft tissue tumors, disease of the brain, spinal cord, cardiac, major blood vessels and the musculoskeletal system. The Department has recently completed an assessment of additional need for MRI access in rural Nova Scotia. The resulting recommendations will see new machines at four sites: New Glasgow, Antigonish, Kentville, and Yarmouth. Delivery is expected in 2006.	A Provincial Project Management Committee (PMC) completed development of a Request for Proposals and evaluation process to procure a number of MRI units for Nova Scotia. Purchased six new MRI units from GE Healthcare, one each for sites where this technology is being introduced for the first time: New Glasgow, Antigonish, Kentville and Yarmouth, and two replacement units for the Capital District Health Authority. Individual DHAs achieved progress towards construction/renovation activity, the recruitment and training of MRI technologists, and raising community funding. The PMC began examining issues related to general practitioner referral and patient access to MRI and will make recommendations in support of provincial policies. The new MRIs will bring critical diagnostic services closer to home for residents in rural regions of the province. This also responds to the First Ministers' commitment to improve patient access to this diagnostic imaging technology.
Provincial Approach To Stroke Care Stroke and heart disease are the leading causes of death and disability in Canada. In 2005-2006, the Department of Health will invest $500,000 to pilot the implementation of a comprehensive and integrated program of stroke prevention, emergency services, acute care and rehabilitation. Partnering with the Heart and Stroke Foundation, health providers, researchers and the DHAs, the Department of Health will continue planning provincial approaches to stroke and heart disease prevention and outcomes improvement.	Drafted and circulated Provincial Acute Stroke Care Guidelines throughout the province for feedback. Implemented a pilot project to introduce a comprehensive and integrated stroke program in the South West DHA under the guidance of a local steering committee. The stroke program includes a secondary stroke prevention clinic, a stroke team, clustering of stroke patients within the medical unit, professional education based on a needs assessment, and public awareness of the warning signs of stroke. A stroke physician consultant oversees the program along with the stroke care coordinator. Lessons learned will be shared with other DHAs. In addition, a provincial stroke audit covering the period April 1, 2004-March 31, 2005, was initiated to learn more about the status of stroke care in Nova Scotia and provide baseline data for Cardiovascular Health Nova Scotia. A professional education partnership with Heart and Stroke Foundation of Nova Scotia and

Priority	Accomplishments
	the Atlantic Health Promotion Research Centre is underway to conduct a needs assessment of health professionals and an intervention plan. These activities will result in a number of outcomes: baseline data on current stroke care; lessons learned from the pilot project that will inform system changes to ensure best practices in stroke care; and increased professional knowledge and skills related to stroke care. These activities will develop the potential to identify high-risk individuals, prevent strokes, and improve rehabilitation and care for people who survive a stroke.
Dialysis Program Expansion With renal disease growing by 10% annually across Canada, there is increasing pressure for more dialysis capacity. A provincial approach to the development and long-term management of dialysis is being developed. The Provincial Dialysis Group has identified four priorities: infrastructure, satellite dialysis programming, peritoneal dialysis and risk modification. Each priority will be addressed with strategies to resolve the issues.	An external consultant's review of satellite dialysis recommended the development of an enhanced case model. The new model will be piloted in a new satellite location in Antigonish by December 2006. This will provide services closer to home for dialysis patients. It will also provide an opportunity to test a model of care that could be applied across the province and enable more dialysis patients who travel to Halifax to be serviced in a community satellite closer to home.
Hospital Additions and Renovations Projects nearing completion and occupancy are: Cape Breton Regional Hospital Renal Dialysis Expansion, Dartmouth General Hospitals Renal Dialysis Unit and the IWK Parkade and Research Building. Construction continues on the new Cobequid Community Health Centre toward a planned occupancy in Fall 2005. Design is underway for the Queens Hospital Primary Care Building and the Halifax Infirmary Emergency Department Expansion. Design will be underway shortly for the replacement of Colchester Regional Hospital and a major upgrade to the IWK Health Centre, Children's Site. A third operating room is being built at the Cumberland Regional Health Care Centre in Upper Nappan, near Amherst.	The Cape Breton Regional Hospital Renal Dialysis Expansion, Dartmouth General Hospitals Renal Dialysis Unit and the IWK Parkade and Research Building were all completed and opened in 2005-2006. Opened the Cobequid Community Health Centre February 14, 2006. Awarded a contract for the design of the Colchester Regional Hospital to WHW Architects Incorporated. Initiated related design work. A third operating room is under development and scheduled for completion in Fall 2006. This will complete the planning and construction for the Cumberland Regional Hospital. It will help to recruit

Priority	Accomplishments
	health care specialists and save the cost of having Nova Scotia patients treated in New Brunswick facilities.
A phased renovation of the Lillian Fraser Memorial Hospital in Tatamagouche will facilitate the delivery of multidisciplinary primary health care services.	Awarded the contract for design services to William Nycum and Associates in July 2006. Design work has begun.
Alternate Levels of Care Patients in Acute Care Through a collaborative approach with the Continuing Care sector, the DHAs and the Department of Community Services are developing strategies to ensure that clients/patients in acute care are transitioned to alternative settings when appropriate. The Department of Health will fund the addition of fifty restorative care beds throughout the provincial health system as a means of relieving pressure on occupancy rates in the province's hospitals.	The Department of Health provided $4.1 million in additional funding to DHAs to address the pressure of alternate levels of care patients on occupancy rates in hospitals. In 2005-2006, the Department of Health developed criteria for the establishment of fifty restorative care beds and issued a request for proposals. Funding for 29 of these beds has been allocated and the introduction of related infrastructure requirements has been initiated. The Department is committed to implementing the outstanding 21 beds in 2006-2007. Patients will then have alternate and appropriate ways to receive care and treatment within their districts without requiring an extended stay in hospital. This will enable hospital beds to be occupied by those in need of acute care.
Provincial Approach to the Management & Monitoring of Systemic Cancer Therapy A coordinated provincial approach involving the Department of Health, Cancer Care Nova Scotia and the DHAs will be implemented to manage and monitor systemic chemotherapy costs. It is expected that this process will more effectively manage the significant annual increases of recent years.	Assembled, at the request of DHAs, the Cancer Systemic Therapy Policy Committee at the request of DHAs has been meeting regularly. The committee examined two very high cost contemporary drugs. One of these drugs, Herceptin, has been approved for early stage breast cancer throughout the province. Established the New Cancer Drug Fund to fund new high cost drugs. The committee is also working on operational issues to make costly drugs available closer to the patients' home. The committee has been examining and testing ethical decision-making models that will provide a broader perspective on final funding decisions for cancer drugs. Nova Scotia is the first province to use an ethical decision-making model for very high cost cancer drugs.

Priority	Accomplishments
	This approach to the management and monitoring of systemic cancer therapy will increase the accessibility of costly drugs through appropriate and timely planning. It will also more effectively manage the considerable annual increases of chemotherapy costs.
Provincial Approach to Organ and Tissue Donation A QEII-based management team and a broader provincial steering committee have collaborated on professional education and quality improvement processes to increase family approach rates for organ and tissue donation. A provincial approach is intended to increase available donors to support the transplant program at the QEII. Currently, Nova Scotia's donation rates are below those of Newfoundland and New Brunswick.	Approved in principle a revised provincial organ and tissue donation program model for the Department of Health. Conducted a provincial organ and tissue chart audit to identify missed potential donors. Conducted pilot projects in targeted facilities/DHAs, which demonstrated a successful approach for identifying and referring organ and tissue donors. These activities provided additional support to the implementation of a provincial program. The program will provide a system where identification and referral of potential organ and tissue donors will be maximized, leading to an increase in donors and transplant recipients in Nova Scotia. This will directly save lives through organ donation and improve lives by increasing the availability of tissue donation (cornea, skin, bone, heart valves, etc.) for transplant.
Maritime Medical Genetics Services at the IWK Health Centre Responding to a long-standing need for genetic counseling and related services for families, the Department of Health will support establishment of this service in 2005-2006.	Recruited counsellors at the IWK to work with the Medical Geneticists. Counsellors provide information, support and follow-up to families who have had to accept emotionally devastating news. Families have benefited from this support and caring.
Physical Rehabilitation for Children with Disabilities Physical rehabilitation services for children with disabilities have been a service gap in Nova Scotia's health care system for many years. Provincial funding in 2005-2006 will initiate this program at the IWK Health Centre.	Initiated implementation of the second phase of the expanded Physical Rehabilitation for Children with Disabilities program in 2005-2006. A provincial plan led by the IWK to expand physical rehabilitation services for children with disabilities began in 2004. This program enables the IWK to partner with DHAs to facilitate the provision of follow-up services and care closer to home.

Priority	Accomplishments
Centralized Intra-Venous Admixture and Unit Dose Drug Distribution at the IWK Responding to patient safety and service efficiency concerns raised by both accreditation surveyors and third-party consultants, the IWK will begin implementation of its Unit Dose Drug Distribution System during 2005-2006.	The IWK Health Centre began implementation of its Unit Dose Drug Distribution System. Funding allowed the second phase of the expanded program to move forward. Communications activities commenced in March 2006. This program will improve patient safety.
Twenty One Bed Expansion at Valley Regional Hospital, Kentville Following extensive master planning by the Annapolis Valley DHA, the Department of Health has approved the addition of twenty-one new medical/surgical beds at the Valley Regional Hospital in Kentville. Renovations to the emergency room are also planned.	The Annapolis Valley DHA developed architectural designs for the expansion of the Valley Regional Hospital. The expansion project is targeted for completion in early 2007. The expansion will address a significant shortage of space in the district, particularly the critical need for additional beds and an expanded Emergency Room at the Valley Regional Hospital. This will reduce the number of patients occupying emergency room beds while awaiting admission to a hospital unit for ongoing acute medical care.
Cobequid Community Health Centre With construction nearing completion, occupancy of the new Cobequid Community Health Centre in Lower Sackville is planned for late Fall 2005.	Opened the Cobequid Community Health Centre on February 14, 2006. This centre replaced an old facility. It has state of the art equipment, an increased number of stretchers and new clinical services that provide residents with access to services closer to home.
A Sound Start for Hearing and Speech Speech language pathology services are under-developed in Nova Scotia relative to the rest of the country. The Department of Health will invest $275,000 in 2005-2006 to extend access to universal newborn hearing screening services beyond the Halifax area to Nova Scotia Hearing and Speech Centres across the province. There is clear evidence that early detection and treatment of hearing disorders improves the development of speech, language and literacy skills.	Fully funded the Sound Start Program at $275,000 in 2005-2006. This funding provided universal access across the province for newborn hearing screening. In addition, the funding contributed to reduced wait times for pre-schoolers to review speech, language and literacy skills. The program will identify hearing disorders early so treatment can be more effective.
Integration of Mammography Services The Nova Scotia Breast Screening Program provides access to mobile screening services to all residents of Nova Scotia. Several DHAs have fixed sites that will be integrated in the provincial Nova	Integrated all DHA mammography sites (except DHA 7) into the provincial Nova Scotia Breast Screening Program.

Priority	Accomplishments
Scotia Breast Screening Program in 2005-2006 (integrating screening and diagnostic services and data). The intended outcome will improve wait times for both screening and diagnostic testing and provide more accurate information on screening rates in the province.	Undertook a provincial review of all mammography units. The goal was to develop a provincial plan for the future. This review was completed and a decision made to move to digital mammography equipment for both fixed and mobile sites throughout the province. An equipment vendor was selected in Fall 2005. The first digital unit was purchased for Cape Breton DHA mobile van. This project will examine and plan for implementation of full field digital mammography across Nova Scotia over the next five to seven years. As a result of this project, wait times for both screening and diagnostic testing will improve. This project will also enable more accurate information on screening rates in the province. Ultimately, this project will improve mammography services for patients.
Infection Control Responding to a need identified by the DHAs, a provincial approach will be established through a Provincial Infection Control Consultant. The Consultant will develop and implement an infection control framework to support the DHAs and align their programs with the Department of Health's vision for the provincial health system.	Initiated the development of an Infection Control Framework for the province. A proposal will be presented to the Department of Health by November 2006. The Provincial Infection Control Consultant has been supporting healthcare providers across the Nova Scotia health care system by offering advice on various infection control issues. Consistent infection control practices and the ability to provide surveillance of key infection control issues will enhance patient safety in acute, continuing and primary care sectors.
Palliative Care in South West Nova District Health Authority Responding to a long-standing service gap in palliative care services in the Yarmouth area, the Department of Health will provide funding in 2005-2006 to add a coordinator and support the development of an interdisciplinary palliative care team. The approach will be consistent with the work of the Provincial Hospice Palliative Care Project and will serve people living with a life-threatening illness or grieving the loss of a loved one.	In 2005-2006, the Department of Health provided funding to the South West Nova District Health Authority to add a palliative care coordinator and support development of an interdisciplinary palliative care team. The Coordinator position and palliative care team will provide needed supports for those patients and their families coping with the difficult effects of a life-threatening illness.

