NOVA SCOTIA
Department of Health

DEPARTMENT OF HEALTH

ANNUAL ACCOUNTABILITY REPORT FOR THE FISCAL YEAR 2006-2007

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Annual Accountability Report for the Year 2006-2007

Department of Health

Accountability Statement

The accountability report of the Department of Health for the year ended March 31, 2007, 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 2006-2007. The reporting of Department outcomes necessarily includes estimates, judgments and opinions by Department management.

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

The Honourable Chris d'Entremont
Minister of Health

Cheryl A. Doiron
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 2006-2007.

The health needs of Nova Scotians are constantly changing. Compared to 20 years ago, it's now much more common for citizens to access their health care from an integrated team of professionals in their community.

I'm proud to tell you that we're making significant inroads into moving services out of the hospital and into the community, closer to where patients and their families need them. That is evident in the results you will see from many of our core business areas, including Primary Health Care, Mental Health, Children Services & Addiction Treatment, and Continuing Care. Likewise we are taking steps to offer acute care services closer to home for patients and their families. One great example of this approach is in the expansion of oncology services to various sites across the province, including a new oncology clinic for the Annapolis Valley.

In continuing to improve our responsiveness to the health needs of Nova Scotians, we've also moved ahead with cultural and social diversity projects this past year, including educational and other resources for health care providers, districts, and others.

This past year also saw great success in implementing and expanding electronic systems and services, to better support health care providers. For example, 260 new users began working with the Primary Health Care Information System Program, and the province became one of the first in the country to go film-free for diagnostic imaging services with the completion of the Picture Archive Communications Service (PACS).

And yet with all this progress, we still face many challenges in our health care system, not unlike every other province in the country. We are constantly recruiting health care staff. We are constantly working to improve access and wait times.

Nova Scotia is aggressively tackling all of these challenges. We're competitive and successful in training and retaining our nurses and recruiting specialties like diagnostic imaging technicians and anesthesiolgists. We are reducing waits and travel time for patients who need important diagnostic tests with the introduction of six new MRIs across the province over the last year.

It is accomplishments like these, and many others that you will read about in this report, that will allow us to continue to provide the health services needed, to help generations of Nova Scotians to live well in this beautiful province.

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 2006-2007 fiscal year. This report should be read in conjunction with the 2006-2007 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 2006-2007, 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, and care for people of all ages and cultures in their communities, and the appropriate use of technology.

Mental Health, Children Services & Addiction Treatment

The Mental Health, Children Services & Addiction Treatment Branch is responsible for policy, standards, monitoring and funding of Mental Health, Children Services & Addiction Treatment. Mental Health, Children Services & Addiction Treatment 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, Children Services & Addiction Treatment, and
- community supports.

Specialty Mental Health, Children Services & Addiction Treatment include seniors' mental health, eating disorders, adult and youth forensic services, sex offender treatment, early psychosis, and neurodevelopment services. Services are consumer and family-focused, and community-based where possible. Some Mental Health, Children Services & Addiction Treatment 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 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.

[1] Victorian Order of Nurses

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 2006-2007

Primary Health Care

Priority	Accomplishments
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 reported to the Department of Health in June 2005 with recommendations aimed at developing the legislation and infrastructure needed to support interdisciplinary primary maternity care models. The aim in 2006-2007 is to introduce legislation to regulate the practice of midwives in Fall 2006.	A Legislation Committee was formed in 2005 to enable work on midwifery legislation to proceed. Based on that work, the Department of Health introduced legislation in Fall 2006 to regulate the practice of midwifery in Nova Scotia. Work began and will continue to implement a regulatory framework for midwives as well as the integration of midwives into interdisciplinary teams to deliver primary maternity care in Nova Scotia beyond 2006-2007. This will result in a comprehensive range of care aimed at reducing health disparities and inequities, and improving health outcomes.
Primary Health Care Evaluation Complete and disseminate the evaluation framework for Primary Health Care by March 2007.	A final evaluation framework entitled, "A Primary Health Care Evaluation System for Nova Scotia" was presented and forwarded to DoH Primary Health Care Section in October 2006. The final report included an executive summary, context and approach, indicator development process, data infrastructure, development of data collection tools, system development, conclusion and recommendations for next steps to implement the evaluation framework. This report was shared with the DHAs and the PHC Evaluation Working Group.
Primary Health Care Renewal Support the leadership infrastructure within the DHAs to change to a coordinated primary health care system. This includes program planning, development and implementation, partnership development, and physician engagement. The Department will continue to provide resources to sustain existing Electronic Patient Record (EPR) operations, including leadership for provincial coordination, decision support and data	Sustainable funding for the DHA leadership infrastructure was secured for 2006-2007 and enabled DHAs to establish permanent positions to support Primary Health Care. In addition to these positions targeted funding for physician engagement supported the continuing work required to prepare for and support new and expanded PHC teams. DHAs are also working with physicians on the change management, consultation and team development required to

Priority	Accomplishments
governance, training and the development of best practice tools.	support change in Primary Health Care.
Electronic Patient Records The implementation of the Nova Scotia Primary Health Care Information System Program (PHIM) is a first step in the development of shared electronic health records across levels of care. In 2006-2007, the program's immediate goal is to increase the number of primary health care providers using electronic patient record (EPR) systems. PHIM 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. Federal funding for the PHIM Program terminated with conclusion of the PHCTF in October 2006. The Nova Scotia Department of Health has made the decision to sustain the hosting of this successful program beyond the PHCTF initiative.	During 2006-2007 the rollout of the PHIM Program proceeded to provide a provincial primary health care information management program in which providers can participate. During this time the hosting environment and provincial help desk continued to be provided to make this an operational service for participating clinics. Stakeholder engagement activities were held to inform primary health care providers about the program. Health transition funds were made available to encourage participation in the program. In 2006-2007, 260 new users in 30 clinics started using the software. By March 2007, 36 clinics were actively using the system with 22 other clinics preparing to participate in the program. The PHIM Program continued to provide change management tools and education services to enhance the effectiveness of the program for participating clinics. These change management support tools have been streamlined with the learning gleaned from each implementation. In August 2006 the electronic transfer of laboratory and Diagnostic Imaging results from Nova Scotia's three acute care systems to the PHIM program was formally launched. 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; making Nova Scotia the first province to provide this service from all acute care facilities to all provincially approved EMRs. At the end of March 2006, 54 physicians were receiving electronic results. Streamlined implementation processes for clinics participating in the PHIM Program continued to

Priority	Accomplishments
	be provided to facilitate a smooth transition. 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.
Collaborative Practice Teams ***Enhanced Teams and Primary Health Care Nurse Practitioner Positions*** There is a Blueprint commitment to support the formation of interdisciplinary teams of primary healthcare providers, including Nurse Practitioners. Evidence suggests that collaborative teams are better able to deal with the increasing complexity of care, increase focus on health promotion and disease prevention, coordinate and meet needs of the population being served in a cost effective way. DHAs have identified populations and practices that would benefit from a team approach. The Department will support increasing the number of interdisciplinary teams of primary health care providers so Nova Scotians have equitable access to high quality, comprehensive care. Each DHA will implement new models of care delivery that meet the needs of the defined population, and residents will have reasonable access to multidisciplinary teams.	The Department of Health continues to work with District Health Authorities to promote and support the formation and implementation of interdisciplinary teams of primary health care providers. During the 2006-2007 fiscal year, three proposals for new and expanded teams were approved with the remaining proposals being held over for funding in 2007-2008. This process saw the approval of funding for two new nurse practitioner positions, resulting in a total of 21 primary health care nurse practitioner positions across Nova Scotia. In addition, one new family practice nurse and a community health nurse were approved through the proposal process. These positions will contribute to the implementation of new models of care delivery and increased access to multi-disciplinary teams.
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	Accomplishments of the Diversity and Social Inclusion in Primary Health Care Initiative have included the development of 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 that are in use and will be used beyond 2006-2007 include: • *The Cultural Competence Guide for Primary Health Care Professionals*; and • *Cultural Competence for Primary Health*

Priority	Accomplishments
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 2006-2007 will include prioritizing and implementing the guidelines for *Diversity and Social Inclusion in Primary Health Care*.	*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 2006-2007 include partnering with DHAs, completing the delivery of the continuing professional education modules by September 2006 and continuing to negotiate the sustainability of these modules with partner agencies such as universities.	BBTI modules continued to be delivered throughout the province and included Understanding Primary Health Care, Building Community Relationships, Team Building, Conflict Resolution, Facilitating Adult Learning, Electronic Patient Record, and Program Planning & Evaluation**.** Six hundred and eighty three educational modules were delivered to 8,891 health professionals in Atlantic Canada. Seven hundred and fifty-one joint Dalhousie/Memorial University Certificates were also issued to each participant completing five core training modules. A meeting was held with the University partners to continue the certification process until March 31, 2007. A final evaluation report for BBTI was prepared and submitted by Memorial University in September, 2006. 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.
Health Literacy Awareness In 2006-2007, 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	*Health Literacy Making the Connection DVD* has been an important tool to advance the understanding of literacy as a determinant of health. The DVD highlights the impact of limited literacy on health and suggests ways in which health providers can provide health information and advice in ways that people with different levels of literacy can understand. In 2006, Primary Health Care (PHC) section continued to

Priority	Accomplishments
care providers of literacy issues, as well as strategies to improve the understanding and use of health information by patients.	disseminate the DVDs. To date, over three hundred DVDs have been distributed to primary health care settings as well as educational institutions within and beyond Nova Scotia. The *Health Literacy Intersectoral Action Strategy Planning Workshop* was held in May 2006. The purpose of the workshop was to bring stakeholders together to learn about and celebrate existing work in health literacy and to consider what actions are necessary in moving an intersectoral strategy forward. To follow through on the workshop suggestions, a Health Literacy Working Group with representation from the Department of Health, Department of Health Promotion and Protection, Department of Education and the Senior's Secretariat was initiated in August 2006. The main objective of the Working Group is to develop a draft provincial framework for a provincial health literacy strategy, share it with key stakeholders and coordinate and facilitate the implementation of the strategy.
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	The Primary Health Care Transition fund ended in September 2006, with final reporting and a closing conference in Ottawa in February 2007. Nova Scotia's share of this fund was 17 million dollars. Many accomplishments were achieved over the four year life of the fund, both in DHAs and at the provincial level. Accomplishments included introduction of an electronic medical record in primary care, with over 25% uptake in the first year. Other provincial initiatives, Health Literacy, Diversity and Social Inclusion and Evaluation are reported on separately. Over the course of this fund, DHAs have been enabled to develop new models of care that have increased Nova Scotian's access to a number of Primary health care providers. The final report submitted to Health Canada can be accessed through the Primary Health Care branch.

Mental Health, Children Services & Addiction Treatment

Priority	Accomplishments
Standards An amount of $1,000,000 will be invested in 2006-2007 to continue implementation of provincial mental health standards. • Continue to implement core and specialty mental health standards that will improve the quality of Mental Health, Children Services & Addiction Treatment across the life span.	The Mobile Crisis service offered by the Capital District Health Authority was expanded to include the IWK Health Centre. Additional enhancements to this service were also made across the province. Enhancements were also made to case management services. Regulations related to the Involuntary Psychiatric Treatment Act were developed and education for provincial stakeholders was provided. Enhancements were made in the area of Education. Specifically, an investment in the RN-PDC (Registered Nurse Professional Development Centre) for the development and implementation of the Psychosocial Rehabilitation Module.
Improving the Quality of Mental Health, Children Services & Addiction Treatment The Health of the Nations Outcome Scale (HoNOS) will provide the Department of Health and the DHAs and the IWK Health Centre with outcome measures and indicators for monitoring Mental Health, Children Services & Addiction Treatment. The HoNOS is now a standard component of clinical practice in many parts of the United Kingdom, Europe, and Australia. • Continue implementation of the 2005-2006 plan to monitor the quality, appropriateness and effectiveness of Mental Health, Children Services & Addiction Treatment. DHA/IWK Mental Health Profiles, performance indicators for in-patient services, and expanded technology to support the local analysis of ambulatory health care information will be used for monitoring. • Initiate a one-year demonstration of the new approach to outcome measurement as part of this monitoring plan.	The Mental Health Outpatient Information System was reviewed by external consultants with a recommendation to implement a new system. The one-year demonstration project was completed with a recommendation to implement the tool province-wide pending funding.

