

Nova Scotia



Annual Statistical Report

Fiscal 2005-2006

**NOVA SCOTIA DEPARTMENT OF HEALTH
ANNUAL STATISTICAL REPORT
2005 – 2006**

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Copies of this report are available on line at www.gov.ns.ca/health/reports.htm

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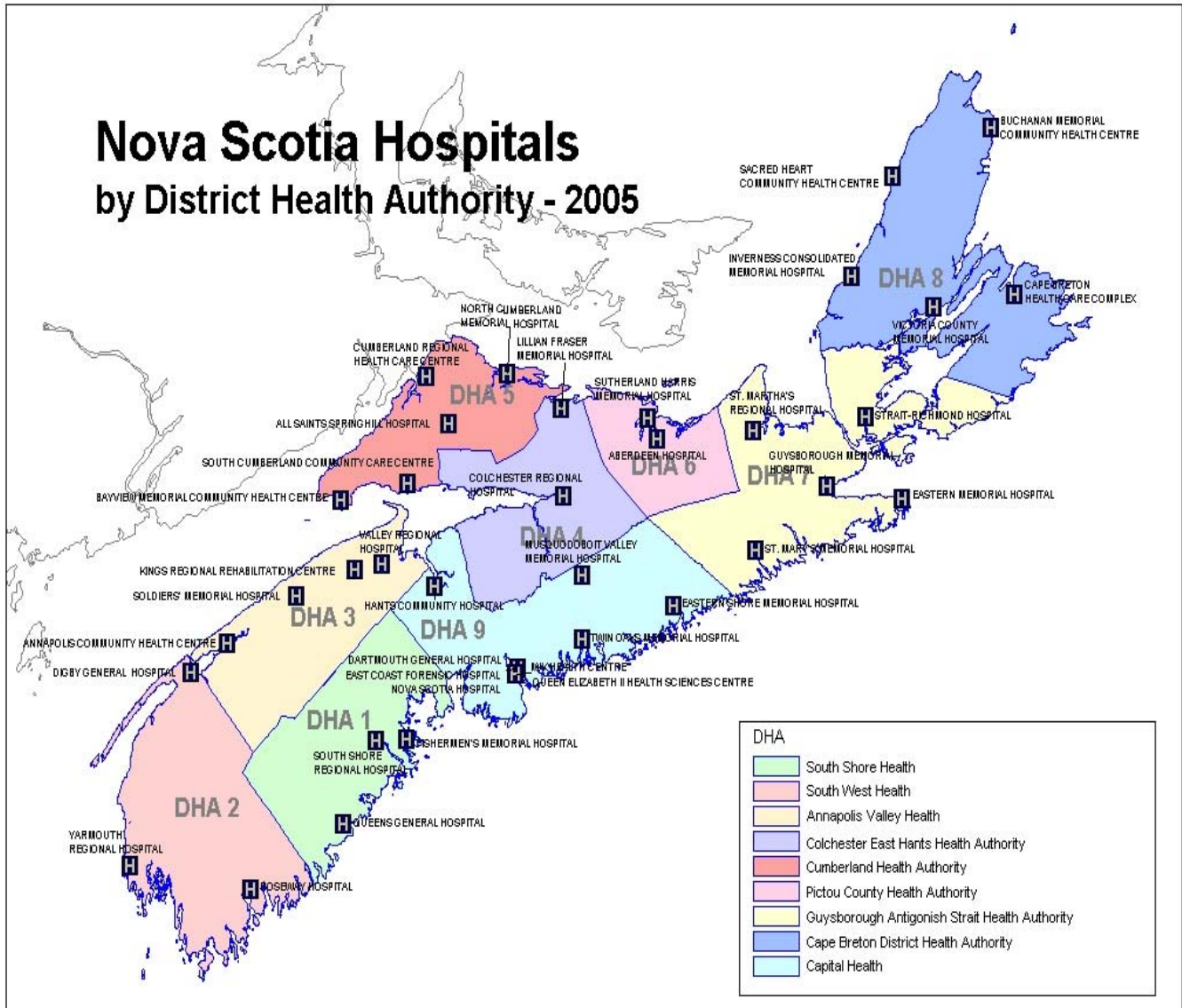
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The 2005 – 2006 Annual Statistical Report provides data from all District Health Authorities, informing Nova Scotians of health measures and the health care system performance in Nova Scotia. All of these facilities work together to provide the utmost quality of care to the people of Nova Scotia in accordance with the *Canada Health Act's* tenets of portability, accessibility, universality, comprehensiveness and public administration.