Pharmaceutical Services

Priority	Accomplishments
Prescription Monitoring Program (PMP) Renewal On January 1, 1992, Nova Scotia implemented a manually administered PMP to monitor the prescribing, dispensing and utilization of a specific list of drugs in Nova Scotia. Within the last few years, the PMP Board identified the information delays of the manual system and the Program's lack of legislated authority as issues reducing the Program's effectiveness in dealing with drug abuse. As a result, a new *Prescription Monitoring Act* received Royal Assent on October 18, 2004. Regulations to the Act are being drafted and will be proclaimed along with the Act. A new Prescription Monitoring Board will be appointed at the same time. A computerized information system to support the PMP is being developed and will begin implementation in 2005-2006. An extensive communication plan is being developed to promote the changes and subsequent benefits of the new legislation and computerized information system.	Established the new PMP Board, which held its first meeting January 2006. The board meets quarterly with a focus on maximizing benefits for prescribers, pharmacists and on the overall health promotion of Nova Scotians. The new board changes the mandate of the PMP by having the ability and legislative authority to analyze and problem solve within the PMP. The development of the computerized information system was completed in June 2005. The first pharmacies went online in November 2005. This system provides real time data, instant messaging, management of the triplicate prescription pads, maintenance of a provider registry and refined data analysis, which includes profiles of patients, prescribers, specific drugs and prescribing patterns.
National Common Drug Review (CDR) The CDR is a single process for reviewing new drugs and providing formulary-listing recommendations to participating publicly funded federal, provincial and territorial (F/P/T) drug benefit plans in Canada. All jurisdictions are participating except Quebec. The objectives of the CDR are to provide a consistent and rigorous approach to drug reviews and evidence-based listing recommendations; reduce duplication of efforts by drug plans; maximize the use of limited resources and expertise; and, provide equal access to the same high level of evidence and expert advice. From the time the CDR began accepting submissions, September 1, 2003 to December 2004, it has provided recommendations on 16 new drugs. Nova Scotia continues to support the CDR and is refocusing the Atlantic Common Drug Review to provide expert advice in areas not covered by the CDR.	The Province received 16 formulary-listing recommendations during 2005-2006. Processed all 16 recommendations with an average time between receipt of the recommendation and implementation of a decision of 11 weeks. This efficient timetable in getting recommendations published ultimately results in patients having faster access to drugs.
Drug Evaluation Alliance of Nova Scotia (DEANS) Led and supported by the Department of Health, DEANS draws on health professional and academic	**Cholesterol Management** Developed a summary workbook reviewing and updating the Canadian and United States guidelines for managing cholesterol. Academic detailers

Priority	Accomplishments
expertise to consider drug utilization issues in conjunction with other drug program components. DEANS identifies drug utilization issues; develops targeted interventions for health care professionals and consumers; and evaluates the impact of interventions. Interventions generally take the form of multi-faceted evidence-based educational programs, which can include academic detailing, didactic presentations, workshops, prescriber profiling and feedback, or mailed printed material. Areas of focus in 2005-2006 include cholesterol management, management of chronic non-cancer pain and acid suppression therapy.	delivered the workbook to 54 per cent of Nova Scotia's family physicians and highlighted key messages during one-to-one encounters. In addition, two specialists, nine nurse practitioners/nurse practitioner students, 24 nurses, 27 medical students, 14 pharmacists and five other healthcare professionals met with the detailers to discuss the topic. Key educational messages were also presented at the Conjoint Assembly of Family Physicians in Charlottetown and the QEII Health Sciences Centre Division of Cardiology Grand Rounds. This provides current evidence-based information to physicians and saves time on research, which results in more effective prescription practices. Studies suggest that patient adherence to cholesterol-lowering medications is poor. DEANS provided funding to the Department of Family Medicine, Dalhousie University to identify rates of adherence in Nova Scotia and patient reported factors associated with adherence. The survey completion rate was 82.5 per cent. Results of the survey are being analyzed and are expected to help improve patient adherence rates in the future. **Management of Chronic Non-Cancer Pain** DEANS, with its network of partners, brought together a group representing medicine, pharmacy, dentistry and the Cape Breton Community Partnership on Prescription Drug Abuse. The group secured funding from Health Canada and supplemental funding from DEANS to develop, implement and evaluate a needs-based and evidence-based educational intervention on the management of chronic non-cancer pain for doctors, dentists and pharmacists in the Cape Breton District Health Authority. Using the results of their needs assessment and environmental scan, the group developed an evidence-based, interprofessional educational intervention, which is expected to commence in May 2006. The intervention is expected to assist in understanding how to best manage chronic non-cancer pain.

Priority	Accomplishments
	<u>Acid Suppression Therapy</u> Refer to the accomplishments for COMPUS below.
Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) Launched in 2004, COMPUS is a Canadian service to promote and facilitate best practices in drug prescribing and use among health care providers and patients/consumers. Critical to its future success is the participation and support of F/P/T jurisdictions and other parties in implementing and evaluating best practice initiatives. COMPUS will provide the avenue for improved information sharing, and through its coordinating role, will assist jurisdictions and other parties in building on established initiatives, such as DEANS. Initially COMPUS will focus on three priority areas where improvements to medication prescribing and use would contribute to improvements in health outcomes for a large number of Canadians and would result in more cost-effective utilization of widely prescribed medications. The three priority areas include: proton pump inhibitors (for the treatment of gastrointestinal problems); diabetes management; and anti-hypertensives (drugs used to lower high blood pressure). COMPUS is expected to provide jurisdictions with a toolkit on the first of these priority areas (proton pump inhibitors) in 2005-2006.	During late 2005 and early 2006, the Canadian Agency for Drugs and Technologies in Health (CADTH), which houses COMPUS, underwent reorganization. This, coupled with challenges in filling COMPUS positions, negatively impacted the delivery of the proton pump inhibitor (acid suppression therapy) toolkit. Nova Scotia continues to actively participate on the COMPUS Advisory Committee and has two experts on the committee specifically examining best practices in the prescribing and utilization of proton pump inhibitors. The final report and intervention toolkit are now expected to be complete by the end of 2006. The report and toolkit will provide evidence-based guidelines for physicians, which should influence their prescribing practices in a positive way.
Assistance Program for Low Income Nova Scotians with Diabetes At 5.9% of the population, Nova Scotia's diabetes prevalence is the second highest in Canada. Left untreated, diabetes can lead to complications such as heart disease, kidney failure, blindness and amputation. Drugs and supplies to manage diabetes are benefits for Nova Scotians covered under the Seniors Pharmacare and Community Services Pharmacare programs. However, many other Nova Scotians with diabetes have no such insurance coverage for the drugs and supplies needed to prevent or delay the onset of complications from their disease. During 2005-2006, an income-based program will be designed and targeted to families with low incomes and no prescription drug coverage. With $2.5 million in new provincial funding, the new program will cover insulin, oral diabetic drugs, glucose test strips, syringes, needles and lancets as listed on the Nova Scotia Formulary.	Implemented the Assistance Program for Low Income Nova Scotians with Diabetes program on January 1, 2006, which targets families with low incomes and no prescription drug coverage. Eligibility is based on family income and size. The program was initially conducted manually, but was quickly automated to allow direct billing to the program. The Diabetes Care Program of Nova Scotia is conducting evaluation of the program. Self-care materials will to be sent later in 2006. Over 1600 families are enrolled in the program.

Priority	Accomplishments
The cost to the family will depend on income. In addition, a self-management support component will be developed and extended to our new clients.	

Physician Services

Priority	Accomplishments
Enhanced Accountability with Alternative Funding Plans Approximately 40% of physicians are remunerated through some form of alternative to traditional "fee-for-services" funding. A recent audit of the largest academic alternative-funding plan demonstrated the benefit of alternative forms of payment, while at the same time indicating the need for enhanced accountability. This is critical as the Department of Health moves forward in the development and re-negotiation of alternative payment and funding plans throughout the province.	Developed a new AFP/APP (Academic Funding Plan/Alternative Funding Plan) Funding Framework during the 2005-2006. A multi-stakeholder task group that included Doctors Nova Scotia, Dalhousie University's Faculty of Medicine, Capital District Health Authority, IWK and Government developed the new framework. The Labor Relations Committee of Executive Council accepted the general direction of the proposed new AFP/APP Framework at its March 30, 2006 meeting. This new framework responds directly to 41 of the 43 recommendations contained in the Audit of the Department of Medicine. The Framework is in the process of being applied to all AFPs. The Framework establishes performance expectations for such things as wait times, patient care and research. In addition, it improves accountability mechanisms in AFPs.
Physician Resource Planning Physician resource planning in Nova Scotia is a tool that will inform other decision-making processes from recruitment activities to training program needs. It is a critical tool for informed decision making. Work in this area will be linked with planning for health human resources and district based initiatives.	Completed physician resource plans for some specialties (paediatrics, neurology) during 2005-2006. The physician resource plans will help to establish an appropriate supply and distribution of physician services in Nova Scotia in the coming years. In the next fiscal year, work toward developing physician resource plans for additional specialties and family medicine will take place.
Physician Recruitment Strategy Development A comprehensive physician recruitment strategy is required to maximize physician recruitment activities for areas of need. The Department of Health role in physician recruitment is to inform, support, and provide districts with the tools to recruit required physicians. While the Department presently engages in significant activities in this area, a comprehensive strategy considering physician resource requirements is required.	Undertook an analysis of Nova Scotia's physician recruitment needs and existing recruitment programs in 2005-2006. Opportunities for improvement in the tools and support offered to DHAs were identified. New initiatives that align with these opportunities are being developed on an ongoing basis. For example, the four-year retention program offered to physicians who successfully complete the College of Physicians and Surgeons of Nova Scotia's Clinician Assessment for Practice Program creates increased opportunity for international medical graduates to practice in Nova Scotia. Continued evaluation and development of the Department of Health's physician recruitment strategy will help to ensure a sufficient and stable supply of physician services in Nova Scotia.

Continuing Care Services

Priority	Accomplishments
Strategic Framework for Continuing Care Services In order for the Department of Health to respond appropriately to changing care needs for Nova Scotians, work will begin on the development of a strategic framework for continuing care. This will enable the Department to validate current services, identify and examine service delivery alternatives, and develop appropriate legislation accordingly. A series of public consultations are planned for this year.	Completed the consultation phase of the strategic planning framework on March 31, 2006 and presented a preliminary report to the Minister. Over 1400 Nova Scotians provided input. Provincial, national and international environmental scans were completed to identify best practices and alternate approaches to care. A final report, which will include the recommendations from the consultation with a five to10 year plan for continuing care services in Nova Scotia, is expected to be presented to Cabinet prior to distribution to the public in Fall 2006. This process enabled Nova Scotians to inform the government on how they want continuing care services to be delivered. An over-riding theme clearly identified in the consultation is Nova Scotians want more care at home and in their community.
Continuing Care Assistant (CCA) Recruitment Strategy The demand for CCAs to assist in meeting the health care needs of Nova Scotians has increased significantly in recent years. The Continuing Care Branch, in collaboration with partners, is planning a concentrated and coordinated approach to recruitment of CCAs in 2005-2006.	Engaged an external public relations consultant to develop a Nova Scotia Continuing Care Assistant (CCA) recruitment strategy through sector consultation, including the development of a brand and marketing campaign. The advertising campaign is scheduled to start in June 2006. Offered $600,000 in CCA bursary funding, with return for service agreements, to assist in recruiting new people to the field. Hired a consultant to develop and test implementation of the Prior Learning Assessment and Recognition (PLAR) process for people to achieve CCA certification. Twenty-two PLAR assessors have been trained and selection of the students began for Winter 2006. Established CCA certification as the educational requirement for entry to practice as a CCA in nursing homes. This requirement for home care becomes effective April 2006. This provides reassurance to clients that caregivers are trained to provide appropriate care, and also increases the profile of the CCA as a member of the health care team.

Priority	Accomplishments
	Although continued efforts are required, enrollment in CCA programs has increased. As a result, some areas of the province were able to reduce or eliminate their waitlists for homecare.
Information Management Strategic Plan Evidenced-based decision-making for health policies and programs requires data collection and analysis of pertinent information. Currently, the Department of Health collects data from several sources but information system differences limit its use for decision-making. A strategic plan for continuing care information management is planned for the Fall of 2005-2006.	The Information Management Strategy had a delayed start as resources were redirected to the Continuing Care strategic planning initiative. Information Management strategic planning will provide direction for the Information Strategy. A steering committee and working group were established with representation from providers of continuing care and internal staff. An external consultant with Information Management expertise has also been contracted. The expected completion date for recommendations is November 2006.
Direct Funding Program Direct Funding is an alternative way to deliver home care services. By providing funds directly to individuals for them to secure and manage their own care, this approach provides increased flexibility and greater independence. The Department will finalize policies and standards and introduce this program as a part of the integrated array of continuing care services available to Nova Scotians.	Developed the Direct Funding policy and introduced the provincial Self Management Care program in January 2005 as an alternate way to deliver home care services. This program is primarily accessed by younger adults with significant physical disabilities and enables them to customize care to match their needs and lifestyle. Applicants are assessed and provided an orientation workshop to enable them to enter into a direct funding relationship with their care providers. After one year, 47 participants benefit from this flexibility in care delivery, with more expected to join.
Long Term Care Policy Changes On January 1, 2005 the government began covering the health care costs of residents in long-term care facilities under the mandate of the Department of Health. In 2005-2006, the Department of Health will begin evaluating the impact of these new policies on residents and families.	An external consultant evaluated the impacts of the Long Term Care Policy changes introduced on January 1, 2005. Both the process and the outcomes of implementing the policies were evaluated through consultations with residents, family, providers, senior advocacy groups and other partners in care provision. The evaluation found the policies were implemented consistently across the province. The outcomes were generally as intended with the majority of residents and families indicating that they were better off than before the policy changes and that the process of financial assessment was less intrusive than before.
Adult Day Care Programs Adult day care programs provide personal assistance, supervision, educational and	Deferred the development of standards for adult day care programs until completion of the Continuing Care Strategic Plan because it will inform the development

Priority	Accomplishments
recreational activities, and respite services to individuals and their caregivers. The Department will develop standards for adult day programs during 2005-2006.	of adult programs. The new dates for this initiative will be set after the release of the Strategic Planning Recommendations, which are scheduled for Fall 2006.
New Continuing Care Beds To better meet the needs of individuals who require short term rehabilitative care, the Department will develop standards for and establish 50 restorative care beds in locations across the province. Access to these beds will be through the Single Entry Access program.	The Department of Health has been working with the DHAs to determine the location of 50 restorative beds and the services that will be provided with them. They will be in a variety of locations in Nova Scotia, and will bring this service "closer to home." Some progress has been made. It is expected this will be finalized over the 2006-2007 fiscal year.