CHOICES Relocation This move will align services for children and youth up to their 19th birthday with the Mental Health and Youth Forensic programs already at the IWK Health Centre. This will allow for clinical capacity building and clinical efficiencies. The relocation will also provide a much improved physical facility that has been renovated to meet the needs of clients and staff. • Relocate CHOICES from Capital Health to the IWK Health Centre.	On April 1, 2006, CHOICES officially came under the responsibility of IWK. In August of 2006 the CHOICES program moved into its new home at the corner of Barrington and Morris Streets in downtown Halifax. It has been integrated into the Mental Health Program at the IWK Health Centre and is managed by the Mental Health and Addictions Program senior director.
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 Health Centre and the Nova Scotia Hearing and speech Clinic. • Recruitment and training of therapists will be a priority in order to maintain standards and ensure evidence-based practices.	The EIBI Program has been implemented in 8 DHAs and at the IWK. Teams are now trained in the treatment model and ongoing collaboration is occurring with Child Care Programs, Early Intervention Programs and local school boards. A graduated treatment model has been introduced to ensure that as many children as possible are able to take advantage of this Program. As of February 29, 2007, there were approximately 55 children involved with the Program. New children become involved with the program on a regular basis. The multi-disciplinary teams consist of psychologists, speech language pathologists and/or, occupational therapists and/or, social workers and individuals working one-on-one with children and families. There has been some challenge in recruiting these disciplines however, every team has a master's prepared clinician acting in a supervisory capacity with those working one-on-one with the children and families. A train-the-trainer model has been adopted. We have capacity within the province to provide ongoing training for teams and families. In addition, professional development opportunities are offered to teams at least yearly.
Mental Health Legislation Funding for implementation of Mental Health Standards will assist with implementation of the Assertive Community Treatment Teams (ACT Teams), as required by the new legislation. • Develop regulations for the new mental health	The Department is awaiting government approval for the regulations and a date for proclamation of the Act.

act, the Involuntary Psychiatric Treatment Act, approved in the fall of 2005 and expected to be proclaimed in the spring of 2006.	
Labour Market Agreement for Persons with Disabilities • Continue to evaluate the effectiveness of Addictions Services in addressing vocational crisis and client employability. The impact of addictions treatment on employability is well documented.	An evaluation of the impact of addiction services on the employability of clients was undertaken by a consultant. The final report was received February 2007. Approximately, 41% of adults reported benefits to their employability as a result of addiction treatment; meaning Addiction Services helped clients maintain employment and/or helped clients obtain employment. This finding is important because it demonstrates that participation in Addiction Services contributes significant cost saving to society.
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* was published, including standards for methadone maintenance treatment services. Direction 180 provides timely access to treatment, reduces incidences of blood borne pathogens (i.e. Hepatitis B, Hepatitis C, and HIV), and improves client safety. • Support Capital Health's Direction 180 methadone treatment program	Funding was provided to Capital Health for Direction 180 in the amount of $400,000 to enhance the delivery of 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. • Prepare a provincial report on the impact of enhanced addiction services for women and youth	The provincial report is delayed until ASsist (client information system) is stabilized and the reporting function completed.
Client Information System for Addiction Services This collaborative effort between the Department of Health and the DHAs will provide both with	All DHAs and IWK have implemented ASsist. The reporting function of ASsist will be ready for use by December 2007.

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. • Continue implementation of a provincial client information system for Addiction Services.	
Youth at High Risk Initiative This is an initiative shared between the Departments of Health and Community Services to develop and enhance services to youth at risk and their families. This initiative will also require strong linkages with the Departments of Education, Justice, and other community stakeholders. • Work collaboratively on the Youth at High Risk Initiative	With the release of the Nunn Commission Report in December 2006 and the Government's Response released in January, 2007, the Youth at High Risk initiative is now being captured in the Child and Youth Strategy with anticipated release in the fall of 2007. The Nova Scotia Crime Prevention and Crime Reduction Strategy are to be released later in the fall of 2007.

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. Beginning in June 2006, the budget for operational costs for this equipment is $3,000,000 for this fiscal year. • Support the implementation of new Magnetic Resonance Imaging (MRI) scanners to four sites in rural Nova Scotia: New Glasgow, Antigonish, Kentville, and Yarmouth • Provide replacement scanners to the QEII Hospital in Halifax	MRI services became operational in Yarmouth in September 2006; New Glasgow in February 2007; Kentville in March 2007; and is scheduled for Antigonish in April 2007. The existing unit at the Victoria General Site in Halifax was replaced and the new equipment became operational in March 2007. Site preparations for the installation of the second replacement unit at the Halifax Infirmary Site are in progress and scheduled to open Summer 2007. Funding to support the operational costs of the four new sites was in place.
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. • Partner with the Heart and Stroke Foundation, health providers, researchers and the DHAs to continue to plan provincial approaches to stroke and heart disease prevention and outcomes improvement	A stroke pilot in South West Nova District Health Authority is underway. The first phase of the evaluation is completed and informing planning for system-wide provincial enhancement for the prevention and management of stroke care.
Dialysis Program Expansion The model will target improved care, coordination and access to satellite dialysis services. A profile will be developed that will inform development of a provincial approach to renal care. The Provincial Dialysis Group has identified four priorities: infrastructure, satellite dialysis programming, peritoneal dialysis, and risk modification. • Pilot a new service delivery model in Antigonish	A satellite dialysis pilot opened in Antigonish in January 2007. A new Provincial Renal Program was also established.
Hospital Additions and Renovations • Complete the Cape Breton Regional Hospital Renal Dialysis Expansion, Dartmouth General Hospital Renal Dialysis Unit and the IWK Parkade and Research Building	Completion of the Cape Breton Regional Hospital Renal Dialysis Expansion, Dartmouth General Hospital Renal Dialysis Unit and the IWK Parkade and Research Building were completed prior to 2006-2007.

Priority	Accomplishments
• Design work for the Queens Hospital Primary Care Building, the Halifax Infirmary Emergency Department Expansion, the replacement of Colchester Regional Hospital, and the major upgrade to the IWK Health Centre, Children's Site continues • Continue to build a third operating room at the Cumberland Regional Health Care Centre in Upper Nappan • Continue the phased renovation of the Lillian Fraser Memorial Hospital in Tatamagouche to facilitate the delivery of multidisciplinary primary health care services • Renovate St. Martha's Hospital by 2009	Queens Hospital Primary Care Building - Primary Healthcare planning is ongoing. Project planning was expanded to include renovations of the medical unit in hospital. Halifax Infirmary Emergency Department Expansion – planning and design work continues. IWK Health Centre, Children's Site – work on inpatient area and planning of perioperative services is ongoing. Colchester Regional Hospital – design work initiated by WHW architects and preliminary costing prepared in Fall 2006 indicating that project costs would exceed the original $104 million budget. The Department, the District and independent consultants reviewed the project to contain costs without impacting service requirements, given that the project ran over budget. Cumberland Regional Health Care Centre – the third operating room was completed in Fall 2007. Lillian Fraser Memorial Hospital – the contract for design services was awarded to William Nycum and Associates in July 2006. Design work was started on the project and the planning committee submitted a Primary Care Program Proposal to the Department for Review. This Program Proposal was accepted by the Primary Health Care Branch and is informing the renovation designs of the hospital. In addition, there was an additional $1 million allocated to this project to upgrade the mechanical and electrical systems for the building. St. Martha's Hospital Renovations – renovations to the education area and chapel were completed September 2006. Renovations to the Martha Centre, completed in March 2007, allowing for the relocation of Nova Scotia Hearing & Speech, Addictions Services and Child/Youth Mental Health, Children Services & Addiction

Priority	Accomplishments
	Treatment. Renovations for the expanded Emergency Department began in February 2007.
Alternate Levels of Care Patients in Acute Care In collaboration with Continuing Care, the DHAs, and the Department of Community Services, develop and pilot innovative community-based strategies to transition acute care patients/clients to appropriate community settings.	All DHAs have initiated community based projects ranging from Seniors response teams, adult day programs, geriatric assessment and treatment programs to supports for the caregivers in an effort to keep the elderly out of hospital. In 2007-2008 DHAs will share their successes and challenges in implementing their initiatives with the Department.
Provincial Approach to the Management & Monitoring of Systemic Cancer Therapy It is expected that a coordinated effort by the Department of Health, Cancer Care Nova Scotia, and the DHAs will improve the ability to anticipate cost pressures and to better manage overall costs. This committee began in June 2005. • Continue implementation of a coordinated provincial approach to the management and monitoring of systemic cancer therapy	A provincial committee was established and began operating with a mandate to approve or not approve new oncology drugs within a $6.7 million budget.
Provincial Approach to Organ and Tissue Donation A QEII-based management team and a 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. • Further implement components of the provincial approach to increasing organ and tissue donation	An Organ and Tissue Provincial Program was established and included the development of a provincial advisory council. Expected outcomes to this approach include: - increase the number of individuals who choose to donate - increase the number of potential donors approached to donate - increase donor and family satisfaction - create a Nova Scotia legislative framework for organ and tissue donation
Physical Rehabilitation for Children with Disabilities Provincial funding in 2006-2007 will enable the IWK Health Centre to initiate collaborative services in the DHAs. Funding for these services began in 2004-2005. The IWK has been working with the Guysborough Antigonish Strait Health Authority and, most recently, South West Health, as part of a plan to reach out to all district health	Phase III of implementation process is underway, including continued work with DHAs to enhance outreach partnerships and facilitate the inclusion of all DHAs in a more timely manner. IWK is continuing to recruit occupational therapists and physiotherapists to improve access to pre-school and school-based services.

Priority	Accomplishments
authorities. • Support continued implementation of physical rehabilitation services for children with disabilities, using a three-year, phased-in approach	
Centralized Intra-Venous Admixture and Unit Dose Drug Distribution at the IWK The system will improve patient safety and contribute to service efficiency. • Continue to implement the Unit Dose Drug Distribution System at the IWK Health Centre to address concerns raised by accreditation surveyors and third-party consultants	Implementation of a Centralized Intra-Venous Admixture (CIVA) and Unit Dose Drug Distribution system continued. Progress included the operationalization of a Drug Information Service; implementation of seven day centralized services to the neonatal intensive care unit; installation of a Pyxis MedStation in the Emergency Room; the purchase of a unit dose packager; and, initiation of strip packaging of solid dosage forms.
A Sound Start for Hearing and Speech There is clear evidence that early detection and treatment of hearing disorders improves the development of speech, language and literacy skills. A further $700,000 has been invested into this program this year. • Extend access to universal newborn hearing screening services beyond the Halifax area to Nova Scotia Hearing and Speech Centres across the province	Funding received in 2006-2007 supports the full implementation of *A Sound Start*, to provide earlier access to preschool speech and language services and hearing screening for all babies born in Nova Scotia hospitals. Recruitment of new clinical staff and related facility planning is ongoing as a major component of this initiative. Clinical implementation of *A Sound Start* involved technology acquisition and training for the Newborn Hearing Screening component (completed September 2006). Full-time screening coverage (seven days a week) was established at the IWK Health Centre resulting in 96% of babies being screened prior to discharge. Universal newborn hearing screening commenced in six birthing hospital sites throughout the province in January 2007.
Integration of Mammography Services The program provides access to mobile screening services to all residents of Nova Scotia. This will improve wait times for both screening and diagnostic testing and provide more accurate information on screening rates in the province. • Integrate the last two fixed breast-screening sites into the Nova Scotia Breast Screening Program	All fixed breast screening sites are now integrated into the Nova Scotia Breast Screening Program. Following the decision to move to digital mammography equipment for both fixed and mobile sites throughout the province, a Provincial Mammography Equipment Committee was established. This committee will plan for implementation of full field digital mammography across Nova Scotia over the next five to seven years.