In this report, various health measures, from cancer mortality and incidence rates to patient days at hospitals, will be reported. Each indicator reported will include technical specifications, significance and rationale for reporting, analysis and data graphs or tables for the 2005/06 fiscal year.

Nova Scotia Hospitals by District Health Authority - 2005



Hospitals 2005

Nova Scotia Department of Health, November 2005

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Several experts throughout the Department of Health provided invaluable advice, information and editing support throughout the development process, including:

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Section 1 Health Promotion and Population Health

Health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹ Our health status is influenced by a variety of factors, called “Determinants of Health”, from genetic predisposition to disease to personal health practices such as nutrition and exercise. The determinants of health are factors that have been shown to predict or influence disease later in life. The determinants of health are:

- Income and Social Status
- Social Support Networks
- Education and Literacy
- Employment/Working Conditions
- Social Environments
- Physical Environments
- Personal Health Practices and Coping Skills
- Healthy Child Development
- Biology and Genetic Endowment
- Health Services
- Gender
- Culture

For instance, studies have shown that obesity plays a major role in the development of Type 2 diabetes and cardiovascular disease. We know that obesity most often results from poor nutrition or lack of physical activity. People could have poor nutrition habits for a number of reasons, including a lack of education on appropriate nutrition, or perhaps not having sufficient income or time to buy and prepare nutritious foods. By examining the characteristics of obese people in our population, we can plan effective programs and services targeted at the underlying causes of obesity such as inadequate income or inadequate nutrition education. Enacting programs and services to get at the root causes of obesity could result in reduced rates of Type 2 diabetes and cardiovascular disease in the long run.

In this section, indicators that reflect the determinants of health, called “population health indicators,” are included to give us an idea of how healthy our population really is. Health promotion indicators show us the number of people using the services and programs in place that promote proactive health and disease prevention.

¹ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

One of the ways that we collect information on population health and health promotion indicators is through population surveys such as the Canadian Community Health Survey and the National Population Health Survey. Several of the indicators in this report are from the Canadian Community Health Survey Cycle 3.1. The Canadian Community Health Survey (CCHS) collected information from about 130,000 Canadians, aged 12 to 102 years, about health conditions, health practices and lifestyle, access to health care and general information such as age, sex, income, and education. People in the military, living on Indian Reserves or living in some remote areas were not included in the Canadian Community Health Survey.