Emergency Health Services[1]

Priority	Accomplishments
Enabling Framework for EHS Legislation A major priority for EHS in 2005-2006 is the establishment of a legislative framework for all aspects of emergency health services delivery in Nova Scotia.	The regulations in support of the EHS Act and the Paramedic Act are in the final stages of development. The EHS Act was proclaimed and the Paramedic Act is awaiting royal assent. These two acts provide legislative authority for the systems already in place and both will protect the public by ensuring that the care delivered is at a standard that keeps the public safe.
Emergency Preparedness and Response The Department of Health is developing plans for comprehensive emergency preparedness and response across the Nova Scotia health sector. Rather than focus planning on a single or anticipated group of potential hazards or threats, the intended "all hazards" approach will address the threats of CBRNET attacks, world economic uncertainty, weather-related and other natural disasters, and infectious diseases (e.g. SARS, BSE, WNV, pandemic influenza, etc.). This is consistent with the efforts of other provinces and the federal government. The Department of Health's emergency preparedness and response planning spans the health sector and integrates with plans in health service delivery organizations (DHAs and long-term care facilities), the provincial Emergency Measures Organization (EMO), Health Canada, and other provincial government departments.	*This priority will remain in both the Department of Health and Health Promotion and Protection's accountability reports. The Department of Health's focus will be the health system and "all hazards". Health Promotion and Protection's focus will be on public health emergency planning.* **Department of Health Promotion and Protection** Extensive pandemic influenza preparedness work has been done which provides the foundation on which to continue development of a coordinated operational plan. The Department of Health and Health Promotion and Protection (HPP) have jointly sponsored the Pandemic Health Services Influenza Planning Project. It emphasizes health system-wide planning, integration and development of consistent and informed communication between and among stakeholders. HPP and Health have jointly developed a project charter has been developed to guide the continued work required. A pandemic influenza project management office, which has been created. Completed and submitted the first draft of the pandemic influenza plan to the Emergency Preparedness and Planning Committee. **Department of Health** Established the Preparedness, Planning and Equipment Resource Working Group (PP&ERWG) in March 2006. Emergency Health Services is responsible for the health emergency model that is approved within the

[1] Priorities 5.7.2, 5.7.3, 5.7.4, and 5.7.5 from the 2005-2006 Department of Health Business plan are covered in the 2005-2006 Department of Health Promotion and Protection Accountability Report.

Priority	Accomplishments
	department. The PP&ERWG is one of the working groups within the model. Membership on this working group comes from almost every branch of the Department of Health, as well as representatives from the DHAs, municipal and provincial emergency management offices, the Department of Community Services and others such as the RCMP. The PP&ERWG created two sub-groups: Contingency Planning and Physical Resources. The Contingency Planning sub-group began work on educating its membership on the assorted contingency plans that will be required for a health care sector response. The Physical Resources sub-group began building a pandemic personal protective equipment stockpile and preparing the warehousing proposal for these items. This is the surge inventory that will be required by the DHAs. A final version of the warehousing position paper is expected to be ready for Department of Health Senior Leadership consideration by October 2006. All work done by the PP&ERWG and its sub-groups is directed toward ensuring that there will be an adequate health care sector response for the population of Nova Scotia during any emergency by having appropriate contingency plans in place and adequate resources for use by the health care sector. Established Critical Issues Communications Working Group (CICWG), whose goals are to instill and maintain public confidence in the public health system, especially its ability to respond to and manage the appearance of pandemic influenza. It also aims to provide accurate, rapid and complete information before, during and after an outbreak and the general health risk it poses. The Working Group set out media guidelines for use during a pandemic and completed the first draft of the health services communications plan. The Working Group also made presentations to Communications Nova Scotia, Capital Health workers and International Association of Business Communicators (IABC); produced information letters to businesses and pandemic fact sheets; and contributed to the province's pandemic website. These efforts have increased awareness of pandemic influenza and ensured appropriate planning in the event of an outbreak.

Priority	Accomplishments
	Created the Health System Emergency Planners Working Group (HSEPWG) to enhance Nova Scotia's emergency preparedness and response capacity across the health sector. Essential to improvement were self-evaluations and their review of the states of preparedness of the DHAs in 2004 and 2005. In the stream of the "all-hazards" approach that the province takes to emergency preparedness, the HSEPWG crafted a DHA Duty Officer Manual for use in times of crisis and developed an all-hazards planning template. The Working Group also outlined the accessibility protocol for medical care for individuals in emergency shelters. In addition to assisting in pandemic planning initiatives, the HSEPWG also delivered education training to the health emergency planning community in the form of workshops & educational sessions. It also began the very important work of developing a mutual aid agreement for the sharing of resources between HSEP members in emergency situations, designing an emergency exercise, and develop standards. All of these tasks enhanced the collaborative networking and relationships among health emergency planners throughout the province.

Health Information Management

Health Information Management supports the strategic goals of the Department of Health by:

- Implementing information tools to facilitate the development of a portable, person-based electronic health record.
- Developing policies, procedures, and practices to protect health information privacy while ensuring appropriate and timely access to health information when it is required for health provision.
- Producing valid, timely information for reporting and decision-making purposes.
- Promoting optimal use of health information and investment in information technology.

Priority	Accomplishments
Towards an Electronic Health Record The Department of Health continues to work in partnership with the DHAs and its key health stakeholders to advance the implementation of a portable person-centric longitudinal electronic health record. The Nova Scotia Hospital Information System (NShIS) and the Nova Scotia Picture Archiving and Communications System (PACS) are two initiatives that are key to the development of an interoperable electronic health record.	
Nova Scotia Hospital Information Systems (NShIS): Implementation of the NShIS began with the Guysborough-Antigonish-Strait DHA in February 2003. Since then, the system has been implemented in the Cape Breton, South Shore, Colchester East Hants, Pictou County and Cumberland DHAs. Approximately 5,000 users in 26 hospitals are using the system on a daily basis. In 2005-2006, implementation will continue in the Annapolis Valley and South West Nova DHAs.	Completed the NshIS project in March 2006. NshIS was installed in 34 hospitals in DHAs 1 through 8 (excludes Capital District and the IWK). This achieves the goal of having one province-wide hospital information system in DHAs 1 thru 8. NShIS consists of administrative and clinical modules (i.e. Admissions/Registration, Medical Records and Abstracting, Appointment Scheduling, Billing and Accounts Receivable, Pharmacy, Imaging and Therapeutic Services, Laboratory, Order Entry, Results Reporting and the Patient Care System) that make it easier for patient information to be shared between providers in these areas. The Office of the Auditor General conducted a thorough review of the NShIS project. The results were part of the June 2005 report of the Auditor General.
Nova Scotia Picture Archiving and Communications System (PACS) Project: The PACS is a high-speed, graphical, computer system that stores, retrieves and displays diagnostic images. Several DHAs have already implemented	Completed the PACS project. Additional support work will continue until March 2007. PACS will allow for more efficient patient treatment decisions as digital

Priority	Accomplishments
PACS technology. A province-wide network has been established for storing and viewing these images. Over the next 18 months, the NS PACS Project will expand current installations and implement PACS in all remaining diagnostic imaging facilities in DHAs throughout the province. Completion of the project will mean that health professionals will be able to view any image, anytime, and in anyplace.	images are retrieved automatically and instantaneously and can be securely accessed by multiple users anytime, anywhere. Medical staff can remotely discuss patient treatment or transfers. It will also allow quicker patient recovery time and earlier discharge due to the increased efficiency in treatment decisions, improved accuracy in diagnosis as digital images can be manipulated, reduced need for repeating procedures as digital images are always available and have little chance to be lost or misplaced and improved cost efficiency as digital images do not require physical storage space and transportation. This will all lead to lower operational costs. PACS is a vital stepping-stone toward an Electronic Health Record system within Nova Scotia as well as better individual health outcomes and increased efficiency of the healthcare system.
Nova Scotia Telehealth Network (NSTHN) The Nova Scotia Telehealth Network (NSTHN) facilitates the provision of diagnostic, monitoring and videoconferencing services over distance. The NSTHN connects all nine DHAs and the IWK, and offers secure access in 46 health facility sites across the province. In 2005-2006, the Department of Health will engage key stakeholders in developing an action plan to increase the utilization of telehealth technologies in acute care settings while enhancing access in home care, long term care and community settings. Particular access needs of francophone and First Nations communities will also be identified.	Undertook a number of NSTHN initiatives in 2005-2006. Planning began in February 2006 for the expansion of the Telehealth Network with a planned expansion starting date of April 2006 and a target completion date of September 2006. This will provide 50 new video conferencing units across Nova Scotia. Commenced an initial investigation in February 2006 into the Department of Psychiatry Telehealth Project. The First Nations Telehealth project planning began in February 2006. Specific applications of interest are diabetes care and education as well as mental health care and education. The NSTHN supports clinical programs (i.e. dermatology, genetics, geriatrics, lung transplant, mental health, oncology, preoperative, and rehabilitation), education activities (i.e. continuing nursing education, continuing medical education, other healthcare professions, medical rounds, and sessions for patients and families), and administrative distance meetings.
Privacy and Access The implementation of federal privacy legislation in January 2004 and the demand for more consistent privacy regimes within Canada have reinforced the need for a comprehensive privacy framework for health information in Nova Scotia. Priorities in 2005-2006 include:	Implemented privacy standards for NShIS, PACS, and Remote Access. Undertook a Multiple Privacy Impact Analysis for all new systems that are in the planning stages (Client Registry, Provider Registry), and established a consistent methodology for doing Privacy Impacts Analysis (PIA) for all systems in 2005-2006. These standards and analyses will create an

Priority	Accomplishments
• Developing and implementing privacy standards for the NShIS and other health information systems • Implementing a Privacy Impact Assessment policy for Department of Health programs, services or systems that require personal information • Consulting with stakeholders on a health information privacy framework • Working with the DHAs and the Department of Health's Provincial Programs on privacy best practice guidelines.	environment with the healthcare stakeholders where PIAs and the privacy standards are part of normal operations.
Decision Support and Information for Management The Department supports the development of integrated information products to support evidence-based decision-making at the Department, program, and DHA level. Morbidity and mortality data, the Canadian Community Health and National Population Health Surveys, as well as a range of demographic, economic and social databases are mined for information to support effective policy analysis and decision-making. A range of information products such as comparative health system performance measures, a wait-time web site and community/population health indicators are produced by Health Information Management to inform the public and support decision making. 2005-2006 will see an expansion of the range of products being provided. Closely aligned with the analysis of data and production of information products are the development, monitoring, and enhancement of information or data standards. The Department will continue to work closely with CIHI (Canadian Institute for Health Information) and Canada Health Infoway to support the development of national data standards; these standards are essential building blocks toward the electronic health record. The Department has taken a leading role nationally and with the DHAs in data quality improvement for various clinical administrative databases as well as in the implementation of new classification systems. The production of meaningful information products such as the "Report on Comparative Health	Continued production of Canadian Community Health Survey (CCHS) and health indicator reports. Acquired SAS software (advanced statistical and analytic software). Expanded the use of survey and administrative data for research. Supported data standards and quality through participation in several national committees, leadership of the provincial data quality committee, and data review processes with Medavie and provincial health programs. Continued to provide leadership in the analysis of CIHI indicators and methodology in 2005-2006. This work has increased the department's capacity for data linkage, data mining, and applied research.

Priority	Accomplishments
Indicators," "The Minister's Report to Patients," the Department's Business Plan, and CIHI's "Health Care in Canada" rely on the integrity of the data.	
Wait Times Monitoring Project Access to valid and reliable information on health system performance is critical to managing the system effectively. Timely and relevant information provides evidence to support resource allocation and other management decisions aimed at meeting identified health needs. The Wait Time Monitoring Project's goal is to define, collect and report standardized information across the entire health care system. During 2005-2006, we will continue to work with physician specialists to pilot an approach to collecting data on wait times for specialty consults. As well, work will continue with the DHAs to find and report wait time information for diagnostic and surgical services. Department of Health staff will support the work of the Wait Time Advisory Committee in its mandate of providing independent advice to the Minister on strategies for collecting data, reporting findings and ultimately, shortening wait times. A new website containing wait time information on selected health care services will be launched in 2005-2006.	Established the Wait Time Advisory Committee in 2005-2006. One recommendation of the Wait Times Monitoring Project was to establish this committee to provide independent advice to the Minister on how to shorten wait times. The committee met three times and offered advice that the Department is acting upon. Launched a wait time website in October 2005. This site contains wait time information on selected consults (medical oncology and radiation oncology), a number of diagnostic services, including MRI and CT scans, and selected treatment services such as radiation therapy. Nova Scotians now have access to a broad range of information about wait times that was unavailable in the past. They now know how long they will have to wait for various services. They can make informed choices about receiving service in another district where wait times may be shorter. Through fiscal year 2005-2006, the number of specialists and specialty groups participating in voluntary wait time data collection through the physician billing system continued to increase. The Wait Times Monitoring Project continues to work with various health services and programs to define data collection and reporting standards for wait times.
Client and Provider Registries A Client Registry provides an authoritative source of information related to clients of the healthcare system and their demographic information. This will enable those delivering healthcare services within Nova Scotia to uniquely and unambiguously identify their clients. In addition, the implementation of a Client Registry supports Canada Health Infoway's (CHI) vision of a Pan Canadian Client Registry and the eventual deployment of an individual longitudinal Electronic Health Record (EHR) for all Nova Scotians and, ultimately, all Canadians.	Awarded detailed planning consulting services for the Client Registry through a Request for Proposals in 2005-2006. Completed the detailed planning for Client Registry deployment and produced the Project Plan for Phase II. Developed a Change Management Strategy and plan. Conducted a detailed requirements analysis for both the business and technical functions within the Client Registry. Undertook a comprehensive replication feasibility study and high-level design specifications and standards for data, interfaces and technology components of the Registry. Completed a high level Privacy Impact Assessment and a detailed strategy for data sharing among stakeholders. The detailed governance

Priority	Accomplishments
	framework for the Client Registry was also completed. This work will provide an improved quality of identification and demographic information of health service recipients across health services by creating a single source of information and support development of the Electronic Health Records in Nova Scotia by providing reliable and accurate client demographic information for every health service event.
The provider registry will provide a definitive source for health service provider identification and related provider information supplied by authorized sources. All authorized systems / users that require health service provider identification capabilities will be able to integrate with the provider registry to confirm the identity of an individual provider and resolve provider identity conflicts / questions. The provider registry is considered to be another essential underpinning to the successful delivery of the interoperable EHR.	Continued development of the HIA Atlantic Provider Registry Business Case in 2005-2006. The expected completion date is June 2006. The intent of the business case was to examine the feasibility of a common Provider Registry for all four Atlantic Province health jurisdictions under the HIA model. This phase of the project delivered a high level technical architecture plan that will provide a Provincial Provider Registry system that coordinates provider identifiers and links them to the single source of accurate information about a service provider. It will also support the development of the Electronic Health Record in Nova Scotia through providing reliable and accurate service provider information for every health service event.