Priority	Accomplishments
	A 6 month Pilot Project involving fixed digital sites at Yarmouth Regional Hospital and Cobequid Community Health Centre. A full field digital mobile unit in Cape Breton will start in June 2007 to identify and resolve implementation issues. 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 The provincial approach is being established through a Provincial Infection Control Consultant who will develop and implement an infection control framework. This is a three-year strategy that will be evaluated in June 2008. • Continue to establish a provincial approach to infection control	A concept document was developed and provided to service delivery providers for feedback. The Department expects to obtain stakeholder feedback and concept revisions, as required, by September 2007.
Pain Management Strategy The Working Group will recommend a service delivery framework and an implementation plan to the department. • Establish a Provincial Pain Management Working Group to develop a pain Management strategy	The Provincial Pain Management Working Group met for 6 months and developed the Action Plan for Chronic Pain Management Services in Nova Scotia. This Action Plan was approved and funded by government at $1 million per year in August 2006. The Provincial Implementation Committee for Chronic Pain Services was developed to implement the Action Plan over the next 2 years. The Action Plan called for enhancement of existing chronic pain services in Capital District Health Authority and Cape Breton District Health Authority and allocated funding for 2 new secondary and 3 new primary pain services in the rest of the province. New sites include – a secondary service in South West District Health Authority, a primary service in Annapolis Valley District Health Authority, and a joint service offering both secondary and primary services in Colchester East Hants District Health Authority, Cumberland District Health Authority, Pictou

Priority	Accomplishments
	District Health Authority, and Guysborough Antigonish Strait Health Authority. Anticipate the new clinics will open in Fall 2007. The implementation of new clinics will reduce wait lists for pain services and provide services closer to home for clients.
Provincial Health Services Operational Review The review will provide a foundation on which to examine operational efficiencies to advance service and to improve system access to patients. The findings will be used to develop a strategic plan for the province's acute and tertiary care system in 2007. • Conduct a comprehensive provincial health services operational review of the DHA delivery system in cooperation with the DHAs and the IWK Health Centre.	A comprehensive review of both the DHA/IWK delivery systems and all provincial programs was conducted. A draft report and recommendations are currently in progress.

Pharmaceutical Services

Priority	Accomplishments
Prescription Monitoring Program (PMP) Renewal Pharmacies across Nova Scotia are making changes to their pharmacy software systems to enable them to link to the PMP system. This will decrease information delays experienced with the manual PMP system that was implemented in 1992. The *Prescription Monitoring Act* and Regulations were proclaimed in July 2005 to provide legislative authority to monitor the prescribing, dispensing and utilization of a specific list of drugs. This will improve effectiveness in dealing with drug abuse. A Prescription Monitoring Board was appointed and a computerized information system has been implemented to support the new, electronic PMP system. • Electronically link all pharmacies to the Prescription Monitoring Program (PMP) system	In January 2007 the PMP Board began a board governance and strategic planning process that resulted in approval of a three-year strategic plan in June 2007. Work is well underway to meet the year-one outcomes. In May 2007 The Nova Scotia College of Pharmacists notified all pharmacies and pharmacists that all pharmacies must be electronically linked to the PMP by December 1, 2007 in order to continue their accreditation as a pharmacy licensed by the College. Therefore, by December 1, 2007 Nova Scotia will benefit from the full functionality of the PMP's computerized information system.
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. • Support the Common Drug Review (CDR) 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 • Continue to refocus the Atlantic Common Drug Review to provide expert advice in areas not covered by the CDR such as drug class reviews and drugs with new indications.	Nova Scotia continues to support the CDR. In 2006, 26 recommendations were made on new drug therapies. Of these, 25 were accepted and implemented in Nova Scotia.

Drug Evaluation Alliance of Nova Scotia (DEANS) Areas of focus in 2006-2007 include management of chronic non-cancer pain, acute coronary syndrome and the appropriate use of proton pump inhibitors for gastrointestinal problems. • Lead and support the Drug Evaluation Alliance of Nova Scotia (DEANS). DEANS identifies drug utilization issues; develops targeted interventions for health care professionals and consumers; and evaluates the impact of interventions	A multi-faceted, interprofessional educational intervention on the management of chronic non-cancer pain is being implemented across Nova Scotia. The Academic Detailing Service has delivered information on *Clopridgrel: Dual and Mono (in acute coronary syndrome)* during educational visits to prescribers across Nova Scotia. Funding has been allocated to do an academic detailing intervention, a pharmacist intervention and a nursing intervention on the COMPUS best practice statements on proton pump inhibitors (PPI) statements beginning in the fall 2006-2007.
Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) COMPUS strengthens DEANS ability to collaborate with other best practice groups across Canada and internationally, and supports federal, provincial, and territorial (F/P/T) jurisdictions in promoting best practices for drug prescribing and utilization. The three initial topic areas for COMPUS include: proton pump inhibitors (for treatment of gastrointestinal problems); diabetes management; and anti-hypertensives (drugs used to lower blood pressure). COMPUS is expected to provide jurisdictions with a toolkit on the first of these priority areas (proton pump inhibitors) by mid-2006. • Review and adopt recommendations of the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS)	COMPUS was delayed in getting final recommendations to the provinces. In September 2007, the Atlantic Expert Advisory Committee will review the COMPUS statements on the proton pump inhibitors (PPIs) and recommend changes to the Pharmacare coverage criteria to make them consistent with the COMPUS PPI statements. In conjunction with the policy change announcements, the Drug Evaluation Alliance of Nova Scotia (DEANS) will coordinate interventions to promote the relevant COMPUS best practice statements on PPIs.
Assistance Program for Low Income Nova Scotians with Diabetes During 2005-2006, an income-based program targeted to families with low incomes and no prescription drug coverage was introduced. The new program covers insulin, oral diabetic drugs, glucose test strips, syringes, needles and lancets as listed on the Nova Scotia Formulary. • Provide diabetes self-management materials to clients and conduct a program evaluation	The Nova Scotia Diabetes Assistance Program currently assists approximately 2000 Nova Scotians with diabetes. The program was automated in May 2006 reducing up front out of pocket costs for families and simplifying claims administration.

• Continue development and introduce technology to allow electronic adjudication of claims	
National Pharmaceutical Strategy (NPS) The National Pharmaceutical Strategy will be presented to the First Ministers by June 2006. This Task Force was asked to focus on issues related to five national priority areas: • Catastrophic drug coverage (CDC) • Expensive drugs for rare diseases (EDRD) • Pricing and purchasing of drugs • Real world safety and effectiveness of drugs • Common national formulary	CDC – Methodology and costing are being refined and broad stakeholder engagement has begun. EDRD – Components of an EDRD framework have been identified. Costing and consultation are underway. Pricing and Purchasing – Business case is being developed to facilitate improved purchasing/pricing strategies. Real World Safety and Effectiveness – Business case that addresses existing evidence gaps has been completed. Common National Formulary – Comparing provincial formulary policy to identify best practices. The National Pharmaceutical Strategy was presented to the First Ministers in June 2006. A report was delivered in June 2006 to the First Ministers titled, National Pharmaceuticals Strategy: Progress Report, Defereal/Provincial/Territorial Ministerial Task Force on the National Pharmaceuticals Strategy.

Physician Services

Priority	Accomplishments
Enhanced Accountability with Alternative Funding Plans Approximately 40 per cent of physicians are remunerated through some form of alternative to traditional "fee-for-services" funding. An 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. • Implement the new Alternative Funding Plan (AFP) framework to all AFP renewals and new AFPs, develop a strategy for future AFP deliverables, and ensure that all contracts have associated deliverables	Significant progress was made as three separate Academic Funding Plans (AFPs) were converted to the new Alternative Funding Framework. Each of these performance contracts have specific and measurable target deliverables for both clinical and non-clinical (ie. academic and research) activity. Among these three was the single largest AFP, the Department of Medicine at the Capital District Health Authority (CDHA), as well as two groups of Anaesthesiologists (the QE2 group and the IWK Women's group). Regular performance management meetings involving the key stakeholders including Dalhousie Faculty of Medicine, CDHA, IWK, the relevant physician departments, Doctors Nova Scotia, and the Department of Health have taken place accordingly.
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. • Develop a physician resource plan for specialists and general practitioners within the context of clinical services planning	At the provincial level, iterative physician resource plans and planning processes evolved in 2006/2007 for Family Medicine, Urology, Pediatrics, and community-based geriatrics. Under the Foundational Services policy initiative, proposed plans for regional anaesthesiology, general internal medicine and general surgery were developed for the appropriate DHAs. Most of the DHAs have physician resource plans in place. Both the CDHA and the IWK submitted comprehensive physician resource plans to the Department of Health in 2006/2007.
Physician Recruitment Strategy Development The Department of Health's role in physician recruitment is to inform, support, and provide districts with the tools to recruit required physicians. • Develop a physician recruitment strategy to maximize physician recruitment activities for areas of need	As a whole, Nova Scotia remains an attractive place for physicians and successful recruitment and retention efforts were realized as a result of existing strategies. Added components to the existing strategies included the addition of nine medical residency positions at Dalhousie University,

Priority	Accomplishments
	eight of which had return of service obligations, as well as continued support for the Clinician Assessment for Practice Program (CAPP).

Continuing Care Services

Priority	Accomplishments
Strategic Framework for Implementation Plan Work began on the Strategic Planning Framework in 2005-2006 to enable the Department to validate current services, identify and examine service delivery alternatives, and develop appropriate legislation accordingly. In 2006-2007, the Department will present final recommendations of the Strategic Planning Framework for continuing care services to the Minister and begin work on an implementation plan.	The *Continuing Care Strategy for Nova Scotia: Shaping the future of Continuing Care* was released in May 2006. The 10-year strategy outlines the direction government will take to achieve its vision "to have Nova Scotians live well in a place they can call home". The document focuses on five key action areas: 1. Supporting Individuals and Families 2. Supporting Community Solutions 3. Investing in Providers 4. Strengthening Continuing Care Services 5. Investing in Infrastructure Since its release a number of initiatives have been completed: • **Self-Managed Care** (December 2005) Program introduced by DoH which helps those with physical disabilities increase control over their lives by providing funds to eligible individuals so that they may directly employ care providers for the purpose of meeting approved service needs. • **Home Adaptations Repairs** (November 2006) Approved transfer of $1 million budget to DCS to build on current success of the Senior Citizens Assistance Program whose mandate is to carry out repairs threatening the health or safety of the 65+ population. • **ALC/ER Backlog** (November 2006) Provided additional funding from the budget to the DHAs for new community-based initiatives to address pressures resulting from Alternate Levels of Care. • **Palliative Care Entitlements** (March 2007) Implemented palliative home care services across the province including home support and nursing services specific to supporting the client and family during the last three months of life. • **Home Oxygen Expansion** (April 2007) Began funding the provision of in-home oxygen concentrators and related supplies to individuals

Priority	Accomplishments
	with a medical need for oxygen supplementation. Services are delivered through approved and contracted oxygen vendors. • **Primary Care in Long-term Care** (Medical Director Pilot, Oceanview Manor) Appointed a full-time physician to provide appropriate levels of medical care to meet the needs of the patients in Oceanview Manor. This includes medical care as well as facilitating transfers to hospital and liaising with hospital physicians as required. • **Investing in Infrastructure** In January 2007, the Minister of Health announced the creation of 832 additional long term care beds to be in place by 2010 throughout the province. The first of the new beds were opened in the Capital District Health Authority in August 2007.
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. The Department will continue to develop a strategic plan for continuing care information management.	Recommendations have been presented and approved by the Continuing Care Leadership Team. The final draft of the Information Management strategy has been sent for feedback before its release internally. The strategy was developed using a comprehensive consultative approach that involved: • a review of the Continuing Care Business Strategy and Vision; • interviews and discussions with a variety of Continuing Care stakeholders; • questionnaires completed by a subset of Continuing Care stakeholders; • input from other jurisdictions that brought "best practices" considerations; and • periodic reviews and feedback sessions with the project's governing and advisory bodies.
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 is providing a concentrated and coordinated approach for the recruitment of Continuing Care Assistants (CCAs) in collaboration with partners.	The demand for CCAs to assist in meeting the health care needs of Nova Scotians continues to increase significantly due to planned expansions to home care, increases in long term care beds under the Continuing Care Strategy, the implementation of CCAs in acute care facilities, and changing demographics. Recognizing these changes, and in response to stakeholders' requests, the Continuing Care Branch provided a

Priority	Accomplishments
	concentrated and coordinated approach for the recruitment of CCAs in collaboration with partners. These initiatives include providing $600,000 each year in CCA student return for service bursaries, the establishment of a Recruitment and Prior Learning Assessment Recognition Coordinator position with the CCA Program Advisory Committee, and sponsoring a Recruitment and Retention tools workshop for the Sector by NSAHO. All of these initiatives are aimed at helping the sector meet the increasing need for CCA recruitment.