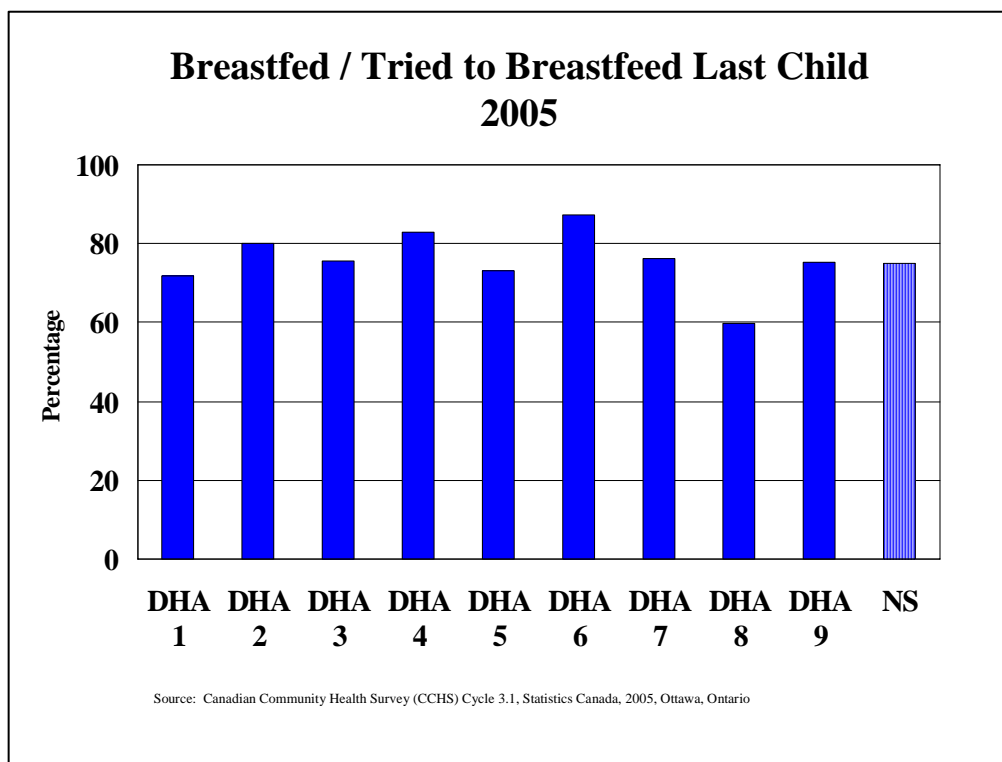
All Canadian Community Health Survey data responses are self-reported. Canadian Community Health Survey data are weighted to represent the proportion of Nova Scotia's population in each Health Zone. The Nova Scotia Department of Health has further analyzed the data to yield DHA level results. All Canadian Community Health Survey data must include a measure of variance in order to illustrate the reliability of the estimate.

Disclosures:

Small sample sizes may affect the validity of the data. Due to this, you will also want to look at confidence intervals. Information on confidence intervals and the analysis of these indicators are available from Annie Xu (902-424-5245) at the Department of Health.

For more information on the Canadian Community Health Survey, visit Statistics Canada Website at www.statscan.ca, or visit the Nova Scotia Department of Health's comprehensive publication on the Canadian Community Health Survey at <http://www.gov.ns.ca/health/reports.htm>

Canadian Community Health Survey (CCHS) Cycle 3.1, Statistics Canada, 2005, Ottawa, Ontario.



Breastfeeding

Definition

1. The percentage of women aged 15 to 55, of those who gave birth in the last 5 years, who breastfed or tried to breastfeed their last child.
2. The percentage of women aged 15 to 55, of those who gave birth in the past five years and breastfed their last child (but do not anymore), by length of time breastfeeding.

Significance - Rationale and Notes for Interpretation

Measuring the prevalence of breastfeeding is one indicator of healthy choices in early childhood development. Measuring the duration of breastfeeding is another indicator of healthy choices in early childhood development. Although rates vary between DHA's they are not statistically significant.