Health Human Resources

The Department of Health is developing health human resource strategies involving collaborative and comprehensive research, consultation with partners, training, recruitment and retention.

Priority	Accomplishments
Health Human Resource Planning Nova Scotia is building a solid plan for Health Human Resources (HHR) that will support the health system's current and future needs. Responding to priorities identified in the First Ministers Accords in both 2003 and 2004, Nova Scotia is developing a comprehensive HHR strategy, which will be completed by the Accord's target of December 2005. Immediate priorities include: • Encouraging young people to choose health-related careers • Training tomorrow's health professionals • Ensuring that the training meets community health needs • Collecting the information needed to help forecast future HHR needs.	Completed and published a summary of the First Ministers' Meeting (FMM) Report on the Department of Health (DoH) web site. This report outlines possible short, medium and long-term HHR planning goals for Nova Scotia. These goals link directly to the identified shortages of health care professionals in the province and speak to a variety of training, recruitment and retention strategies to help increase capacity. Completed the Atlantic Simulation Model and the Department of Health is working toward utilizing this tool for future HHR planning. This tool will help to provide information on how various policy drivers and levers will affect the supply and demand for health care workers in the province. Received funding from Health Canada for the following initiatives: • The HSPnet Pilot, starting in September 2006, will provide a systematic way to schedule clinical placements for trainees throughout the province. • Internationally Educated Health Professionals (IEHPs) Atlantic Connection - Seven shared projects over the Atlantic Region will be funded through Health Canada for the next four years. These projects will focus on integrating IEHPs into their profession as well as into the Atlantic culture. Participated on the Canadian Committee for Entry to Practice (CCETP). This national committee is charged with the task of receiving applications from professional associations who are considering a change to their entry to practice. Recommendations to the applicants are given with direction regarding suitability and appropriateness of the suggested change. Participated in discussions on the development of a HHR web site for 2006-2007. This web site will be for professionals, employers, and others who are interested in the development of HHR in Nova Scotia and the

Priority	Accomplishments
	strategies to increase the numbers of health care providers.
Nursing Strategy The Nursing Strategy includes initiatives to support recruitment, retention and renewal of the nursing workforce in Nova Scotia. In 2005-2006, Nursing Advisory Services will continue to support the initiatives in the Nursing Strategy. Priorities include rural and remote recruitment and retention feasibility assessment of a student employment program, a leadership development strategy, and a strategy to resolve identified staffing challenges (including preliminary work on models of nursing practice). Following the recommendations of a steering committee of the Provincial Nursing Network (PNN), the Department of Health will invest $300,000 in 2005-2006 to: • Market nursing opportunities in rural communities, • Fund opportunities for undergraduate nursing students in rural areas, and • Enhance continuing education opportunities for existing LPNs and RNs in rural areas.	Data shows that the Nursing Strategy has been successful. Overall, the number of employed nurses was higher in 2005-2006 than in 2001. Of these, significantly more nurses are employed in full-time permanent positions versus casual positions. Nova Scotia has also been successful at retaining over 80 per cent of its new graduates. Nearly 90 per cent of them have found full-time employment. Recruitment and retention of nurses to rural and remote communities remains a priority. Initiated implementation of the Rural and Remote Working Group recommendations, in consultation with stakeholder groups, which will continue into the next fiscal year. This includes: 1. Developing and implementing a marketing strategy through partnerships between health providers, educational institutions and communities; 2. Support for employer initiatives that enhance quality of work life; 3. Support for leadership education for rural managers and nursing staff; and 4. Monitoring and evaluating indicators to support planning for recruitment and retention of nurses in rural areas. Explored new opportunities to promote, support and enhance nursing in rural and remote communities, including the development of a continuing education program in rural nursing to be available in January 2007. Fully funded the Cooperative Learning Experience Program for 2005-2006 through the strategy. An additional 100 cooperative education seats were added to the current 120 seats in 2005-2006 so that each and every student had the opportunity to participate in the program. The expansion targeted long-term care and rural and remote communities. These programs better equip students and provide more resources for nurses and as well as attract more nursing graduates to rural areas. To determine the uptake of recommendations, a monitoring committee has been established by the

Priority	Accomplishments
	Provincial Nursing Network (PNN) to oversee implementation activities and report back to PNN. Leadership development continues to be a top priority for nursing. Continued to hold the annual Conference on Nursing Leadership with increasing numbers of nurses registering each year. In addition, recognizing that leadership development for nurses is critical to the success of the health care system, the Leadership Development for Professional Practice Working Group, which was established in 2004 under the Provincial Nursing Network (PNN), released its final reporting February 2006. This report sets the direction for nursing leadership development in Nova Scotia. These initiatives help nurses to develop leadership skills and address the challenge of filling nursing leadership roles in the health care system.
Medical Laboratory Technologists In 2005-2006, for the second year, Nova Scotia will fund a joint initiative between the New Brunswick Community College (NBCC) and Nova Scotia Community College (NSCC) to train twenty-five Medical Laboratory Technologists. Nova Scotia will offer students bursaries of $4,000 in each year of the 2-year program of studies and in exchange, these students will commit to working in the Nova Scotia health care system for a two-year period. Other options for meeting the need to train Medical Laboratory Technologists will be identified and explored during 2005-2006.	The third cohort of Medical Laboratory Technology (MLT) students began at NBCC. NSCC will open its new campus in September 2007 for the first Nova Scotia provincial Medical Laboratory Technologist program since the 1990s. When this new program is underway, it is expected that Nova Scotia will have 24 new MLT graduates each year starting in 2009.
Enhancing Physician Training Capacity In 2003-2004, Dalhousie University increased enrollment in the undergraduate medical program by eight seats bringing the total yearly undergraduate enrollment to ninety seats. The Department of Health has committed to providing increased funding to support these students through to the end of their four-year MD program and to continue with a class size of ninety students.	In 2005-2006, the Department of Health continued to fund eight additional seats in the undergraduate medical program at Dalhousie University. Beginning with 2003-2004, each undergraduate medical class at Dalhousie has contained an additional eight seats. A total of ninety students have been enrolled in each of these classes. This increase in the number of positions in undergraduate medicine at Dalhousie University is intended to increase the supply of locally trained physicians to the province of Nova Scotia in the coming years.

Priority	Accomplishments
Reducing Barriers to Practice for International Medical Graduates (IMGs) and Internationally Educated Health Professionals (IEHPs) About 25% of all practicing physicians are IMGs. All IMGs seeking license in Nova Scotia are screened and assessed by the College of Physicians and Surgeons of Nova Scotia (CPSNS) to ensure that their credentials (training, experience, and qualifications) are at the standard of Canadian medical graduates. With support from the Department of Health and the Dalhousie Faculty of Medicine, CPSNS has developed a business plan for a Foreign Credential Assessment Centre for Physicians beginning June 2005. Nova Scotia is leading an Atlantic regional collaborative effort aimed at reducing barriers to practice for IMG/IEHPs. This work is linked to the Provincial Immigration Strategy.	The College of Physicians and Surgeons has, to date, assessed three groups of International Medical Graduates (IMGs) through its Clinician Assessment for Practice Program. Opportunities for IMGs to enter into residency training at Dalhousie University are also being made available in the first round of the 2007 CaRMS program. The Clinical Assessment for Practice Program (CAPP), through Health Canada, was funded to develop an evaluation of their Assessment Centre. In June 2006, CAPP will assess approximately 25 candidates. From that group, 10 to 12 new IMGs will be granted a defined license to practice family medicine in Nova Scotia. In order to best prepare these new physicians, CAPP has developed a one-week orientation. This orientation will be funded through IEHP funds and contributions from both the Department of Health and CAPP. Nova Scotia is working to increase the capacity of IEHPs in the province. With Health Canada funding until 2010, Nova Scotia and Prince Edward Island have partnered on eight projects. These projects will speak to the unique needs of IEHPs as they relate to overall HHR requirements including training, recruitment and retention. The development of assessment and training options for IMGs in Nova Scotia has not only created professional opportunities for physicians educated in other countries, but has strengthened the province's supply of qualified physicians.
Occupational Health & Safety The Department of Health values the health and safety of employees. The Department strongly supports the policy of the Government of Nova Scotia to protect and promote employee health and safety and to take every precaution, reasonable in the circumstances, to ensure that workplaces are safe and healthy for employees, clients, and the general public. • Implement an Ergonomics Program for Department of Health employees. • Develop a Violence in the Workplace policy and guidelines.	The Department of Health established a Healthy Workplace Committee, which meets monthly. The Committee has initiated a lunchtime walking club, is working with an interior designer to select a more pleasing colour scheme for interior office walls, and is looking at healthier food selections for meetings and the local food providers. The Department is represented on the Public Service Commission-led Employee Safety and Well Being Committee. The purpose of the committee is to develop a policy on violence in the workplace that encompasses

Priority	Accomplishments
• Continuing to provide courses in Occupational Health and Safety to employees.	all Government of Nova Scotia departments, agencies and commissions. The Department conducted ergonomic assessments on approximately 95 per cent of Continuing Care staff and, as requested, for the remainder of staff in the Joe Howe building. The Department helped to develop new standardized OHS training for all Government of Nova Scotia employees. A schedule has been provided to the Public Service Commission, who will coordinate this new initiative.
Affirmative Action/Valuing Diversity The Government of Nova Scotia and the Department of Health are committed to providing a workplace that is free of discrimination and promotes equality of opportunity for all persons accessing employment positions within the Government of Nova Scotia, in general, and the Department of Health, in particular. • The Department of Health has introduced the practice of providing new employees with the "Workforce Survey" upon appointment and of providing survey (self-identifying) data to the Public Services Commission in its "workforce profile" of designated groups. • The Department of Health will complete an Employment Systems Review that will help to identify and remove barriers to employment, retention and advancement for members of designated groups in 2005-2006.	The Department of Health increased the hiring of individuals in the following areas: Persons with disabilities 2005 = 4.53% 2006 = 10% Aboriginal persons 2005 = .60% 2006 = .75% Other racially visible persons 2005 = 1.51% 2006 = 1.65%
Bilingual/French Language Services The Department of Health is committed to improving access and availability of French language health services through partnerships with DHAs, the IWK Health Centre and members/organizations in the Acadian and francophone community. The Department of Health has hired a Coordinator of French Language Health services to: • Consult and collaborate with the DHAs and other stakeholders to determine the present state of health services in French in the province • Participate in departmental, interdepartmental and provincial planning to ensure delivery of	In 2005-2006, for the first time the Department of Health offered French Language Nursing Bursaries to increase the number of French-speaking nurses retained and recruited to Nova Scotia. This new initiative was designed to increase the number of nurses that provide services to French-speaking Nova Scotians and to build awareness among employers and nurses that French is an asset in the health field. The success of the program will be evaluated in the upcoming year. The Department of Health, District Health Authorities, IWK, and Réseau Santé partnered on Primary Health Care Transition Fund - Official Language Minority Communities projects with the goal of increasing access

Priority	Accomplishments
French language health services is incorporated into the planning process • Provide advice and feedback to the Department of Health and DHAs on the implementation of new initiatives to enhance access and availability of services within the health system	to French language health services. Some of these projects include: • Directory of French Speaking Primary Health Care Professionals • Translation of IWK Health Centre website • Capital District's translation of patient education materials project • Youth and Senior's Health Centre in Chéticamp • Youth Health Centre in Isle Madame • The Primary Health Care "Setting the Stage" project was initiated to identify which French language primary health services are available and how they can be improved for the benefit of the Acadian and francophone community.
Responses to Employees Survey/Opinion The Department of Health values the input and opinion of its employees. The "How's Work Going" 2004 employee survey results showed that the Department of Health had strengths in teamwork, employee involvement, quality of work life, safety, knowledge of benefits, and knowledge of fit between individual roles and departmental purposes. Areas needing improvement include workplace ethics, diversity, department leadership, retention, merit, and opportunities for career advancement. To complement a corporate advisory committee, the Department of Health will create an internal departmental committee to respond to the survey's concerns. Membership will be drawn from the Senior Leadership Team, Human Resources, Management, and Bargaining Unit employees. There will be a cross section from Department of Health branches.	The Department of Health created an Employee Recognition Program as well as a Healthy Workplace Committee in response to concerns raised in the Employee Survey.
Performance Review The effective operation of the Government of Nova Scotia and its ability to satisfy customers are the cornerstones of its success as a professional public service. Operational effectiveness and business capability are built and sustained by high performing employees. The success of employees depends on clear performance management. The science and art of performance management comprise a complex array of skills, knowledge, processes, and tools. The performance management process is designed to recognize the accomplishments and capabilities of Department of	The Department of Health continued to strive to meet the standardized distribution rates that are assigned by the Public Service Commission. All performance reviews were submitted in a timely manner in 2005-2006.