Emergency Health Services

Priority	Accomplishments
Emergency Pre-Hospital Services Pre-hospital services will be delivered to meet targets set out in legislation and contracts governing the delivery of emergency health services. • Emergency out-of-hospital services will be provided across the province and will include communications/dispatch, ground ambulance, air medical transport, medical oversight, trauma, medical first response and emergency preparedness.	Performance targets for response times were met and exceeded in 2006/2007.
Emergency Preparedness and Response Plans will focus on an "all hazards" approach to address threats of CBRNET (chemical, biological, radiological, nuclear, explosive and terrorist), world economic uncertainty, weather-related and other natural disasters and infectious diseases (e.g. SARS, BSE, WNV[1], pandemic influenza, etc.). The Department of Health's emergency preparedness and response planning spans the health sector and integrates with plans in health service delivery organizations, the provincial Emergency Management Office (EMO), Health Canada, and other provincial government departments. • Continue developing plans for a comprehensive emergency preparedness response across the health sector.	Emergency Health Services completed development of the Health System Pandemic Plan. EHS was involved in the departmental development of a Business Continuity Plan for a comprehensive emergency preparedness response. The Health Emergency Management Centre was successfully transitioned to a new organization.

[1] Severe Acute Respiratory Syndrome, Bovine Spongiform Encephalopathy, West Nile Virus

Information Standards, Services and Solutions[2]

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
Health Information Management: 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 and support systems that move Nova Scotia closer to the vision of an Electronic Health Record. In order to establish long term objectives for Health Information Management, the Department plans to develop a Long Term Strategic Plan for Information Technology and Information Management. Funding of health information management initiatives will be pursued through short term opportunities provided by Canada Health Infoway and collaborative opportunities with Health Infostructure Atlantic (HIA).	The Department of Health continued to work with and provide funding for several DHA initiatives during the 2006-2007 fiscal year including the AVDHA Surgical Information System Implementation and Provincial Food & Nutrition System Planning. The Department approved the strategy priorities and has begun the process to define them. The IS3 Branch will begin planning to align with the Departmental strategic priorities. The Department requested funding from Infoway for the Client Registry, Provider Registry and iEHR/Lab Implementation Projects. The total combined project costs are $28M with an approved Infoway contribution of $17.8M. This combined project will be called the Nova Scotia Electronic Health Record (EHR) Project. The Department received approval of a funding contribution of $5.8M from Infoway for the Panorama Project. The total cost of the project is $10.2M.
Canada Health Infoway Initiatives The Department of Health will pursue every available opportunity to move forward in support of Canada Health Infoway (CHI) initiatives that foster and accelerate the development and adoption of electronic health information systems. Participation will be carried out in the Health	The HIA Provider Registry project was completed in the fourth quarter of 2006. It was determined that the Provider Registry implementations would be done by each provincial jurisdiction. The Public Health Surveillance (Panorama) Phase 1 Planning project was completed May 31, 2007. Each provincial jurisdiction is responsible for determining their work and making decisions to

[2] Previously known as Health Information Management Services

Priority	Accomplishments
Infostructure Atlantic (HIA) project to identify collaborative opportunities for a Provider-Registry among the four Atlantic provinces. The Department of Health will also continue to participate in the pan-Canadian and HIA Public Health Surveillance projects planned to be implemented by all Canadian jurisdictions over the next two to three years. The CHI Drug Information Systems program is focused on creating an interoperable drug information system that will carry all data concerning a patient's medication history. The planning process for the implementation of Drug Information Systems will begin. Nova Scotia Picture Archiving and Communications Systems (NS PACS) is a high-speed, graphical, computer system that stores, retrieves and displays diagnostic images. A province-wide network has been established for storing and viewing these images. The NS PACS Project will expand current installations and implement PACS in all remaining diagnostic imaging facilities in DHAs throughout the province.	begin Phase 2 of the project. The Pan Canadian project is currently undergoing a detailed review and delivery scope. Time is being negotiated by the Pan-Canadian team, Infoway and IBM as the service provider. The following Canada Health Infoway projects specific to Telehealth in Nova Scotia moved forward during the period: • NSTHN Telehealth Expansion Project (Completed) • A Strategy of Telehomecare for Management of Congestive Heart Failure- STARTEL (Ongoing) • Cape Breton First Nations Telehealth Expansion (Ongoing) • NSTHN Clinical & Educational Enhancement (Ongoing) • The iEHR/Lab Detail Planning Project was completed in December 2006, which positioned DoH to move forward in planning the EHR Implementation Project. As of March 2007, the department was waiting for the approval of funding for the $9M Nova Scotia portion to further the EHR.
Nova Scotia Telehealth Network (NSTHN) The Department will continue to work in partnership with the Department of Health Programs, DHAs and the IWK Health centre to expand the clinical capability of the Nova Scotia Telehealth Network. This includes implementation of new Telehealth endpoints throughout the province, increasing clinical usage, introduction of new technology infrastructure and pursuit of joint projects with Canada Health Infoway.	A number of telehealth initiatives moved forward during the period. A planned expansion of the NSTHN was completed in September 2006. This expansion provided over 50 new video conferencing units across Nova Scotia. Planning of further telehealth expansion was undertaken. This includes expanding the NSTHN into new domains including Long Term Care, Home Care and First Nations Communities in Cape Breton. Additionally, new and expanded clinical telehealth applications were undertaken in a number of areas including Autism, Mental Health, Pain Management and Plastic Surgery. NSTHN worked with a number of partners to plan the implementation of a telehealth visitation

Priority	Accomplishments
	project. This project will allow hospital inpatients to virtually visit with family members who are separated by distance through the use of videophones. This project is expected to be implemented in 2007-2008. The NSTHN supports clinical programs (i.e. dermatology, genetics, geriatrics, lung transplant, mental health, and rehabilitation), education activities (i.e. continuing nursing education, continuing medical education, medical rounds, and education sessions for patients and families), and administrative distance meetings.
Privacy and Access The Department of Health will develop and consult on health information legislation to protect the privacy of personal health information while ensuring appropriate access to health information for health care delivery, planning, and administration. New legislation is required to provide clear, consistent rules for the protection of and access to personal health information. The Department will ensure it meets its obligations under the new Privacy Impact Assessment (PIA) policy.	The Department began working on the development of a Departmental Breach Policy, which will be completed by Fall 2007. The Department implemented secure shredding boxes on all floors in the Joe Howe Building. Development of Health Information Legislation is underway. With the introduction of new electronic health systems, there is a need to address who, where, how, when and why health information can be shared.
Decision Support and Information for Management The Department supports the development of integrated information products to support evidence-based decision-making. The range of products provided to support the development of integrated information and evidence-based decision-making in the Department, programs, and within the DHAs and IWK Health Centre will be expanded. 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 development of the electronic health record. The Department will continue to develop, monitor, and enhance information and data standards.	The Department will continue to report on population health and health utilization indicators to support DHA and Departmental decision making. Significant work has been done to improve the quality of clinical information reported to CIHI. Staff continue to participate on several CIHI committees, improving data quality and data standards. Preliminary steps are being taken to begin restructuring the branch to better meet departmental and DHA decision-making needs. The branch will continue to work with Canada Health Infoway to develop and maintain national data standards.

Priority	Accomplishments
Wait Times Monitoring Project The Ten Year Plan, committed to by First Ministers, identified the objectives necessary for better management of wait times and the measurable reduction of wait times in five priority areas (cancer, heart, diagnostic imaging, joint replacements and sight restoration). Governments committed to establishing comparable indicators and evidence-based benchmarks for wait times by December 31, 2005 and multi-year targets to achieve priority benchmarks by December 31, 2007. Work will continue in this area. During 2006-2007, the Department of Health will begin collecting wait time data for specialty consults on a voluntary basis from specialists' offices. The Department will also continue working with the DHAs and the IWK Health Centre to define, gather, and report wait time information for diagnostic and surgical services. New systems such as Operating Room Systems, Emergency Department Systems, and Knowledge Management Systems will all be investigated, along with options in support of Wait Times Monitoring.	A Strategic Plan to Improve Access to Healthcare Services was created and adopted by government. An Executive Director position has been created to manage and implement the strategic plan. It is anticipated this position will be filled in Fall 2007. The Wait Times website continues to be updated on a regular basis. Improvements in wait times data capture and reporting will not be possible without the deployment of more information systems that support the business process. The Wait Times Advisory Committee mandate concluded upon the creation and adoption of the strategic plan to improve access to health care services. The federal government announced funding for 4 projects to improve access to health care services. These include funding for a radiation therapy guarantee, 2 pilot projects; one in surgery and one in diagnostic imaging, and funding to support the creation of a national paediatric surgical wait list. All projects have a 3 year time line with the exception of the paediatric project, which is one year in duration.
Health Administrations Systems Project (HASP) The Health Administrative Systems Project (HASP) is in the project preparation stage with detail system design to be completed by the end of 2006. This project will improve the effectiveness of administrative systems, facilitate implementation of standards and adoption of best business practices, increase financial accountability and improve planning through evidence-based decisions making. Financial accountability and reporting will be standardized, while providing a consistent foundation in core systems such as human resources, payroll, budgeting, procurement, and inventory management.	HASP has successfully completed the Project Preparation and Project Blueprint phases, and is currently in the Project Implementation phase for all Provincial District Health Authorities and the IWK Health Centre. The project will implement all systems in the following scheduled deployment order: 1. June 2008 (Districts 1,2,3 & 8) 2. January 2009 (Districts 4,5,6 & 7) 3. July 2009 (District 9) 4. October 2009 (IWK Health Centre)
Health Information Technology Services – Nova Scotia (HITS-NS) Considerable investment has been made in Information Technology projects that support the	HITS-NS is located in Halifax with a satellite office in Sydney and some support staff located in other DHAs. New terms of reference have been developed for the Management Committee

Priority	Accomplishments
delivery of healthcare to Nova Scotians. This new support structure will be responsible for the operational support for provincial IT systems such as the Nova Scotia Hospital Information System (NSHIS), Picture Archiving and Communication System (PACS), Primary Healthcare IT Component, Continuing Care Single Entry Access (SEAScape) and Telehealth. HITS-NS will also be responsible for the operational support of all future provincial health initiatives such as client and provider registries and interoperability projects. This system will be put into place in 2006-2007.	including a new list of members. One hundred and eight staff are hired on a permanent basis with eight more positions filled on a temporary basis. Operational support is provided to users of the PACS, PHIM, NSHIS, Telehealth and SeaScape systems as well as users of the nsheath.ca network. In January 2007 the NShIS MEDITECH system was successfully upgraded to the 5.5 version release. PACS storage was significantly upgraded to allow for the continued increased demand for storage capacity for diagnostic imaging images. New Telehealth units were added and old ones replaced in an effort to grow and maintain the availability of the Telehealth system. Work continues on developing support for new initiatives such as the Electronic Health Record (EHR) along with all associated parts within (client and provider registries and interoperability projects).
Primary Health Care Information Management Implementation of the PHIM project started in 2005-2006, with the adoption of the program into a number of Primary Healthcare clinics. Information technology is improving the way health information is stored, used and disclosed by health providers. A one-time injection of Health Transition Funds and sustaining funding through the Department of Health has enabled Nova Scotia to launch the innovative Primary Healthcare Information Management (PHIM) program to improve the management of health care information. Twenty five percent of existing primary health care physicians will be enrolled in the PHIM program by September 2006.	During 2006-2007 the rollout of the PHIM Program proceeded to provide a provincial primary health care information management program in which providers can participate. During this time, the hosting environment and provincial help desk continued to be provided to make this an operational service for participating clinics. Stakeholder engagement activities were held to inform primary health care providers about the program. Health Transition Funds were made available to encourage participation in the program. In 2006-2007, 260 new users in 30 clinics started using the software. By March 2007, 36 clinics were actively using the system with 22 other clinics preparing to participate. The PHIM Program continued to provide change management tools and education services to enhance the effectiveness of the program for participating clinics. These change management support tools have been streamlined with the learning gleaned from each implementation.

Priority	Accomplishments
	In August 2006 the electronic transfer of laboratory and Diagnostic Imaging results from Nova Scotia's three acute care systems to the PHIM program was formally launched. 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, making Nova Scotia the first province to provide this service from all acute care facilities to all provincially approved EMRs. At the end of March 2006, 54 physicians were receiving electronic results. Streamlined implementation processes for clinics participating in the PHIM Program continued to be provided to facilitate a smooth transition. 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.

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 Responding to priorities identified in the First Ministers Accords in both 2003 and 2004, Nova Scotia is developing a comprehensive HHR strategy. 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 • Continue to build a solid plan for Health Human Resources (HHR) that will support the health system's current and future needs	In accordance with the agreement signed by the First Ministers in September 2004, the Department's HHR division has made positive strides. Accomplishments in 2006-2007 include: • A continued commitment to encourage young people to choose health related careers achieved through planning activities to enable the future implementation of an HHR strategy that includes both Allied Health Care and Long Term Care. • Part of the Continuing Care Strategy is building/replacement of 832 long-term care beds scheduled to "open" in 2008-2009. The HHR division has commenced planning activities and strategies to proactively enable accessibility to appropriate staffing complements in 2008-2009. • In an effort to build a solid plan for HHR to support both current and future needs of the Province's health care system, the HHR division continues to build and maintain partnerships between DoH and other governmental departments (i.e. Department of Education). This has enabled an integrated approach to health workforce planning.
Nursing Strategy The Nursing Strategy targets recruitment, retention and renewal of the nursing work force, including both Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). Priorities include rural nursing, cooperative student employment, new graduate bursaries, relocation allowances, re-entry support, orientation for new graduates to transition to the work setting, and support for continuing education to ensure ongoing competence of the workforce. Other strategies include incremental seat increases, initiatives to support late career nurses remaining in the workforce and focus on quality practice environments.	The Summary Report of the Nursing Strategy 2001-2006 (www.gov.ns.ca/health/nursing) indicates the Nursing Strategy is working. However, there needs to be support for nurses given the system demands and the pending shortage as a result of an aging nursing workforce. Following a review of the Summary Report, a Phase II Nursing Strategy was developed in consultation with the Provincial Nursing Network, a leadership group of nurses comprised of representation from employers, unions, nursing education, practitioners and government. The Strategy identified a need to continue with priorities identified in 2001 with a focus on

Priority	Accomplishments
• Support the initiatives in the Nursing Strategy. • Review the outcomes of the current Nursing Strategy from the last five years and plan for a new nursing strategy • Provide funds to expand the nursing seats at St. Francis Xavier and Cape Breton universities and the Nurse Practitioner Program at Dalhousie University	renewal of the workforce as well as to continue addressing recruitment and retention. The Nursing Strategy continues to support seat expansion at Saint Francis Xavier, which includes an accelerated nursing program 24 months in length, a 3 year LPN Bridging Program and a joint 4 year nursing education program between Saint Francis Xavier and Cape Breton University. The Dalhousie University School of Nursing continues to receive support for delivery of the Nurse Practitioner Program.
Medical Laboratory Technologists Nova Scotia will offer students bursaries of $4,000 in each year of the two-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. In order to avoid a gap in Medical Laboratory Technologist graduates, a group of 22 students will be supported for training at New Brunswick Community College and will graduate in 2008. This will align with Nova Scotia's new Medical Laboratory Technologist program, which will graduate its first class of 24 students in 2009. • Fund the joint initiative between the New Brunswick Community College and Nova Scotia Community College to train Medical Laboratory Technologists	To ensure HHR planning is exercised in consultation and collaboration with key stakeholders, the DoH's HHR division has successfully funded a joint Medical Laboratory Technologist initiative between the New Brunswick Community College and the Nova Scotia Community College (NSCC). The initiative is comprised of three cohorts of students. The second cohort of 22 Medical Laboratory Technologist students will graduate in June 2008, with the final class scheduled to graduate in June 2009. Additionally, DoH has collaboratively invested in construction of the new NSCC campus on the Dartmouth waterfront. Nova Scotia's new Medical Laboratory Technologist program at NSCC will graduate its first class of students in 2010.
International Educated Health Professionals Initiative Regulatory barriers, inadequate assessment and educational opportunities have contributed to a significant pool of IEHPs who are either underemployed in their chosen profession or unable to work in their profession in Atlantic Canada. There are also Canadian residents who attend health education institutions outside of Canada who plan to return to Canada upon graduation. The Atlantic provinces have collaborated on projects to address the capacity building needs of	To proactively plan for an adequate supply and mix of health care professionals to deliver health care services to Nova Scotians, DoH's HHR division has worked to accelerate and expand the assessment and integration of International Educated Health Professionals (IEHPs). The IEPHs initiative is now in its third year and has expanded to include all four Atlantic Provinces in partnership. HHR at the DoH continues to develop services to increase the capacity of IEPH in Atlantic Canada through collaborative projects.

Priority	Accomplishments
IEHPs. These projects have been sent to Health Canada to be considered for funding through the IEHP Initiative. The projects will require partnership with key stakeholders such as the Atlantic Advisory Committee for Health Human Resources (AACHHR). • Accelerate and expand the assessment and integration of International Educated Health Professionals (IEHPs) to contribute to the First Ministers' Ten-Year Plan (September 2004) to reduce wait times and increase the number of health care professionals	
HSPnet – Clinical Placement Web Based Tool HSP*net* is a web-enabled system that coordinates student placements in all health sciences disciplines across a practice education jurisdiction (typically a province). Planning for the pilot project has been underway since December 2005. Implementing HSP*net* across District Health Authorities will provide considerable short-term benefits including: • improved communication and information exchange among schools and agencies that accept students throughout the placement process • reduced handling of paper • improved turnaround on placement requests • productivity tools • an enhanced ability to plan and build capacity	Information Communication Technologies (ICTs) will play a pivotal role in determining future models of health care delivery, including staffing of health care professionals. The HHR division identified "discussion re: implementation of a pilot project to test HSPnet" as one of its priority areas for 2006-2007. Achievements include: • Successful completion of a HSPnet pilot project in January 2007. The "Go-forward": 2007-2008 achievements to date include the Academic Health Council's agreement (March 2007) to fund HSPnet throughout the Province. The Council has placed primary emphasis on Nursing with an "eye" to expand and encompass additional healthcare professions in the future.
International Medical Graduates In December 2005, Health Canada accepted the joint proposal from the Department of Health and the College of Physicians and Surgeons of Nova Scotia to provide funds for the evaluation. Recruitment of International Medical Graduates continues to be a priority for the Department • Evaluate the effectiveness of the Clinical Assessment for Practice Program (CAPP) initiative	The CAPP program has successfully worked to enhance Nova Scotia's accessibility to International Medical Graduates. The third iteration of the CAPP initiative occurred during the 2006-2007 fiscal year. The College of Physicians and Surgeons of Nova Scotia approved nine IMG candidates for a defined license. Of those who successfully passed the CAPP, six were placed in rural areas of the Province (Barrington, Berwick, Springhill, Truro, New Glasgow and Bridgewater). The other three were dispersed as follows: one accepted a residency position; one

Priority	Accomplishments
	returned to their homeland for personal reasons; and one is practicing in urban Nova Scotia as a fee for service physician and as such is not under the CAPP contract.

Health System-Wide Priorities

Priority	Accomplishments
Health Care Safety Work will commence to develop a provincial policy disclosure of adverse events in the continuing care sector. A framework for conducting quality review, applicable to District Health Authorities and the IWK Health Centre will be completed by the provincial Quality Review Working Group. Opportunities will be explored to expand relevant quality review mechanisms to other sectors of the health system. In addition, mechanisms to support receipt and handling of hazard alerts within continuing care will be pursued.	District Health Authorities, with funding from multiple sources including the Department of Health, participated in a Pan-Canadian initiative aimed at implementing 6 hospital practices proven to improve safety and outcomes of care.
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 developed nine Ministerial Advices to address the reduction of wait times throughout the province. These advices were presented to the Minister and consisted of the following: • Develop a strategic plan • Increase DHA accountability • Implement an Operating Room Management System • Establish an industrial engineering partnership • Fund an operating room efficiency study • Devolve Continuing Care to the DHAs • Increase number of long term care beds • Fund the National Ambulatory Care Reporting System (NACRS) • Implement radiology appropriateness criteria The Wait Times Advisory Committee mandate concluded upon the creation and adoption of the strategic plan to improve access to health care services.
Chronic Disease Management The management of chronic disease and the burden of illness of the 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	As part of the Provincial Health Services Operational Review, Provincial Programs, including the chronic disease program, underwent external review. Planning and collaboration across all chronic

Priority	Accomplishments
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.	disease related programs are ongoing.

Government-Wide Initiatives

Priority	Accomplishments
Human Resources Plan The Human Resources Plan sets out the values and principles that will guide decision making and actions to support the continuous development and availability of skilled, diverse, responsive and dedicated employees. The plan is aligned with the Corporate Human Resources Plan for the Nova Scotia Provincial Government. The five goals and related strategies within the plan are as follows: • To be a preferred employer • To be a learning organization • To make a difference through a skilled, committed and accountable public service • To be a safe and supportive workplace • To be a diverse workforce	One of the most significant accomplishments for the DoH's Human Resource Department was the "solidification" (January 2007) of a departmental vision, mission, and objectives. Collectively these will guide the department's strategic direction. During the 2006-2007 fiscal year priority emphasis was placed on two of the four identified strategic directions, namely: • Strengthen the capacity of clients to achieve and sustain performance. • Optimize the quality, effectiveness, and efficiency of Human Resources Processes The DoH HR has also worked to expand the scope of the department's diversity and social inclusion initiative in addition to the Primary Health Care Initiative to include the entire Department of Health. To focus in the appropriate direction, Human Resources facilitated employee focus groups coupled with the completion of key document reviews (including the corporate Employee Survey). This work activity enabled development of the Department of Health's "Human Resources Plan." Additional accomplishments include the following: <u>To be a preferred employer:</u> • Enhanced client communications in 2006-2007 • A formalized Reward and Recognition Program has been implemented. • In October 2006 the first employee appreciation month was launched enhancing a culture of recognition. • Staff Appreciation Week was also celebrated in October 2006. • Provision of funding to unit managers to hold appreciation events for staff. • DoH participated in the corporate Long Service Awards.

Priority	Accomplishments
	• The Human Resources Department began reviewing internal HR practices with a view to both improve and align to best practice. Case example: HR used CQI methodology to examine the recruitment and selection process specifically to examine ways to improve the same. This enabled internal changes and a tool to inform the Public Service Commission of needs. Subsequently, a new recruitment and selection policy is being drafted. This work will continue into the 2007-2008 fiscal year. The Human Resources Department will engage in a two phase process followed by establishing priorities and implementing improvements in the logistic and technical aspects of work. <u>To be a Learning Organization</u>: • A comprehensive orientation program for new employees was developed. • Human Resources commenced work with an external consultant to identify the resource requirements for DoH. • Performance management sessions were rolled–out to all DoH staff. • The Human Resource Development Consultant developed a Performance Management and Career Development Workshop encompassing both MCP and unionized employees. • The Director Human Resources initiated and completed a 360 Leadership Assessment process with DoH's Senior Leadership Team. This process was rolled out to Human Resources Consultants with plans to cascade to organizational managers in 2007-2008. • A coordinated approach was implemented to adopt a centralized approach to collecting all 2006-2007 performance review submissions. Goal: Collection of centralized training and development data.