Priority	Accomplishments
Health employees, to support the professional development of employees, and to deploy that capability to best meet the business needs of the Department. Performance management is a strategic leadership tool for organizational effectiveness. It helps ensure that the efforts of the Nova Scotia civil service are focused on the priorities and strategies in the departmental business plans. Performance management is also a framework for developing competent leadership for the future. Using the services of an external consultant, the Department of Health will train all management personnel on the process of completing a performance review.	

Health System-Wide Priorities

Priority	Accomplishments
Health Care Safety Although thousands of Nova Scotians get safe, quality care every day, recent studies about adverse events highlight the fact that no system is error-free. Patient safety and quality remain priorities for everyone involved in the health care system. In 2004, the Department of Health initiated a provincial Healthcare Safety Working Group to recommend an action plan aimed at improving safety across the continuum of Nova Scotia's health care services. The Group gathered information about leading practices in safety, approaches used in other jurisdictions, current activity in the province, and issues faced by provider agencies in Nova Scotia. System stakeholders were engaged in identifying priorities for action at the provincial level. The Department of Health accepted the recommendations for the Healthcare Safety Working Group. The following actions are planned for 2005-2006:	In October 2005, the Department of Health established the Healthcare Safety Advisory Committee (HSAC) in response to the recommendation of the predecessor Healthcare Safety Working Group. The mandate of the committee is to advise on annual priorities for action, maintain a network for communication on safety and oversee action as designated by the Department of Health. Working from the recommendations of the earlier Healthcare Safety Working Group, the Advisory Committee identified four priority areas for action. These include culture and leadership, occurrence reporting, information technology and human factors engineering. Working groups were established to focus on these areas.
• Establish a Healthcare Safety Advisory Committee to advise on annual priorities and oversee initiatives on an ongoing basis • Explore opportunities to incorporate safety mechanisms into existing information systems • Initiate or link with at least one expert group to advise on priority issues – identification of leading practices and recommendations in the areas of medication safety, infection control, work design, diagnostic safety and hand-offs of care • Foster meaningful quality review processes preventing things from going wrong or rectifying factors which contribute to adverse events • Expand public information materials to provide suggestions on how individuals seeking care can be active partners in optimizing health care safety • Implement a disclosure policy which requires DHAs to have processes in place to support clients and staff in disclosing adverse events to patients • Sponsor local education on safety for health care professionals	Established a Quality Review Working Group to develop a provincial Quality Review Guideline for use by the District Health Authorities to foster the quality and peer review process. Work was underway throughout 2005-2006 with an expected release in Fall 2006. Developed a provincial Disclosure of Adverse Events Policy to support staff, clients and their families when adverse events occur. The District Health Authorities are developing their own Disclosure of Adverse Events policies. Other activities and initiatives are underway throughout the system to promote an environment of patient safety are highlighted throughout this report. Examples include: • Implementation of a Unit Dose Drug Distribution System at the IWK Health Centre • Offering advice on various infection control issues. The Provincial Infection Control Consultant has been facilitating consistent infection control practices and providing surveillance of key infection control issues. • French Language Nursing Bursaries were

Priority	Accomplishments
	offered in order to increase the number of French Speaking nurses. • Official Language Minority Communities projects are underway. • Renewal of the Prescription Monitoring Program with the first pharmacies coming online with the new computerized system in November 2005. • Sponsorship of the Safer Healthcare Now initiative that provides outreach education to DHAs throughout the province. Through the work of the Healthcare Safety Advisory Committee, the Department and the healthcare delivery system, and sponsorship of safety focused initiatives, progress has been made towards improving safety throughout the healthcare system. Raising awareness and initiating changes that contribute to a reduction in adverse medical events help in the move toward a culture of healthcare safety.
Wait Time Advisory Committee A Wait Time Advisory committee was formed and held its first meeting in March 2005. The purpose of the committee is to advise the Minister on wait time issues; on the development and implementation of a province-wide strategy to collect standardized wait time information on all health care services; on the publication of wait time information for the public and on ways to shorten wait times. The chair of the advisory committee will also communicate with the public and providers on wait time issues.	The Wait Time Advisory Committee was established and met for the first time in March 2005. Subsequently, several meetings were held to address issues identified as contributing factors to the current situation. In fiscal year 2005/06, the Committee provided recommendations to the Minister on a number of issues from the creation of a strategic plan to improve access to health services to an increase in the number of long-term care beds. The nine recommendations made during 2005/06 are: • That the Nova Scotia Department of Health create a strategic plan to improve access to health care services; • That the Nova Scotia Department of Health clarify the District Health Authority's responsibility for access improvement; • That the Nova Scotia Department of Health fund and implement operating room management systems across the province; • That the Nova Scotia Department of Health fund a review of the efficiency of operation rooms across the province; • That the Nova Scotia Department of Health

Priority	Accomplishments
	partner with the Dalhousie University Department of Industrial Engineering to use their expertise to improve access to health care services; • That the Nova Scotia Department of Health increase the number of long-term care beds in the province; • That the Nova Scotia Department of Health devolve responsibility for Continuing Care to the District Health Authorities; • That the Nova Scotia Department of Health work in collaboration with the Canadian Association of Radiologists to deploy software that would reduce inappropriate use of diagnostic imaging services in the province; and • That the Nova Scotia Department of Health implement the National Ambulatory Care Reporting System to acquire the information that will assist in improving the performance of emergency rooms in the province.
Chronic Disease Management The management of chronic disease and the burden of illness of our aging population is a growing challenge for the Nova Scotia health system. Complementing the efforts of the Office of Health Promotion, the Department of Health will work with service providers in primary care, acute care and other settings to improve self-care and promote effective multidisciplinary patient management practices. Efforts will focus on improving care coordination and service integration.	Established a Chronic Disease Management (CDM) working group in March 2006 with broad representation from the Provincial Programs, Cardiovascular Health, Acute Care, Public Health, Health Promotion and Protection, DHAs, and Primary Health Care. The objectives are to: increase awareness and discuss CDM models, select a Chronic Disease Prevention Model for Nova Scotia, and to plan a Forum in Fall 2006 on CDM to engage a broad range of stakeholders across the province.
Multi-Year Funding for Front-Line Health Care Beginning in 2003-2004, the Department of Health committed to increasing funding for hospitals and other services provided by the DHAs by at least seven per cent per year. This assurance of predictable funding envelopes will continue in 2005-2006, adding significant support to front-line health care. This funding is an addition to funding already provided for salaries and negotiated salary increases.	The Department of Health increased operating budgets of the DHAs for 2005-2006 by $102 million over 2004-2005. In 2005-2006, the DHAs again received an increase of 7 per cent for their non-wage expenses in the amount of $25 million. This allows the health care providers to better plan for cost increases and not cut programs. This directly affects patient care by enabling the DHAs to operate the hospitals, clinics, and services that Nova Scotians need to get high-quality health care and shorter wait times for many tests and treatments.

Priority	Accomplishments
Blueprint for Aboriginal Health In September 2004, Canada's First Ministers and Aboriginal Leaders agreed to work together to develop a blueprint to improve the health status of, and health services for, Aboriginal peoples. This blueprint is to include concrete initiatives for: • Improved delivery of and access to health services to meet the needs of all Aboriginal peoples through better integration and adaptation of all health systems • The development of measures to ensure that Aboriginal peoples benefit fully from improvements to Canadian health systems • A forward looking agenda of prevention, health promotion and other upstream investments for Aboriginal peoples Federal/Provincial/Territorial Ministers responsible for Health and Aboriginal Affairs have been tasked to work in partnership with Aboriginal Leaders to develop this blueprint, and report back to First Ministers and Aboriginal Leaders in the Fall of 2005.	A sub-committee of the Tripartite Forum Health Working Group was tasked to coordinate Nova Scotia's submission for the Aboriginal Health Blueprint. As provincial co-chair of the committee, the Director of Primary Health Care was heavily involved in this process, and was Nova Scotia's representative on the FPT Agreement planning committee. Five facilitated engagement sessions were held in Halifax and First Nations communities, and representatives of communities, DHAs, Aboriginal organizations, professionals, and academia attended. The result was the production of a document " Providing Healthcare, Achieving Health" which clearly outlines strengths and issues concerning Aboriginal Health in Nova Scotia. It provides a basis upon which to go forward in a strategic manner to work with partners to improve the health of Aboriginal people. The submission was well regarded in the country and largely informed the final National Blueprint. At the November First Ministers' Meeting, the National Blueprint was approved in principal, but there were no signatories to the document. Nova Scotia continues to use its document to set priorities.
Biomedical Waste Transportation and Disposal Biomedical waste from the province's hospitals will no longer be sent to the Sydney municipal incinerator. A new system of waste disposal is being implemented. Selected using the province's public procurement process, the contractor will make application for the necessary approvals from regulatory agencies. The new system is expected to be in place in December 2005.	The Department of Health issued a request for proposals for the transportation and disposal of biomedical waste. The contract was awarded to Medical Waste Management Inc. of Brampton, Ontario in June 2005. They subsequently received the necessary approvals from regulatory agencies and began operating as per contract in December 2005.

Financial Results 2005 - 2006

Cost Centres	2005-2006 Estimate	2005-2006 Actual	Est./Act.Variance
Total-Administration	37,793,000	35,726,961	2,066,039
Medical Payments	525,314,000	531,397,628	(6,083,628)
Pharmacare Program	119,917,000	116,855,660	3,061,340
Other Insured Programs	42,995,000	37,361,701	5,633,299
Revenue and Recovery	(23,338,000)	(23,091,994)	(246,006)
Emergency Health Services	71,948,600	73,881,269	(1,932,669)
Other Health Care Initiatives	96,543,400	89,721,962	6,821,438
Other Programs	15,680,000	13,918,076	1,761,924
Total - District Health Authorities	1,210,681,000	1,221,867,225	11,186,225
Care Coordination			
Home Care Services	28,294,000	26,452,481	1,841,519
Long Term Care	100,189,000	105,102,654	(4,913,654)
Capital Grants – Health	295,723,000	305,336,744	(9,613,744)
	38,000,000	37,980,876	19,124
*******Department of Health*******	2,559,740,000	2,572,511,243	(12,771,243)

Department of Health
Financial Results 2005 - 2006 Estimate vs. Actual

Estimate: **$2,559,740,000**
Actual: **$2,572,511,243**
Total Variance: **$**(12,771,243)

Variance Explanations:

Administration: Decrease due to vacancies, administration costs, and Facility Management costs less than budgeted.

Medical Payments/Physician Services: Increases in utilization of Fees for Services, Radiology/Pathology utilization costs and cost of moving Emergency Room from Level 4 to Level 3.

Pharmacare Program: Decrease in claims by seniors and overall utilization decreases.

Other Insured Programs: Decrease in utilization.

Revenue and Recovery: Increase due to reduction in recoveries due to vehicle levy charges (Third Party Claims)

Emergency Health Services: An overall net increase in Paramedic Wage Settlement, additional equipment and supplies for ambulances, and reduction in flight time for helicopters.

Other Healthcare Initiatives and Other Programs: Overall decrease due to lower usage of plasma products by Canadian Blood Services, Information Technology Initiatives and delay in implementation of Autism-Mental Health Early Identification Program.

DHA/PHDCC's: Additional funding primarily for oncology drugs, bone marrow transfers for Out-of-Province patients, operating costs related to the 21 new beds at the Valley Regional Hospital and other pressures facing the DHAs.

Care Coordination/Home Care Services: Overall increase in utilization in home care Nursing Services and additional savings in care coordination due to vacancies.

Long Term Care Program: Increase for the new ALC (Alternate Level of Care) and deferred maintenance, reduction in recoveries from clients, and operational pressures.

Capital Grants: Decrease due to reduced Cash Flow requirements.

2005-2006 Department of Health Outcomes Report

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 nine different sources. These data sources have different reporting time periods and capacity to report on data in a timely fashion and are constantly undergoing improvement. For these reasons, primarily, the availability of data will vary by measure.

Outcome Measures - New, Revised and Discontinued

Each year, Outcome Measures are reviewed during the business planning process for the upcoming year. During that year, circumstances may require the development of new measures. Measures may be revised or discontinued to ensure consistency with other jurisdictions and enable cross Canada comparisons. The following table identifies those measures affected by new or complementary information. Complete reports on these and all other measures may be found on the pages that follow.