Priority	Accomplishments
	<u>To be a safe and supportive workplace</u>: • Developing and approving the Corporate Workplace Harassment/Respectful Workplace Policy began in early 2006. • A Healthy Workplace Committee was formed in conjunction with the Corporate Steering Committee. • DHA membership on a Joint Occupational Health and Safety Committee is being established to address workplace health and safety issues. • Preliminary conversations between NSAHO and DoH regarding a Healthy Workplace Policy for the health system have occurred. <u>To be a diverse workforce:</u> • The Department of Health's Diversity and Affirmative Action Commitment Report for 2006-2007 outlines the department's key activities to create a respectful and diverse workforce. There is commitment to improving awareness of and appreciation for diversity within the department, as well as assisting with the development of a health care system that addresses the unique and pressing needs of culturally diverse populations.
Bilingual/French Language Services The Coordinator of French-Language Health Services will: • 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 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	The Department consulted and collaborated with the DHAs and IWK on issues related to the new French Language Services Regulations. Work was conducted toward development of sustainable approaches to providing French Language Health Services that were incorporated in the DHAs and IWK's French Language Services Plans, submitted at the end of March 2007. Nine of ten DHAs/IWK have submitted and published their French Language Services Plan in this initial year. Acute and Tertiary Care partnered with Physician Services, Continuing Care, Nursing Policy, and Health Human Resources to continue to incorporate French language services within their

Priority	Accomplishments
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.	program areas. Extensive work was conducted with Acadian Affairs in the development of the French Language Regulations to ensure that they were sustainable for the health system. A partnership was developed with the Department of Education on the French Language Medical Seats file. Regular meetings were held with senior leadership at the Department of Health, Department of Health Promotion and Protection, DHAs, and IWK to brief them on the French Language Services Regulations (in effect as of December 31, 2006) and on the Acadian and francophone communities's priorities for French Language Services.

Financial Results 2006 - 2007

Cost Centres	2006-2007 Estimate	2006-2007 Actual	Est./Act.Variance (Increase)/Decrease
Total-Administration	39,257,300	35,965,520	3,291,780
Medical Payments	565,004,000	560,145,993	4,858,007
Pharmacare Program	132,867,000	166,681,491	(33,814,491)
Other Insured Programs	47,315,000	42,903,295	4,411,705
Revenue and Recovery	(23,338,000)	(26,963,305)	3,625,305
Emergency Health Services	75,104,000	75,228,882	(124,882)
Other Health Care Initiatives	107,246,400	107,269,122	(22,722)
Other Programs	15,601,300	13,258,422	2,342,878
Total - District Health Authorities	1,289,632,000	1,301,306,116	(11,674,116)
Care Coordination	27,766,000	26,422,276	1,343,724
Home Care Services	121,095,000	125,553,401	(4,458,401)
Long Term Care	326,929,000	331,376,690	(4,447,690)
Capital Grants – Health	40,000,000	49,850,301	(9,850,301)
*******Department of Health*******	2,764,479,000	2,808,998,204	(44,519,204)
Full Time Equivalents	684.9	630.7	54.2
Tangible Capital Assets	11,744,000	14,103,000	(2,359,000)

DEPARTMENT OF HEALTH
FINANCIAL RESULTS 2006 - 2007 ESTIMATE VS. ACTUAL

Estimate: **$2,764,479,000**
Actual: **$2,808,998,204**
Total Variance: **$**(44,519,204)

Variance Explanations:

For 2006-2007 the department was $44.5 million over the original budget. The majority of this difference was due to a change in accounting policy during the year. Generally accepted accounting principles require reporting of revenue and expenses at gross, the $41.7 million in Pharmacare premiums that were netted against Pharmacare costs in the Estimate was therefore recorded as revenue in the actuals. The resulting unfavourable variance in expenses is offset by a favourable variance in revenues.

The remaining $2.8 million expense variance is a result of the approval of $11.6 million for District Health Authorities as a result of the union settlement; a $4.5 million increase for the long term care sector for beds, lifts and a shortfall in resident accommodation charges; and, $4.4 million for home care services for increased travel costs, guaranteed hours and utilization increases.

These funding increases were partially offset by an $8.0 million reduction in drug costs as fewer new drugs come to market; savings of $4.6 million as a result of vacancy management, a $3.7 million increase in revenue recovery related to out of province patients and $1.4 million in various other operational savings across the department.

The TCA policy changed from recording Net assets to the Grossed up costs. The provinces consolidated revenue account includes $2.4 million of Canada Health Infoway revenue which will offset the additional TCA expenditure for a balanced position.

2006-2007 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. Capacity to report on data in a timely fashion is constantly undergoing improvement. For these reasons, primarily, the availability of data will vary by measure.

Each year, Outcome Measures are reviewed during the 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.

Outcome Measures

Revised Pharmaceutical Services Performance Measurements

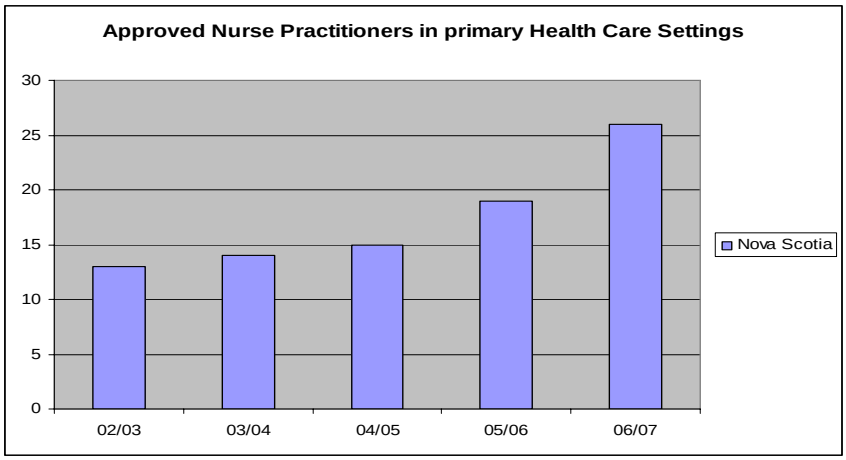
Measure	Explanation
Total number of new drugs approved for reimbursement under Seniors' Pharmacare, as a percentage of those newly approved for use in Canada	When referring to "approved for use in Canada', this measure specifically targets CEDAC recommendations. This is based on data which was available from the Department of Pharmaceutical Services in its 2006-2007 Accountability Report.
Total annual growth in NS Pharmacare program costs as compared to average annual growth in all Provincial drug programs in Canada	This measure specifically targets drug costs rather than total program costs for the Nova Scotia and Canada comparison. This is based on data which was available from the Department of Pharmaceutical Services in its 2006-2007 Accountability Report.

CORE BUSINESS AREA: PRIMARY HEALTH CARE

Outcome: Improved Access to Primary Health 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 2006-2007, the number of approved and funded nurse practitioner positions reached 26. During this same year, the Department of Health also encouraged the introduction of a number of different multi-disciplinary providers including, but not limited to, Nurse Practitioners. 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?
Building on progress made to date, efforts will be targeted to increase support to teams introduced through previous initiatives intended to increase the number of multi-disciplinary, collaborative teams in Nova Scotia. Although the overall goal is to continue to increase the number of collaborative teams, the aim is to increase the number of providers and practitioner types working within multi-disciplinary teams.

CORE BUSINESS AREA: MENTAL HEALTH, CHILDREN SERVICES & ADDICTION TREATMENT

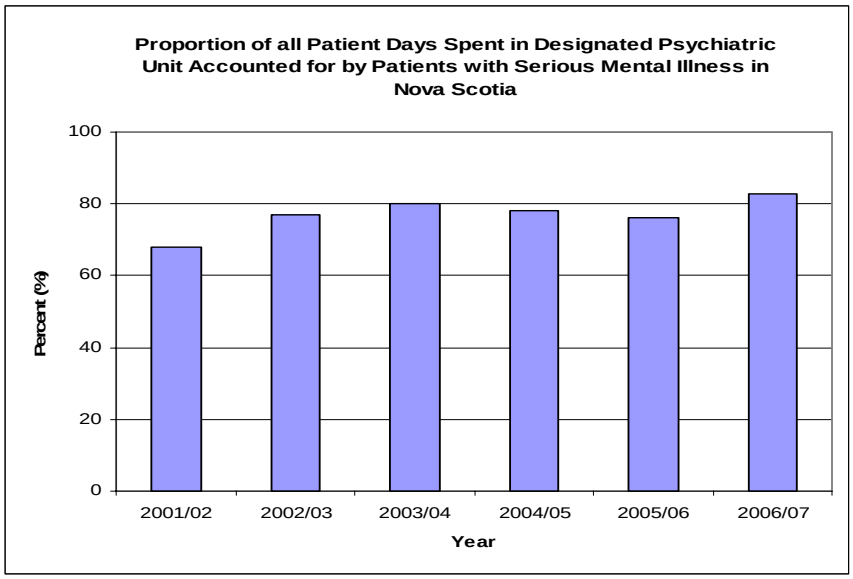
Outcome: Responsive Service to Persons Who Require Hospitalization

Proportion of all patient days spent in a designated psychiatric unit accounted for by patients with serious mental illness

One of the Department of Health's core business areas is Mental Health, Children Services & Addiction Treatment. A higher overall proportion of patient days accounted for by patients with serious mental illness suggest 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 designated psychiatric unit 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 (specifically, schizophrenia, bipolar disorder, and particular mood disorders), in which sufferers are significantly functionally impaired by the illness for an indefinite period of time.



Source: DAD (Discharge Abstract Database), NS Department of Health, September 14, 2007.

Where Are We Now?

In 2006-2007, patients with serious mental illness accounted for 83 percent of patient days spent in psychiatric inpatient units. This represents a slight increase in the utilization of inpatient services in Nova Scotia.

Where Do We Want to Be in the Future?

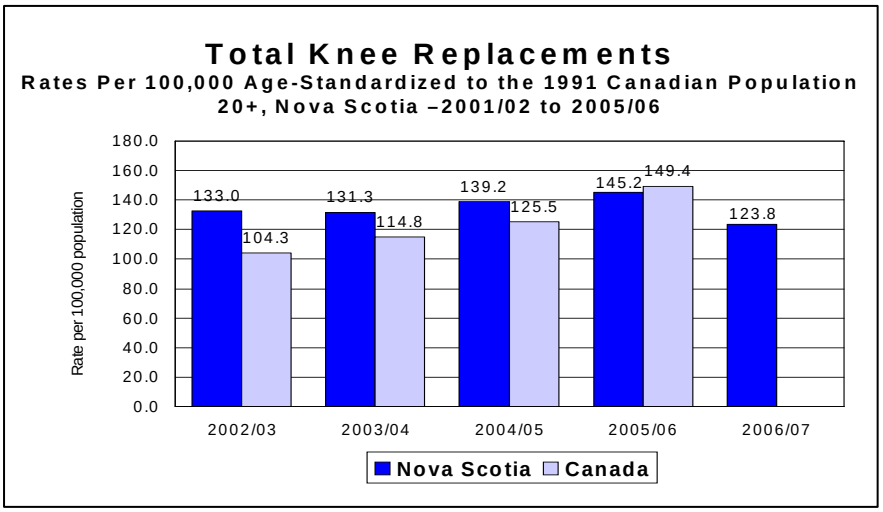
The Department of Health has set a target to maintain or increase the number of persons with serious mental illness being treated in hospital. The strategy to reach this goal is to continue to support shifting service options from inpatient hospital care to alternate settings where appropriate.

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.



Source: DAD (Discharge Abstract Database), NS Department of Health, September 14, 2007

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?

CIHI has recently changed the standardization rate to population aged 20+. To reflect this, all the numbers as of 2002 have been updated using the new standard. The number of knee replacements has increased steadily in both Nova Scotia and Canada since 2003-2004. At the same time, the Canadian rate continues to increase steadily. In 2006-2007, the Nova Scotia rate dropped to 123.8 per 100,000. While the Canadian rate surpassed the Nova Scotia knee replacement rate in 2005-2006, Canadian data has yet to be determined for comparison purposes for the 2006-2007 Nova Scotia Data.