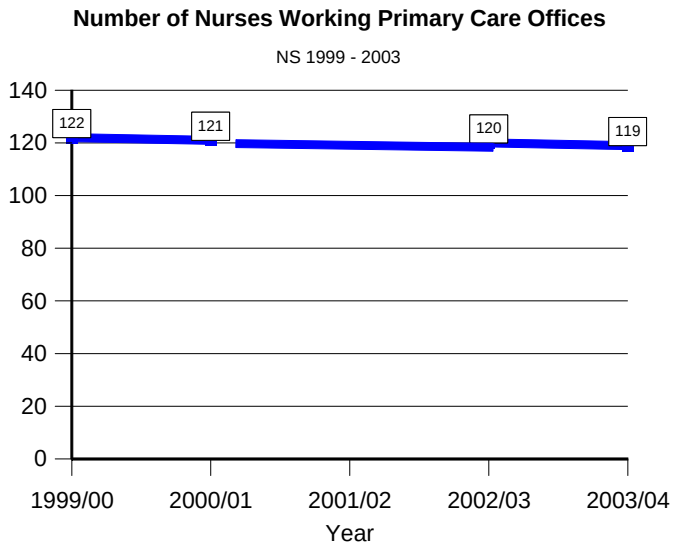
Measure	Explanation
Percentage of Nova Scotians (65 years and older) Who Received a Flu Shot in the Past Year	Due to organizational changes resulting from the establishment of the Department of Health Promotion and Protection, this measure is being reported on by the Department of Health Promotion and Protection in its 2005-2006 Accountability Report.
Hospitalizations of people aged 65 years or older for pneumonia and influenza	Due to organizational changes resulting from the establishment of the Department of Health Promotion and Protection, this measure is being reported on by the Department of Health Promotion and Protection in its 2005-2006 Accountability Report.
Number of Nurses Working in Primary Care Offices	The data to update this measure is no longer available. Therefore, the most recent data available is for 2003-2004. The measure is being discontinued in future business plans and appropriate measures and targets are being developed.
Number of Clients with Serious Mental Health Problems Treated Outside of Inpatient Hospital Settings (Community-Based Visits)	The data for this measure differs from what appeared in previous reports due to changes in the diagnostic groupings to better reflect serious mental illness.
Proportion of People Admitted to Hospital for Conditions Where Appropriate Outpatient Care May Prevent the Need for Hospitalization (Ambulatory Care Sensitive Conditions)	The data differs from what appeared in previous reports due to revisions in the definition of Ambulatory Care Sensitive Conditions.
Percentage of the Population (Age 18 or Older) Receiving Homemaking, Nursing or Respite Services	The age category for the data used in this measure has changed twice in recent years. The age category was originally age 12 years and over before being changed to age 15 years and over in 2003. In 2005, the category was changed again to age 18 years and over.

CORE BUSINESS AREA: PRIMARY HEALTH CARE

Outcome: Improved Access to Primary Health Care

Number of Nurses Working in Primary Care Offices

One of the Department of Health's core business areas is Primary Health Care, which includes the services of many health care professionals. A desired outcome in this area is ensuring the appropriate number and distribution of health care providers. One way to assess the supply and distribution of health care providers is by calculating the number of nurses working in primary care offices.



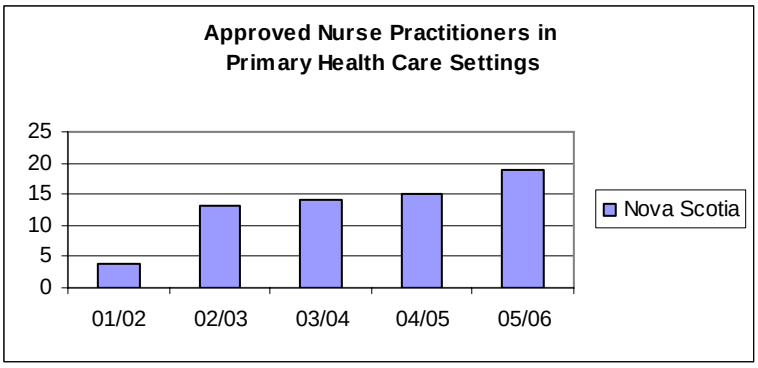
What Does the Measure Tell Us?
This measure is one way of showing what type of, and how much access to health professionals the public has at primary care sites. A limitation of this measure, however, is its inability to discern whether nurses reporting working in primary care practices are providing direct patient care or not.

Where Are We Now?
In 2003-2004, the most recent year for which data is available, there were 119 nurses working in primary care offices. This is a slight decline from previous years.

Where Do We Want to Be in the Future?
The data for this indicator is no longer available. The most recent data available is for 2003-2004. The measure is being discontinued in future business plans and appropriate measures and targets are being developed. However, strategies to promote the number of nurses working in primary care offices include planning for the development of a renewed community-based health care system for Nova Scotia and support for the nurse practitioner education program. One goal of the Department of Health is to increase access to health services for the public by increasing the number of health providers and providing more access to the appropriate health care provider at the appropriate time. This could include providing access to a nurse in a primary care practice for procedures, health promotion or specialty care.

Number of Approved Nurse Practitioners Working in Primary Health Care Settings

One of the Department of Health's core business areas is Primary Health Care, which includes the services of many health care professionals. A desired outcome in this area is ensuring the appropriate number and distribution of health care providers. One way to assess the supply and distribution of health care providers is by calculating the number of nurse practitioners working in primary health care settings.



What Does the Measure Tell Us?
This measure is one way of showing what type of, and how much access to health professionals the public has at primary care sites.

Where Are We Now?
In 2005-2006, there were 15 nurse practitioners working in primary care settings. There has been a steady increase in the number of nurse practitioners in primary care settings since 2001-2002.

Where Do We Want to Be in the Future?
Although targets were not available for the 2005-2006 Business Plan, they subsequently were set in the 2006-2007 Business Plan at 28. Strategies to promote the number of nurse practitioners working in primary care settings include planning for the development of a renewed community-based health care system for Nova Scotia and support for the nurse practitioner education program. One goal of the Department of Health is to increase access to health services for the public by increasing the number of health providers and providing more access to the appropriate health care provider at the appropriate time.

Number of Provincially Licensed Midwives in Primary Maternity Settings

One of the Department of Health's core business areas is Primary Health Care, which includes the services of many health care professionals. A desired outcome in this area is ensuring the appropriate number and distribution of health care providers. One way to assess the supply and distribution of health care providers is by calculating the number of provincially licensed midwives in primary maternity settings.

What Does the Measure Tell Us?
This measure is one way of showing what type of, and how much access to health professionals the public has in primary care settings.

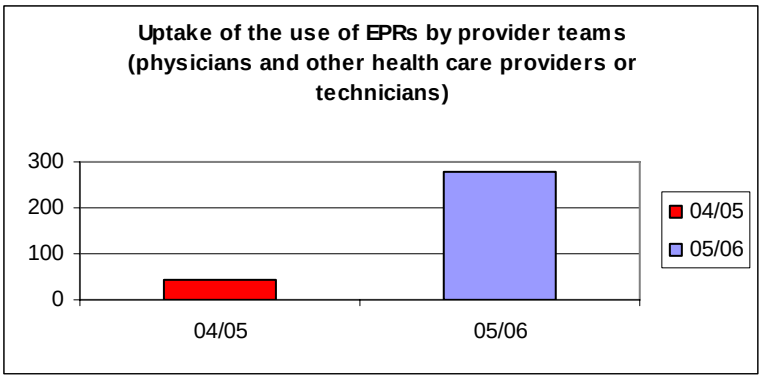
Where Are We Now?
There is currently no data available to track this measure because legislation governing the practice of midwifery is not yet complete. When legislation is complete data will be developed and tracked.

Where Do We Want to Be in the Future?
One goal of the Department of Health is to increase access to health services for the public by increasing the number of health providers and providing more access to the appropriate health care provider at the appropriate time.

Outcome: Improved access to patient information by providers and appropriate sharing among team providers through Electronic Patient Records (EPR)

Uptake of the use of Electronic Patient Records by Provider Teams

One of the Department of Health's core business areas is Primary Health Care, which includes the services of many health care professionals. A desired outcome in this area is ensuring the appropriate sharing and access to patient information among team providers. One way to assess the access and sharing of patient information among team providers is by calculating the number of provider teams that are using Electronic Patient Records (EPR).



What Does the Measure Tell Us?
Improved access to patient information by providers and appropriate sharing among team providers through EPRs improves the care provided to patients in primary care settings.

Where Are We Now?
In 2005-2006, 278 provider teams were using EPRs. This is up from 45 in 2004-2005 and surpassed the target of 150 for 2005-2006.

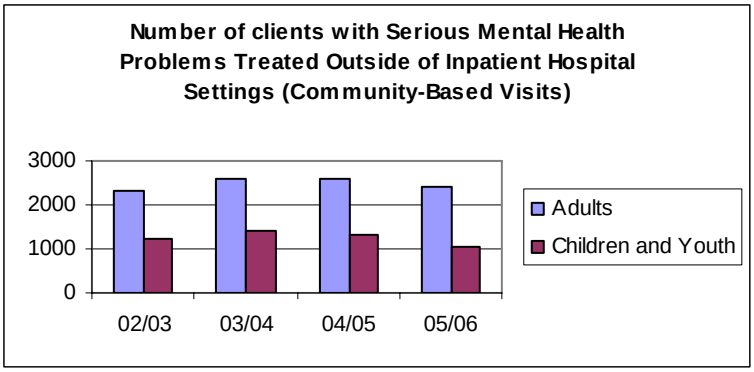
Where Do We Want to Be in the Future?
One goal of the Department of Health is to increase the number of health providers using EPRs.

CORE BUSINESS AREA: MENTAL HEALTH AND ADDICTION SERVICES

Outcome: Maintain Persons with Serious Mental Illness in their Communities

Number of Clients with Serious Mental Health Problems Treated Outside of Inpatient Hospital Settings (Community-Based Visits)

One of the Department of Health's core business areas is Mental Health Services. A higher overall proportion of clients with serious mental health problems being treated outside of inpatient hospital settings is an indicator of increased use of community-based care alternatives for people who suffer from mental illness.



What does this measure tell us?

In most jurisdictions, there is a move from acute hospital-based treatment to community-based care for people who suffer from mental illness. Increasingly, persons with severe and persistent mental illness are being successfully supported in achieving the highest level of functioning possible in the least restrictive setting. This requires an array of treatment alternatives to inpatient hospitalization and the necessary supports to keep people well and living in their communities. This measure indicates progress being made in identifying individuals with mental illness who can appropriately reside in the community and the level of progress made in providing community-based services and supports that suit their needs. Severe and persistent mental illness is defined as one of several diseases affecting the brain (e.g., schizophrenia, bipolar disorder), in which sufferers are significantly functionally impaired by the illness for an indefinite period of time.

Where Are We Now?

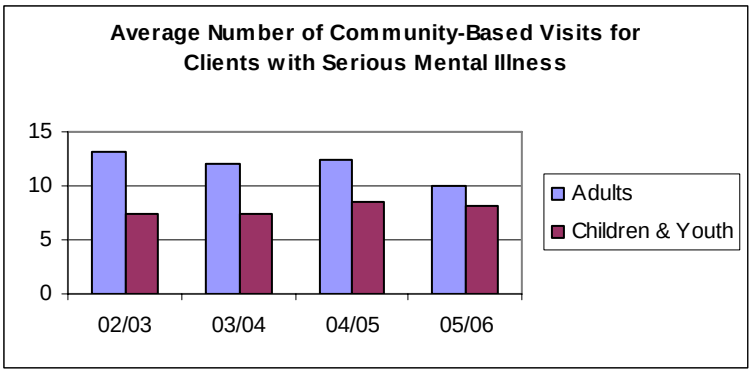
There was an increase in the number of adult clients with serious mental illness being treated outside of inpatient hospital settings from 2337 to 2585 between 2002-2003 and 2004-2005. In 2005-2006, there was a slight decrease to 2402. From 2002-2003 to 2004-2005 there was increase in the number of youth clients with serious mental illness being treated outside of inpatient hospital settings from 1217 to 1334. In 2005-2006, there was a decrease to 1055. The numbers differ from what appeared in previous reports due to changes in the diagnostic groupings to better reflect serious mental illness.

Where Do We Want to Be in the Future?

The Department of Health has a target to increase the number of adults and children and youth with serious mental illness treated outside of inpatient hospital settings. The number of clients treated outside of inpatient hospital settings should increase as the ability to identify individuals increases and as resources are focused on community-based services.

Average Number of Community-Based Visits for Clients with Serious Mental Illness

One of the Department of Health's core business areas is Mental Health Services. A higher average number of visits by clients with serious mental health problems is an indicator of increased use and availability of community-based care alternatives for people who suffer from mental illness.



What does this measure tell us?

In most jurisdictions, there is a move from acute to community-based care for people who suffer from mental illness. Increasingly, persons with severe and persistent mental illness are being successfully supported in achieving the highest level of functioning possible in the least restrictive setting. This requires an array of treatment alternatives to inpatient hospitalization and the necessary supports to keep people well and living in their communities. Those with severe and persistent mental illness are expected to require more intense and frequent support. Therefore, as more services become available, this population should be able to avail themselves of more frequent mental health service contacts. Severe and persistent mental illness is defined as one of several diseases affecting the brain (e.g., schizophrenia, bipolar disorder), in which sufferers are significantly functionally impaired by the illness for an indefinite period of time.

Where Are We Now?

The average number of visits for adults with serious mental illness has declined over the period between 2002-2003 and 2005-2006 from 13.1 to 10.0. This reduction is at least partially a result of a recent significant increase (33 per cent) in the absolute number of adult clients that are being treated (the denominator).

During the same period, the average number of visits for children and youth has generally continued to increase from 7.5 to 8.1. Despite the apparent small increase in visits for children and youth over this period, the increase represents, on a relative scale, a substantial increase in overall visits.

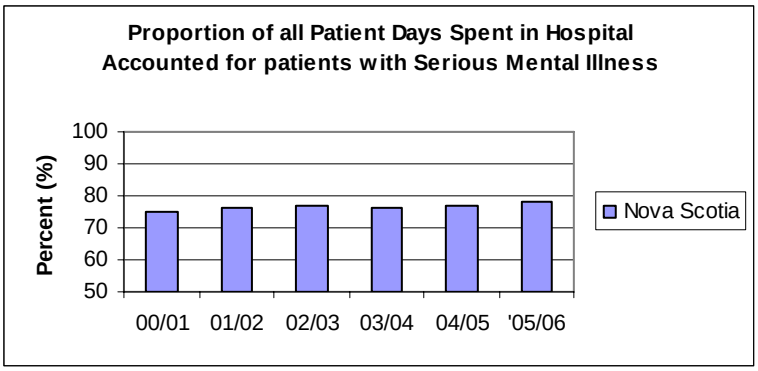
Where Do We Want to Be in the Future?

The target is to maintain or increase the number of contacts per client.