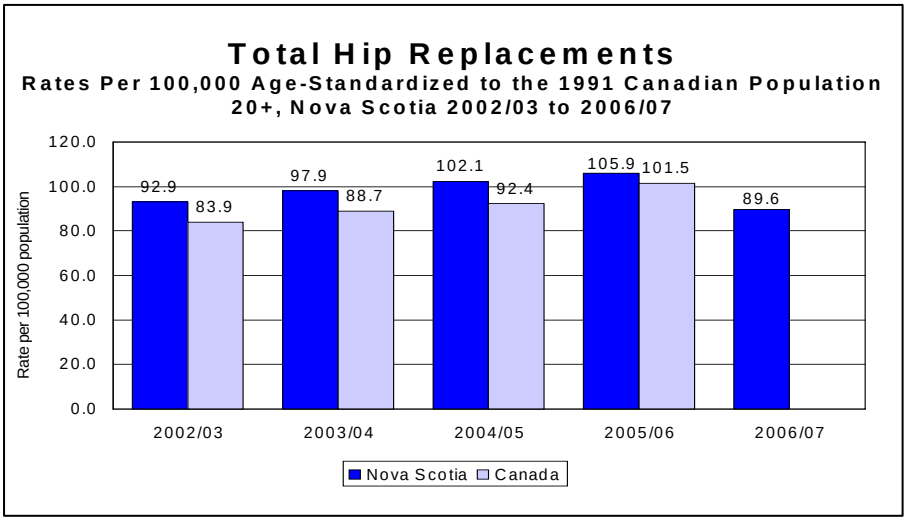
Where Do We Want to Be in the Future?

The Department of Health aims to maintain Nova Scotia total knee replacement surgery rates at levels better than or consistent with the Canadian average.

Outcome: Access to Quality Hospital Services

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.



Source: DAD (Discharge Abstract Database), NS Department of Health, September 14, 2007.

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.

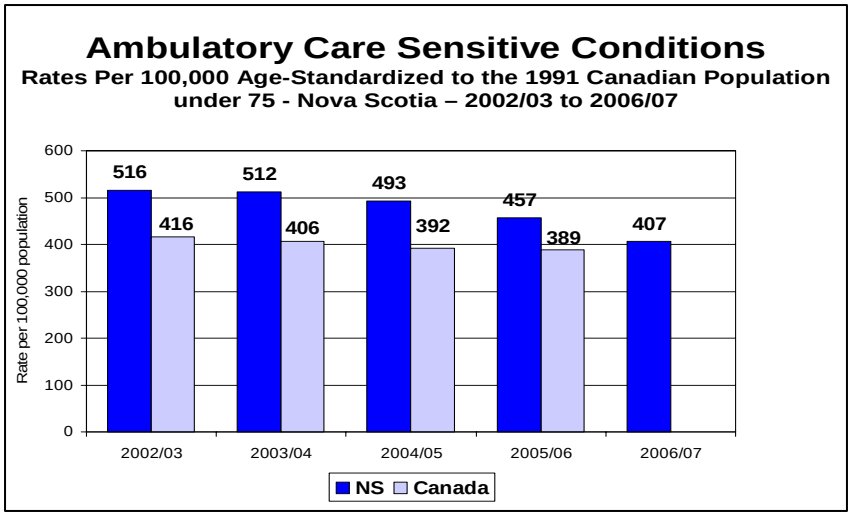
Where Are We Now?
CIHI has recently changed the standardization rate to population aged 20+. To reflect this, all the numbers as of 2002 have been updated using the new standard. The age-standardized rate of hip replacement surgeries in Nova Scotia have increased from 92.9 per 100,000 population in 2002-2003 to 105.9 per 100,000 population in 2005-2006. During the period 2002-2003 to 2005-2006, the most recent year for which data is available, age-standardized total hip replacement rates have increased across Canada from 83.9 per 100,000 population to 101.5 per 100,000 population. In 2006-2007, the Nova Scotia rate dropped down to 89.6 per 100,000 population.

Where Do We Want to Be in the Future?
The Department of Health aims to maintain Nova Scotia Total Hip Replacement Surgery rates at levels better than or consistent with the Canadian average.

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.



Source: DAD (Discharge Abstract Database), NS Department of Health, September 14, 2007.

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?

CIHI has recently changed the standardization rate to population aged 20+. To reflect this, all the numbers as of 2002 have been updated using the new standard. During 2006-2007, the most recent year for which data is available, 407 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 five 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?

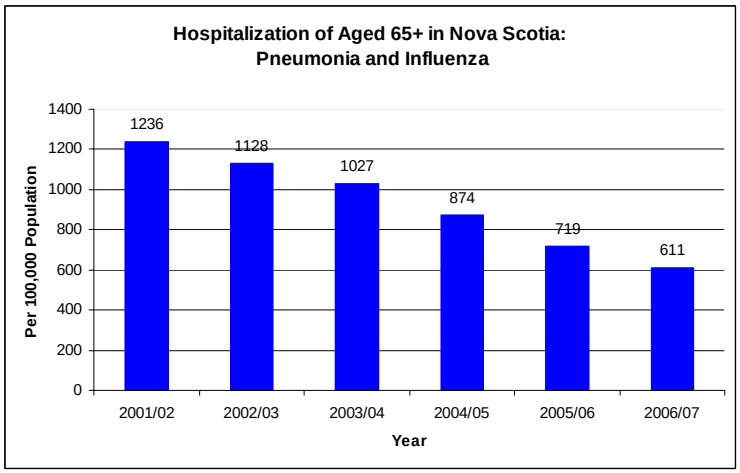
Nova Scotia is aiming to limit the proportion of people admitted to hospital for ambulatory care sensitive conditions to levels consistent with the Canadian average (current Canadian average not available due to change in methodology). Toward this end, the Department of Health will continue to monitor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

Hospitalizations of People Aged 65 Years or Older for Pneumonia and Influenza

One of the Department of Health's core business areas is Acute and Tertiary Hospital Care. One measure for Acute and Tertiary Hospital Care is the percentage of senior Nova Scotians hospitalized for pneumonia and influenza.

What Does the Measure Tell Us?

Calculating the age standardized rate of people aged 65 years or older who are hospitalized for pneumonia and influenza can help to assess the success of programs to prevent illness altogether or contain its severity and permit management outside of hospital, such as vaccination programs.



Source: DAD (Discharge Abstract Database), NS Department of Health, September 14, 2007.

Where Are We Now?

During the year 2006-2007, 611 people per 100,000 population aged 65 years or older were hospitalized for pneumonia and influenza. This shows a significant decrease since 2001-2002 when 1,236 people were hospitalized. Due to classification modifications made by the Canadian Institute for Health Information (CIHI), and inconsistent use of new coding standards, comparable provincial and national data are not available after April 1, 2006.

Where Do We Want to Be in the Future?

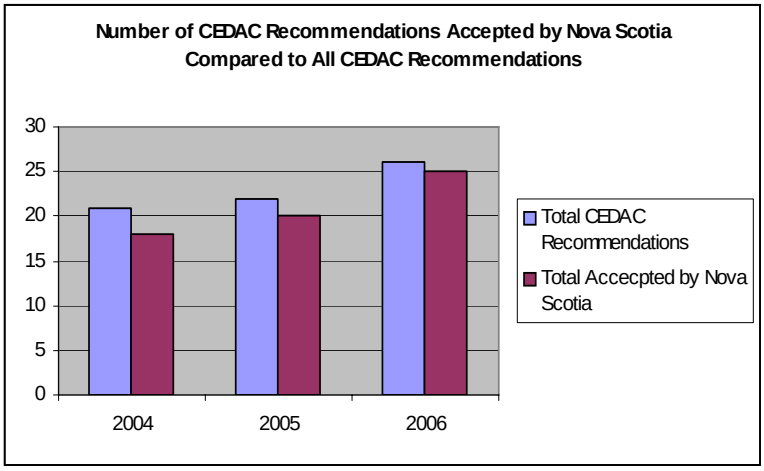
The Department's target was to reduce the number of hospitalizations for pneumonia and influenza to levels consistent with or below the Canadian average of 1998-1999. However, changes in classification system and reporting standards make comparisons between provinces and to the national rate challenging. Further because there is a lag in the release of data by the Canadian Institute for Health Information, the availability of comparable data is still to be determined. The Department of Health will work towards increased vaccination coverage of the population aged 65 years or older.

CORE BUSINESS AREA: PHARMACEUTICAL SERVICES

Outcome: Adequate Prescription Drug Coverage for All Seniors

Total number of new drugs approved for reimbursement under Seniors' Pharmacare, as a percentage of those newly approved for use in Canada

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 the Pharmacare Programs.



Source: MSI database, NS Department of Health, August 29, 2007 and Canadian Institute for Health Information, Drug Expenditure in Canada, 1985 to 2006 (Ottawa: CIHI, 2007).

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

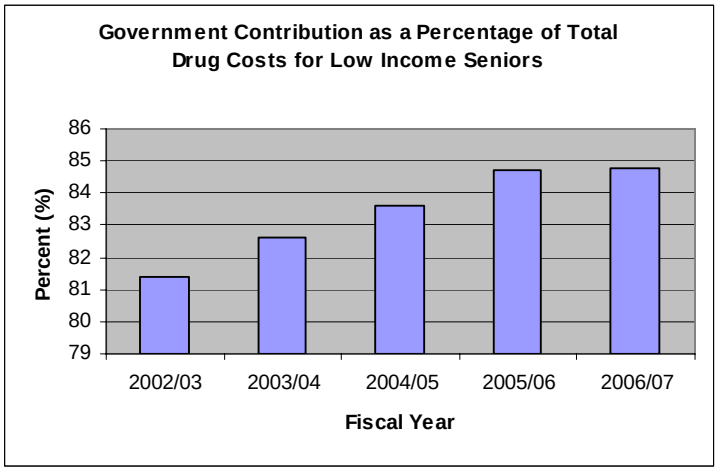
Where Are We Now?
CEDAC made recommendations on 28 drugs in 2006-2007. Two of the 28 drugs were withdrawn from the Canadian market by their manufacturer. Of the remaining 26 recommendations, 25 were accepted by the Nova Scotia Pharmacare Programs. The remaining recommendation is on hold in all jurisdictions pending clarification of the CEDAC recommendation with respect to a patient registry.

In 2004-2005, 18 of the 22 recommendations made by CEDAC were accepted in Nova Scotia and in 2005, 20 of 22 recommendations made by CEDAC were accepted in Nova Scotia.

Where Do We Want to Be in the Future?
The target is to accept all CEDAC recommendations unless there are valid reasons for not doing so, such as the current recommendation that is on hold.

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, regardless of income. One way in which adequate prescription drug coverage for all seniors can be measured is by monitoring the portion of the total drug costs for low income seniors that is covered by the government under the Nova Scotia Seniors' Pharmacare Program.



Source: MSI Database, NS Department of Health, September 14 2007.

What Does the Measure Tell Us?

The measure monitors the government contribution to the cost of drugs for low-income seniors in the Nova Scotia Seniors' Pharmacare Program. It tracks the effectiveness of policy changes that mitigate the impact of costs to the Program.

Where Are We Now?

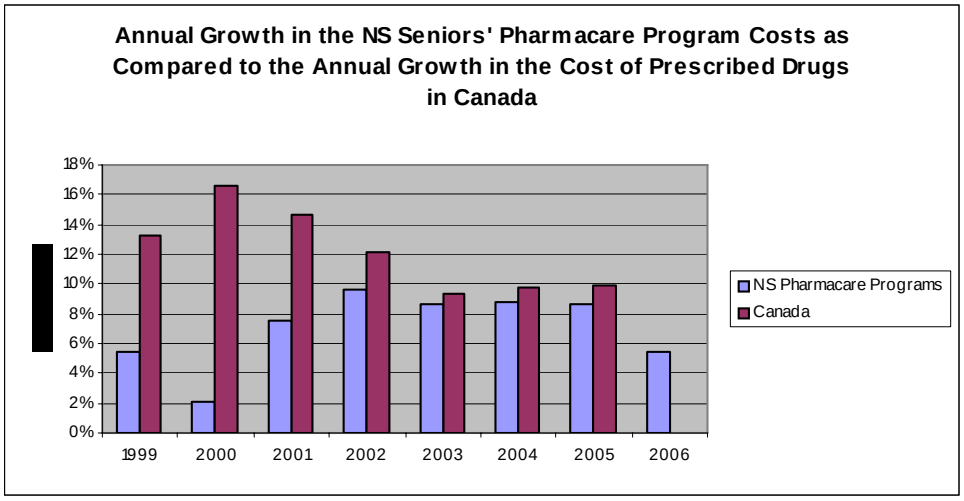
In 2006-2007, the Government of Nova Scotia covered 84.8 percent of the annual drug costs of low income seniors. This is part of an upward trend since 2002-2003.