Outcome: Responsive Service to Persons Who Require Hospitalization

Psychiatric Inpatient Units Days Accounted for by Patients with Serious Mental Illness

One of the Department of Health's core business areas is Mental Health Services. A higher overall proportion of patient days accounted for by patients with serious mental illness suggests success in shifting service options from inpatient to alternate settings for appropriate clients and achieving more appropriate use of inpatient hospital care.



What Does the Measure Tell Us?

Persons with serious and persistent mental health problems are those who benefit most from hospital admissions. Other individuals, however, for whom outcomes are not enhanced by hospital care, may also be admitted to hospital because alternative community-based services or supports are not available. With limited inpatient capacity, this may reduce the availability of hospital care for those who need it most. The percentage of all patient days spent in hospital accounted for by patients with serious mental illness is calculated by dividing the number of patient days on designated psychiatric inpatient units for patients with serious mental illness by the total number of patient days on designated psychiatric inpatient units. Severe and persistent mental illness is defined as one of several diseases affecting the brain (e.g., schizophrenia, bipolar disorder), in which sufferers are significantly functionally impaired by the illness for an indefinite period of time.

Where Are We Now?

In 2005-2006, patients with serious mental illness accounted for 78 percent of patient days spent in psychiatric inpatient units. This represents a moderate improvement in the utilization of inpatient services in Nova Scotia.

Where Do We Want to Be in the Future?

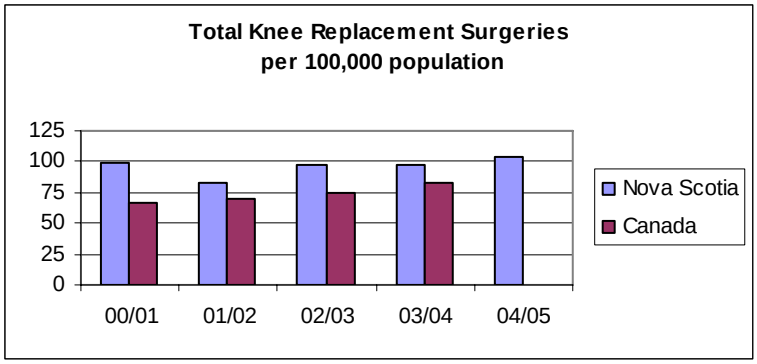
The Department of Health has set a target to maintain or increase the number of persons with serious mental illness being treated in hospital. The strategy to reach this goal is to continue to support shifting service options from inpatient hospital care to alternate settings where appropriate.

CORE BUSINESS AREA: ACUTE & TERTIARY CARE

Outcome: Access to Quality Hospital Services

Number of Total Knee Replacement Surgeries

One of the Department of Health's core business areas is Acute and Tertiary Care. A desired outcome in this area is ensuring access to quality hospital services. This may be measured indirectly by assessing the rate at which various procedures requiring hospital stay are performed. One of these procedures is Total Knee Replacement Surgery.



What Does the Measure Tell Us?

Rates for total knee replacement surgery are age-standardized measures of the number of knee replacement surgeries performed on inpatients in acute care hospitals per 100,000 population. The age-standardized rate of total knee replacement surgeries performed reflects access to health services and improved quality of life. Total knee replacement surgery is known to result in considerable improvements in functional status, pain relief, and overall quality of life.

Where Are We Now?

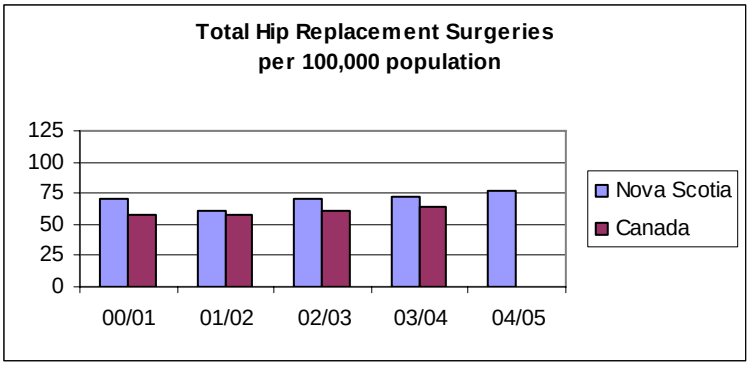
The number of knee replacements increased steadily in both Nova Scotia and Canada from 1997-1998 until 2000-2001. In 2001-2002, Nova Scotia's age standardized knee replacement rate per 100,000 dropped by approximately 17 cases per 100,000. At the same time, the Canadian rate continued to increase steadily. In 2003-2004, the Nova Scotia rate rose to 103.9 per 100,000. While the gap between the Nova Scotian and Canadian knee replacement rate was narrowed in 2001-2002, Nova Scotia continues to have a higher age-standardized rate (97.5 per 100,000) than the Canadian average (83.0 per 100,000) in 2003-2004, the most recent data available for the Canadian rate.

Where Do We Want to Be in the Future?

The Department of Health aims to maintain Nova Scotian total knee replacement surgery rates at levels better than or consistent with the Canadian average (83.0 per 100,000 in 2003-2004).

Number of Total Hip Replacement Surgeries

One of the Department of Health's core business areas is Acute and Tertiary Care. A desired outcome in this area is access to quality hospital services, which can be measured by assessing the rate at which various procedures requiring hospital stay are performed. One of these measures is the Total Hip Replacement Surgery Rate.



What Does the Measure Tell Us?

Age standardized total hip replacement surgery rates measure the number of total hip replacement Surgeries performed on inpatients in acute care hospitals per 100,000 population. The number of total hip replacement surgeries performed reflects access to health services and improved quality of life. Total Hip Replacement Surgery is known to result in considerable improvement in functional status, pain relief, and other gains in health-related quality of life.

Where Are We Now?

The age-standardized rate of hip replacement surgeries in Nova Scotia have increased from 69.8 per 100,000 population in 2002-2003 to 76.4 per 100,000 population in 2004-2005, the most recent year for which data is available. During the period 2002-2003 to 2003-2004, the most recent year for which data is available, age-standardized total hip replacement rates have increased across Canada from 61.5 per 100,000 population to 64.9 per 100,000 population. The trend suggests that Nova Scotians continue to have greater access to this procedure than other Canadians.

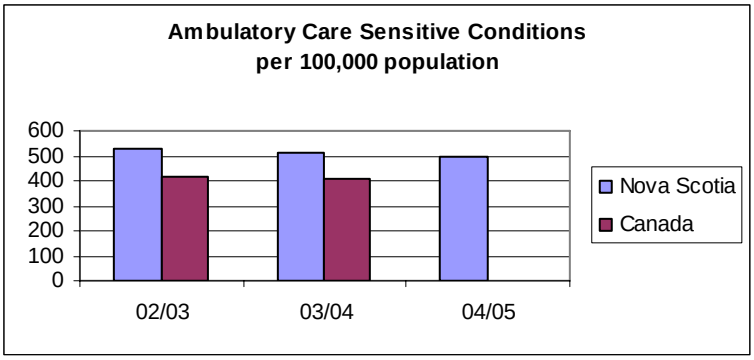
Where Do We Want to Be in the Future?

The Department of Health aims to maintain Nova Scotian Total Hip Replacement Surgery rates at levels better than or consistent with the Canadian average (64.9 per 100,000 population in 2003-2004).

Outcome: Access to Quality Hospital Services

Proportion of People Admitted to Hospital for Conditions Where Appropriate Outpatient Care May Prevent the Need for Hospitalization (Ambulatory Care Sensitive Conditions)

One of the Department of Health's core business areas is Acute and Tertiary Hospital Care. A desired outcome in this area is ensuring the best use of inpatient hospital resources. One way to assess this is by calculating the number of people admitted to hospital for ambulatory care sensitive conditions.



What Does the Measure Tell Us?

The measure describes the age-standardized rate of people per 100,000 admitted to hospital for conditions where appropriate outpatient care may prevent the need for hospitalization. These conditions include long-term health conditions, which can often be managed with timely and effective treatment in the community, without hospitalization. Calculating hospitalization rates for such conditions can help measure appropriate access to community-based care. Health care professionals generally believe that managing these conditions before a patient requires hospitalization improves the patient's health, contributes to better overall community health status, and often saves money because community-based care is typically less expensive than hospitalization. Tracking hospitalization rates for these conditions over time can provide an indicator of the impact of community and home-based services. Ambulatory Care Sensitive Conditions (ACSCs) include conditions such as hypertension, asthma and angina.

Where Are We Now?

During 2004-2005, the most recent year for which data is available, 495 hospitalizations per 100,000 occurred in Nova Scotia for conditions where appropriate outpatient care may have prevented the need for hospitalization. Provincially and nationally, ambulatory care sensitive condition rates have steadily decreased over the last six years reflecting a consistent positive trend towards the more efficient use of health services. The data differs from what appeared in previous reports due to revisions in the definition of ACSCs.

Where Do We Want to Be in the Future?

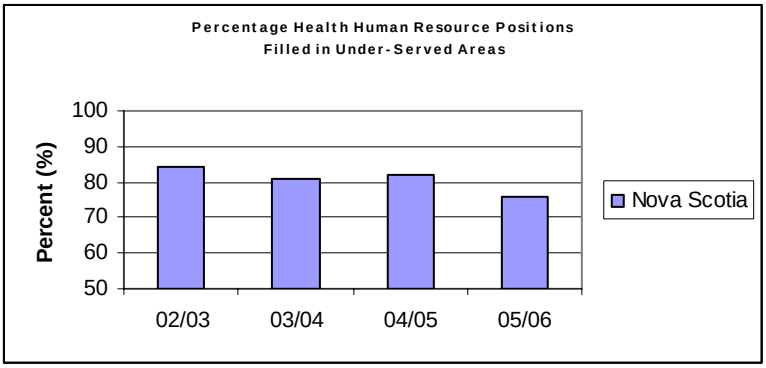
Nova Scotia is aiming to limit the proportion of people admitted to hospital for ambulatory care sensitive conditions to levels consistent with the Canadian average (current Canadian average not available due to change in methodology). Toward this end, the Department of Health will continue to monitor the effective utilization of hospital beds and review opportunities to use outpatient services most effectively.

CORE BUSINESS AREA: PHYSICIAN SERVICES

Outcome: Appropriate Number and Distribution of Health Care Providers

Percentage of Family Physician Positions Filled in Under-Served Areas

One of the Department of Health's core business areas is Physician Services, which includes the services of physicians. A desired outcome in this area is access to quality health care. One way to enhance access is by ensuring the appropriate number and distribution physicians.



What Does the Measure Tell Us?
One measure of the supply and distribution of health personnel is the percentage of family physician positions filled in under-served areas. Under-served areas are defined as those that have a history of recruitment and retention difficulties, where recruiting by local committees has been unsuccessful for more than six months, and where the medical needs of the community are not being otherwise served. Those areas that are designated as "under-served" have incentive programs to support physician recruitment. The total number of under-served areas can change over time.

Where Are We Now?
In 2005-2006, 76 per cent of physician positions areas identified under-served areas were filled. This percentage is down slightly from the 82 per cent in 2004-2005. The total number of family physicians in under-served areas changes rapidly because of natural fluctuations (deaths, retirements, and the voluntary relocation of providers within the province) and successful recruitment. Ongoing recruitment efforts are required to maintain or exceed the provincial target (80 per cent).

The move towards enhanced utilization of nurse practitioners and broader care teams has an effect on this indicator. Where physicians may have been traditionally sought out to fill positions in under-serviced areas, nurse practitioners, in concert with existing physicians in those areas, can now effectively fill the service gap left by the absence of a full physician complement. In years to come, this measure will be adjusted to reflect the role of nurse practitioners.

This measure is not a stable measure. The number of under-serviced areas or hard to service areas can increase and decrease each year. Therefore, the number of positions filled in one year is reflective only of that year's total number of positions available. In future years, the denominator could increase or decrease.

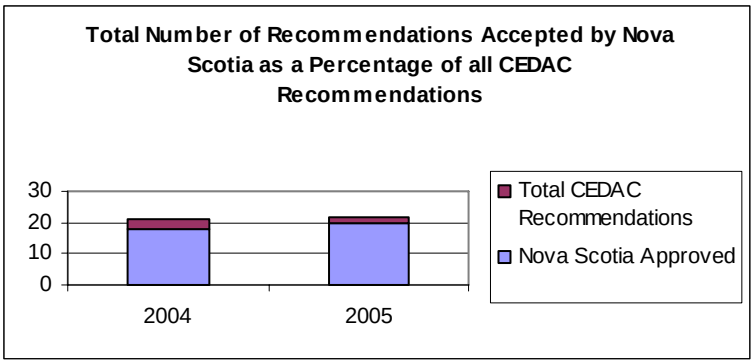
Where Do We Want to Be in the Future?
Nova Scotia's target is to have 80 per cent or more health human resource positions filled in under-served areas of Nova Scotia. The Department of Health has continued to support physician recruitment initiatives throughout the province through its Physician Recruiter and via website listings of vacancies, a recruitment guide, advertising, and incentives.

CORE BUSINESS AREA: PHARMACEUTICAL SERVICES

Outcome: Adequate Prescription Drug Coverage for All Seniors

Total number of recommendations accepted by Nova Scotia as a percentage of all recommendations made by CEDAC

One of the Department of Health's core business areas is Pharmaceutical Services. A desired outcome in this area is adequate prescription drug coverage for all seniors. One way in which adequate prescription drug coverage for all seniors can be measured is by monitoring the uptake of Canadian Expert Drug Advisory Committee (CEDAC) recommendations for drug coverage under Seniors' Pharmacare.



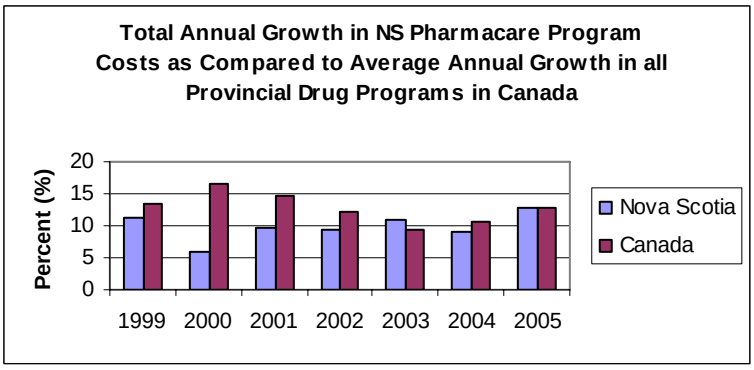
What Does the Measure Tell Us?
The measure monitors the uptake of CEDAC recommendations for drug coverage under Seniors' Pharmacare.

Where Are We Now?
In 2005, 20 of 22 recommendations made by CEDAC were accepted in Nova Scotia. This is up slightly from 18 of 21 in 2004.

Where Do We Want to Be in the Future?
The target is to monitor uptake of CEDAC recommendations in Nova Scotia.

Growth Rate of Total Drug Costs, Seniors Pharmacare Program

One of the Department of Health's core business areas is Pharmaceutical Services. A desired outcome in this area is adequate prescription drug coverage for all seniors. One way in which adequate prescription drug coverage for all seniors can be measured is by monitoring the annual percentage growth rate of total provincial drug costs in Nova Scotia against the national average growth rate.



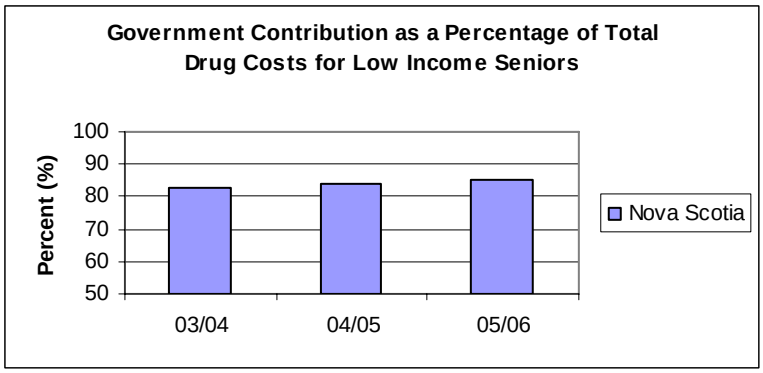
What Does the Measure Tell Us?
The measure monitors the annual percentage growth rate of total provincial drug costs in Nova Scotia against the national average growth rate.

Where Are We Now?
In 2005, the growth of total provincial drug costs in Nova Scotia was 12.9 per cent. This was up from 9.2 per cent in 2004 and is part of a general upward trend since 2000.

Where Do We Want to Be in the Future?
The target is to keep provincial drug program growth in Nova Scotia at or below the average growth rates for similar programs in other provinces by encouraging best practices in purchasing, prescribing and dispensing to ensure all prescriptions are used appropriately.

Government Contribution as a Percentage of Total Drug Costs for Low Income Seniors

One of the Department of Health's core business areas is Pharmaceutical Services. A desired outcome in this area is adequate prescription drug coverage for all seniors. One way in which adequate prescription drug coverage for all seniors can be measured is by monitoring beneficiary cost sharing for low-income seniors against program changes that mitigate the impact of prescription drug cost increases on low-income seniors.



What Does the Measure Tell Us?

The measure monitors beneficiary cost sharing for low-income seniors against program changes that mitigate the impact of prescription drug cost increases on low-income seniors.

Where Are We Now?

In 2005-2006, the Government of Nova Scotia covered 85 per cent of the annual drug costs of low-income seniors. This is up slightly from 84 per cent in 2004 and is part of a slight upward trend since 2003.

Where Do We Want to Be in the Future?

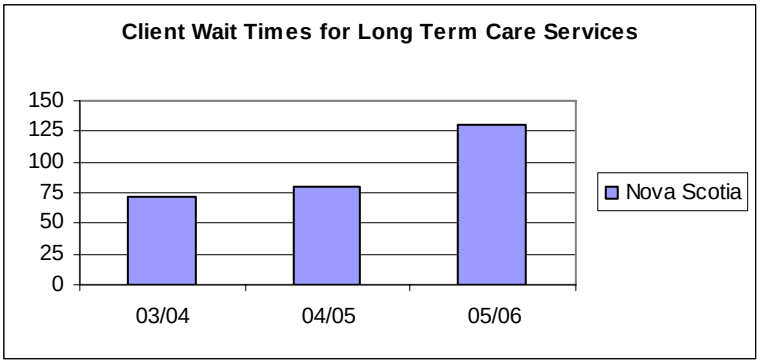
The target is to have the Government of Nova Scotia cover at least 75 per cent of the annual drug costs of low-income seniors.

CORE BUSINESS AREA: CONTINUING CARE SERVICES

Outcome: Access to Long-Term Care Services

Amount of Time Clients Wait for Service

One of the Department of Health's core business areas is Continuing Care Services. A desired outcome in this area is ensuring access to quality Home Care and Long Term Care Services. One way in which access these services can be measured is by assessing the time that clients wait for services.



The Department is developing systems to allow for accurate and timely measurement of wait times. Currently Long Term Care wait times are available, while Home Care wait times are still under development.

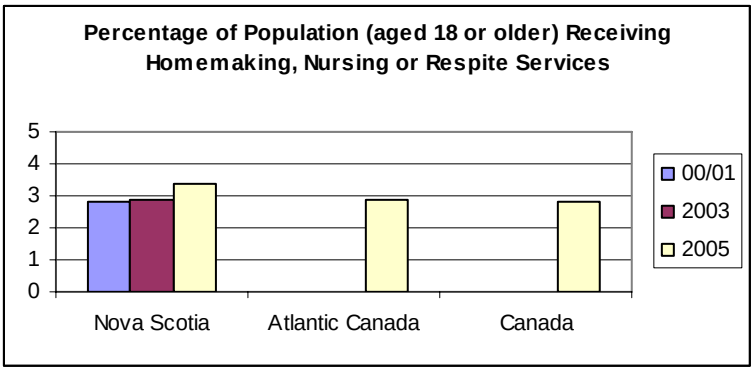
What Does the Measure Tell Us?
Wait times are seen as an important measure of system accessibility and efficiency. Where available, it is important to report on data that measures the wait time for a particular service. This reporting allows service providers to assess and manage wait times better while allowing clients and potential clients to understand the timing of their care. While an efficient health care system has some level of "wait" inherent, reduced wait times are generally interpreted as reflecting improved service delivery.

The Long Term Care wait time is defined as the period, in days, from client assessment until initial admission to a long-term care facility.

Where Are We Now?
In 2004-2005 the average wait time for Long Term Care admission was 81 days. In 2005-2006 the average wait time was 130 days. As a result of changes in long term care funding policy implemented January 1, 2005, more Nova Scotians are seeking long term care placement, resulting in longer wait times in 2005 and again in 2006.

Where Do We Want to Be in the Future?
It is our goal to ensure that Nova Scotians have appropriate access to Home Care and Long Term Care services. More data is required before a formal target can be set. The Department of Health has implemented Single Entry Access processes so that entry into Home Care and Long Term Care services is via a single, more efficient and less complex, process.

Percentage of the Population (Age 18 or Older) Receiving Homemaking, Nursing or Respite Services



One of the Department of Health's core business areas is Continuing Care Services. A desired outcome in this area is ensuring access to quality Home Care and Long Term Care Services. Access to these services may be measured by estimating the percentage of the population (age 18 or over) who receive homemaking, nursing, or respite services.

In recent years, the Department of Health has supported programs to deliver some health services to people in their homes as an alternative to admitting people to acute care or long term care facilities. This has numerous benefits. For example, people needing care are more comfortable, and their life styles and independence are maintained for as long as possible; facility space can be reserved for those with greater health care needs; and lower costs are often associated with home care, compared to care in institutions.

What Does the Measure Tell Us?

As more home care programs are implemented, it is expected that these services will be provided to increasing numbers of people. Estimating the percentage of the population (age 18 years and over) that receive homemaking, nursing or respite service help in understanding growth in, and access to, quality Home Care and Long Term Care Services.

Where Are We Now?

In 2001, 2.8 per cent of individuals age 12 or older received homemaking, nursing or respite services. In 2003, Nova Scotians reported that 2.9 per cent of individuals age 15 or older received homemaking, nursing or respite services. In 2005, 3.4 per cent of individuals age 18 or older received homemaking, nursing or respite services. The age category for the data used in this measure has changed twice in recent years. The age category was originally age 12 years and over before being changed to age 15 years and over in 2003. In 2005, the category was changed again to age 18 years and over.

Where Do We Want to Be in the Future?

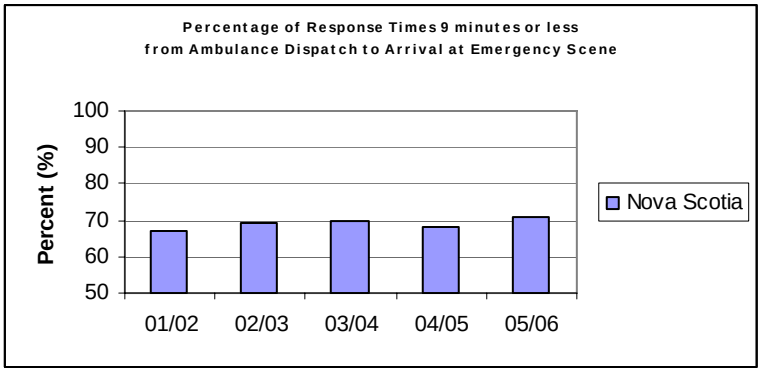
It is our goal to ensure that Nova Scotians have appropriate access to home care services. More data are required before a formal target can be set. The Department of Health has implemented Single Entry Access processes so that entry into Home Care and Long Term Care services is via a single, more efficient and less complex, process. This program will help set targets for and achieve this goal.

CORE BUSINESS AREA: EMERGENCY HEALTH SERVICES

Outcome: Access to Quality Emergency Health Services

Percentage of Response Times at Nine Minutes or Less from Ambulance Dispatch to Arrival at Emergency Scene

One of the Department of Health's core business areas is Emergency Health Services. A desired outcome in this area is timely access to quality emergency health services. One way in which this outcome may be assessed is by calculating response times from the time an emergency call is answered to arrival at the emergency scene.



What Does the Measure Tell Us?

In urban areas, the industry standard for response time is under nine minutes, 90 per cent of the time. This standard is based on chances of survival after a cardiac arrest. That is, a person's chances of surviving a cardiac arrest improve if an ambulance arrives at an emergency scene within nine minutes or less. There are no standards for suburban or rural areas, however, making it difficult to compare Nova Scotia results (which are urban, suburban and rural) with EMS systems in other jurisdictions that are often urban only systems. Geography would naturally dictate that response times would be higher in suburban and rural areas than they would be in urban areas.

Where Are We Now?

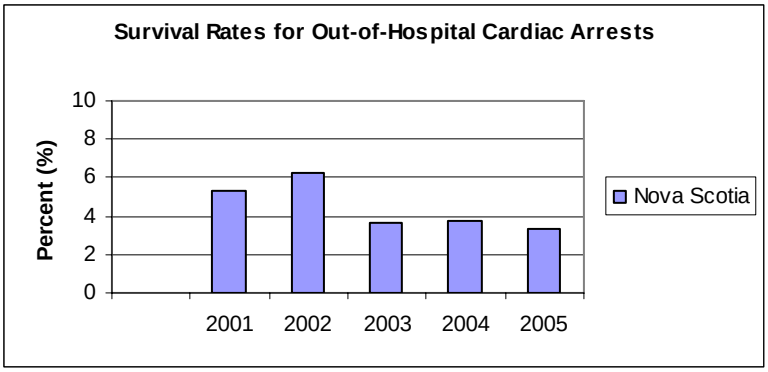
In 2005-2006, response times from the time a call is answered to arrival at the emergency scene was nine minutes or less 71 per cent of the time. This shows an improvement since 2000-2001 when response times of nine minutes or less occurred 66 per cent of the time. This surpasses the Department of Health target of 70 per cent for 2005-2006.

Where Do We Want to Be in the Future?

The Department of Health is dedicated to continually improving response times by using methods and technology that will result in the most efficient use of ambulances.

Survival Rates for Out-of-Hospital Cardiac Arrests

One of the Department of Health's core business areas is Emergency Health Services. A desired outcome in this area is ensuring the effectiveness of Emergency Health Services in the management of out of hospital cardiac arrests.



What Does the Measure Tell Us?

A measure of the effectiveness of emergency health services is survival from out-of-hospital cardiac arrest. Many factors affect out-of-hospital cardiac arrest survival such as whether the arrest occurs in public, whether the victim is witnessed and receives bystander CPR and the timing of defibrillation.

Where Are We Now?

In 2005, the provincial survival rate for out-of-hospital cardiac arrests (OOHCA) was 3.3 per cent. This is down slightly from 3.8 per cent in 2004. It is difficult to compare Nova Scotia's system with other systems because of the different mixes of urban, suburban and rural areas. Most systems reporting survival rates are urban only systems. However, it is possible to compare Nova Scotia's out-of-hospital cardiac arrest survival rates over multiple years. The variation in this measure from year to year is considered to be within the normal range.

Where Do We Want to Be in the Future?

Nova Scotia's goal is to continue to improve survival rates for out-of-hospital cardiac arrests over time. With the involvement of stakeholders, strategies to achieve this target include ongoing training, procedural review and development, the development of a bystander care initiative, and the continuing encouragement of organizations, businesses and public buildings to stock automatic external defibrillators.