Where Do We Want to Be in the Future?

The Government is reviewing this program to ensure adequate prescription drug coverage is available for all seniors, regardless of income. The cost increases on low income seniors will continue to be assessed and mitigated to reduce economic impacts.

Total annual growth in NS Pharmacare program costs as compared to average annual growth in all Provincial drug programs in Canada

One of the Department of Health's core business areas is Pharmaceutical Services. A desired outcome in this area is managing the growth in the Program's cost to minimize the increase in premiums paid by seniors covered under the Program. One way in which program growth can be measured is by monitoring the growth rate in the Nova Scotia Seniors' Pharmacare Program against the growth rate of prescribed drugs in Canada.



Source: MSI database, NS Department of Health, August 29, 2007 and Canadian Institute for Health Information, Drug Expenditure in Canada, 1985 to 2006 (Ottawa: CIHI, 2007).

What Does the Measure Tell Us?

The measure monitors the annual percentage growth rate of Nova Scotia Pharmacare drug costs against the growth rate for prescribed drugs in other provincial drug plans.

Where Are We Now?

In 2006-2007, the cost of the Nova Scotia Pharmacare Programs grew 5.4%. This is part of a downward trend in the rate of growth of Nova Scotia Pharmacare Programs.

Where Do We Want to Be in the Future?

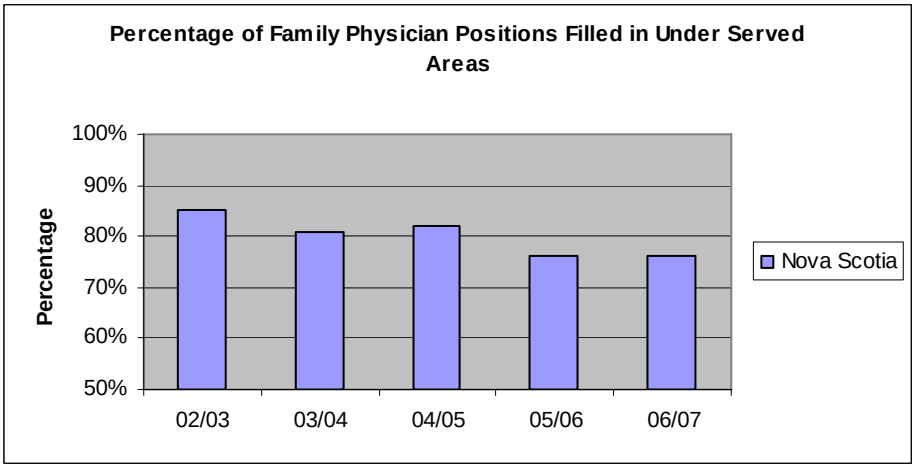
The target is to keep the growth in cost of the Nova Scotia Seniors' Pharmacare Programs at or below the growth rate of prescribed drugs in other Canadian provincially funded drug programs by encouraging best practices in purchasing, prescribing, dispensing and utilization of pharmaceuticals.

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.



Source: Internal consults, Physician Services Branch, NS Department of Health.

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 2006-2007, the per cent of family physician positions filled in under-served areas was the same as 2005-2006, which is 76 per cent. 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.

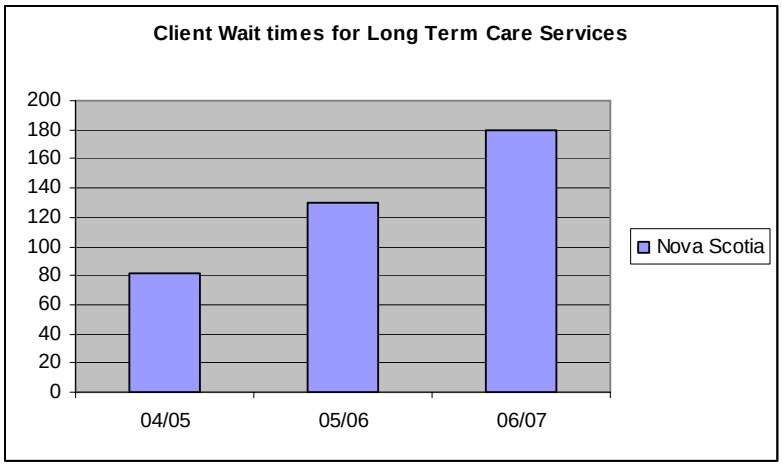
CORE BUSINESS AREA: CONTINUING CARE SERVICES

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.



Source: SEAscape database, NS Department of Health, September 14, 2007.

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?

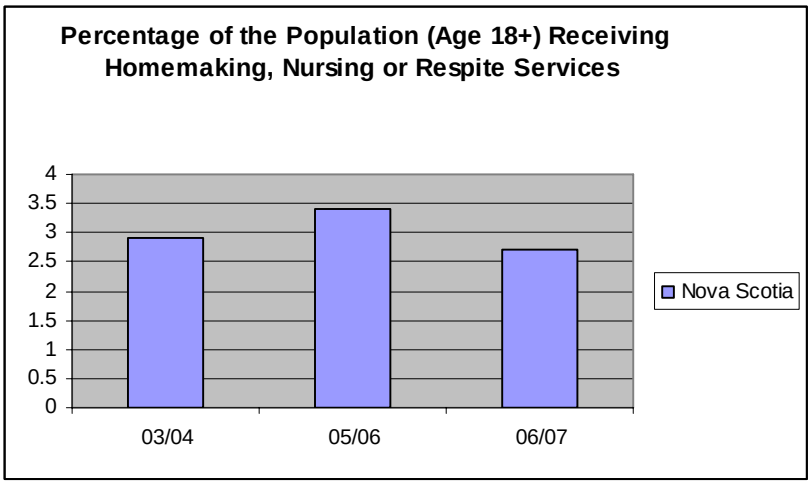
In 2006-2007 the average wait time was 179 days. In 2005-2006 the average wait time was 130 days. In 2004-2005 the average wait time for Long Term Care admission was 81 days. As a result of changes in long term care funding policy implemented January 1, 2005, more Nova Scotians are seeking long term care placement, resulting in longer wait times in 2005-2006 and again in 2006-2007.

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.



Source: SEAscape database, NS Department of Health, September 14, 2007.

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 2006-2007, 2.7 per cent of individuals age 18 or older received homemaking, nursing or respite services. In 2005-2006, 3.4 per cent of individuals age 18 or older received homemaking, nursing or respite services. In 2003-2004, Nova Scotians reported that 2.9 per cent of individuals age 15 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 2003-2004. In 2005-2006, the category was changed again to age 18 years and over.

Where Do We Want to Be in the Future?

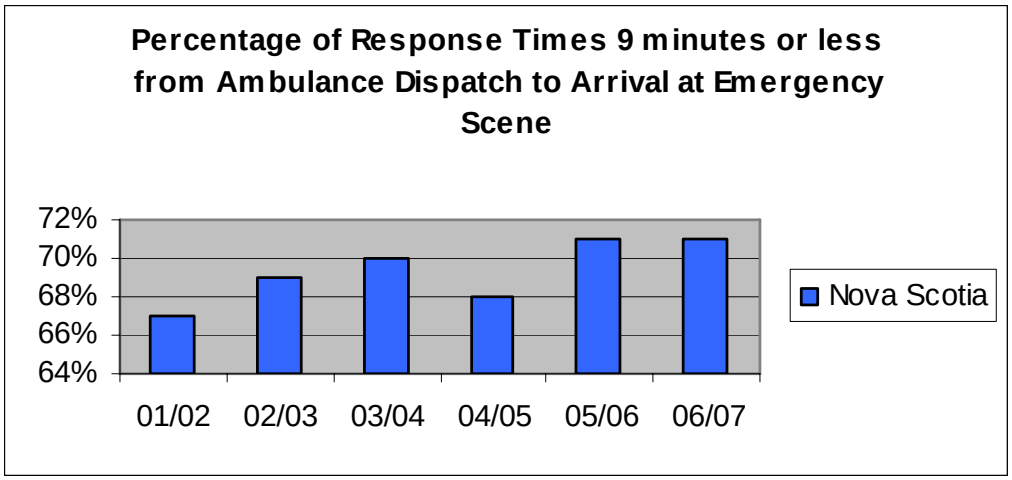
It is our goal to ensure that Nova Scotians have appropriate access to home care services. More data are required before a formal target can be set. The Department of Health has implemented Single Entry Access processes so that entry into Home Care and Long Term Care services is via a single, more efficient and less complex, process. This program will help set targets for and achieve this goal. As part of the province's Continuing Care Strategy, 832 new long term care beds will be built around the province, and nine facilities will be replaced. All of these beds will be ready in 2010.

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.



Source: CAD data from the ground ambulance contractor (EMC), NS Department of Health, September 14, 2007.

What Does the Measure Tell Us?

In urban areas, the industry standard for response time is under nine minutes, 90% of the time. An example of the importance of this time standard is the response of paramedics to cardiac arrests. When an individual sustains a cardiac arrest, for each minute that passes the likelihood of survival reduces by 10%. Having a rapid response time of less than nine minutes allows paramedics to provide life saving interventions such as chest compressions, early defibrillation, and other advanced care. A rapid response is also beneficial for other major diseases, injury, trauma, stroke, and respiratory illnesses. 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?

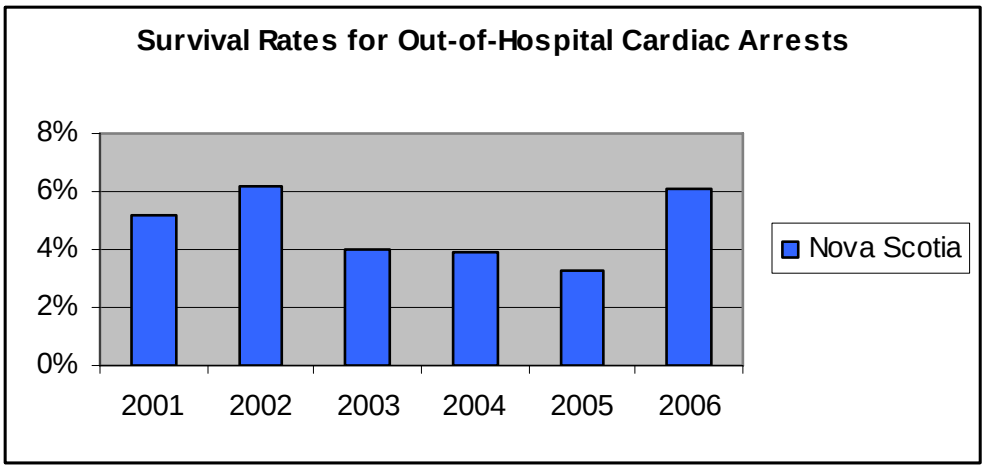
In 2006-2007, response times from the time a call is answered to arrival at the emergency scene was nine minutes or less 71 per cent of the time. This shows an improvement since 2000-2001 when response times of nine minutes or less occurred 66 per cent of the time. This surpasses the Department of Health 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.



Source: CAINT database, NS Department of Health, September 14, 2007.

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. Moreover, if a patient has 'return of spontaneous circulation' while treated by paramedics and survive to arrival to the emergency department, their outcomes are further influenced by optimizing inpatient care in the emergency department, intensive care unit, and rehabilitation centre. This reflects the 'chain of survival' and the important linkage between the pre-hospital community and the hospital.

Where Are We Now?

In 2005, the provincial survival rate for out-of-hospital cardiac arrests (OOHCA) was 3.3 per cent, and has increased to 6.1% in 2006. It is difficult to compare Nova Scotia's system with other systems because of the different mixes of urban, suburban and rural areas in the province. 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 and is influenced by a multitude of factors (age, etiology of arrest, other comorbid medical problems, risk factors, etc).

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 for selected locations of the province.