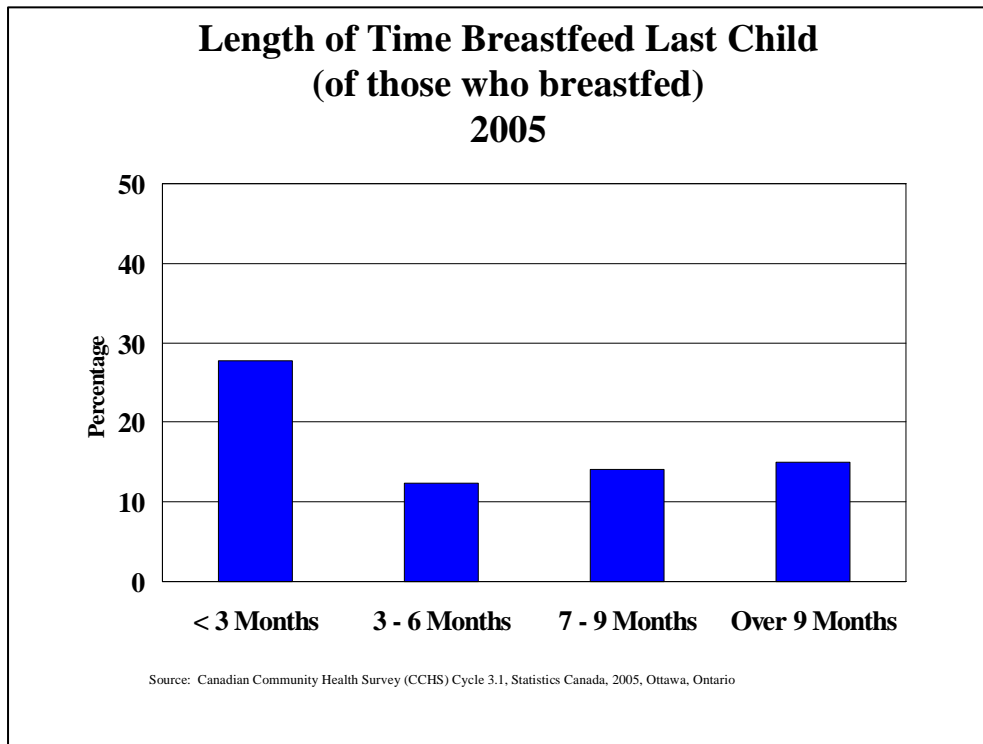
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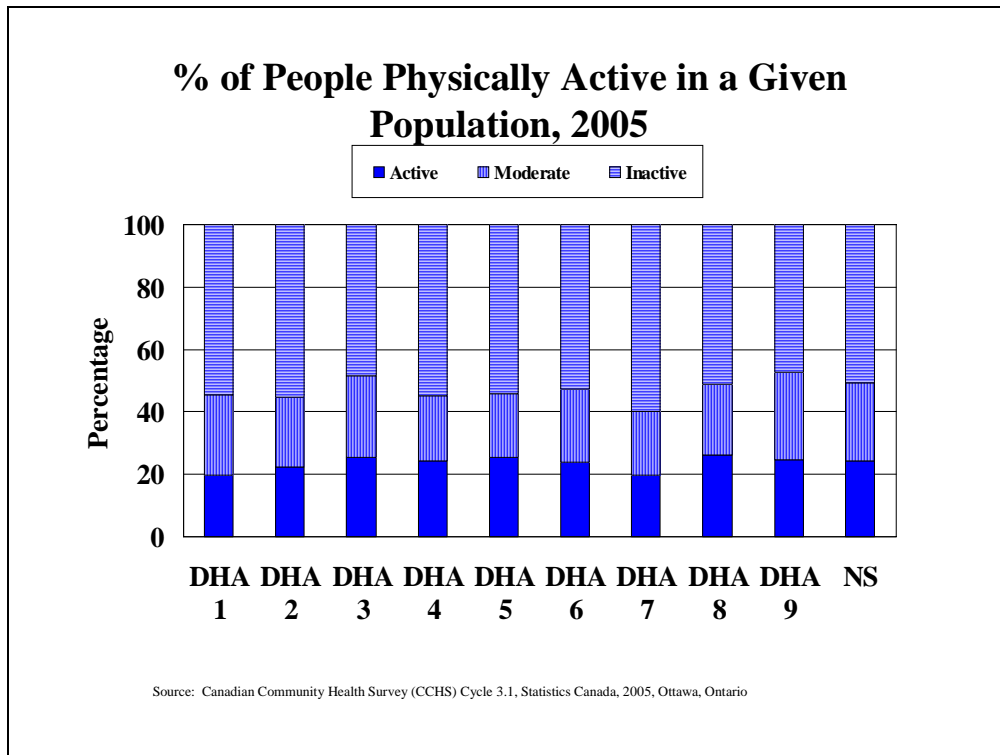
Calculation:

1. $\left(\frac{\text{The number of women aged 15 to 55 who have given birth in the last five years who breastfed or tried to breastfeed their last child even if only for a short time}}{\text{The total number of women aged 15 to 55 who have given birth in the last 5 years}} \right) \times 100$ for each of Nova Scotia's nine District Health Authorities, Nova Scotia.
2. $\left(\frac{\text{The number of women aged 15 to 55 who have given birth in the last five years and who breastfed up to 3 months, 3-6 months, 6-9 months, or over 9 months}}{\text{The total number of women aged 15 to 55 who have given birth in the last 5 years and who have breastfed their last child}} \right) \times 100$ for all of Nova Scotia.

Note: all duration categories are mutually exclusive.

Source: Canadian Community Health Survey (CCHS) Cycle 3.1, Statistics Canada, 2005, Ottawa, Ontario.





% of People Physically Active in a Given Population

Definition

1. The percentage of people whose physical activity level was either active, moderate, or inactive.
2. The percentage of male and female youth (aged 12 to 19) whose physical activity level was active, moderate, or inactive.

Significance - Rationale and Notes for Interpretation

Regular sustained physical activity along with a healthy diet, maintenance of appropriate weight, avoidance of smoking, and adequate rest forms the basis of a healthy lifestyle. The links between regular and sustained physical activity and improved health for individuals has been clearly demonstrated in medical literature. Therefore, physical activity is an important indicator for estimating the general health and possible future health problems of a population.

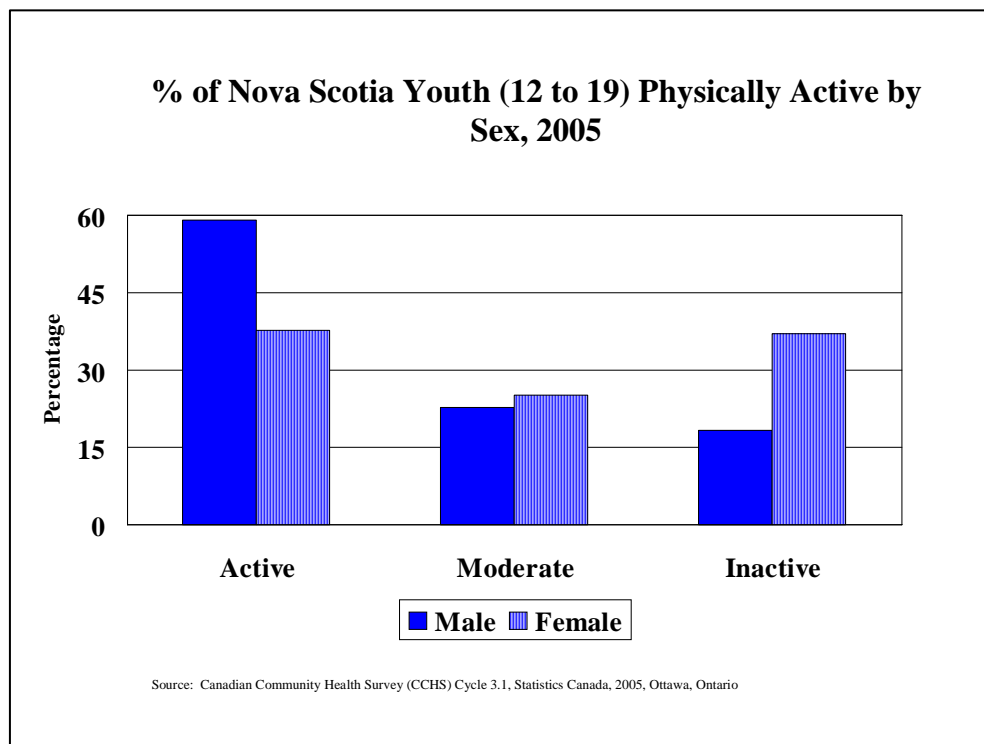
If moderate and active activity levels are combined the difference between DHA 7 and the provincial rate is statistically significant, as is the difference between Males and females, males being higher.

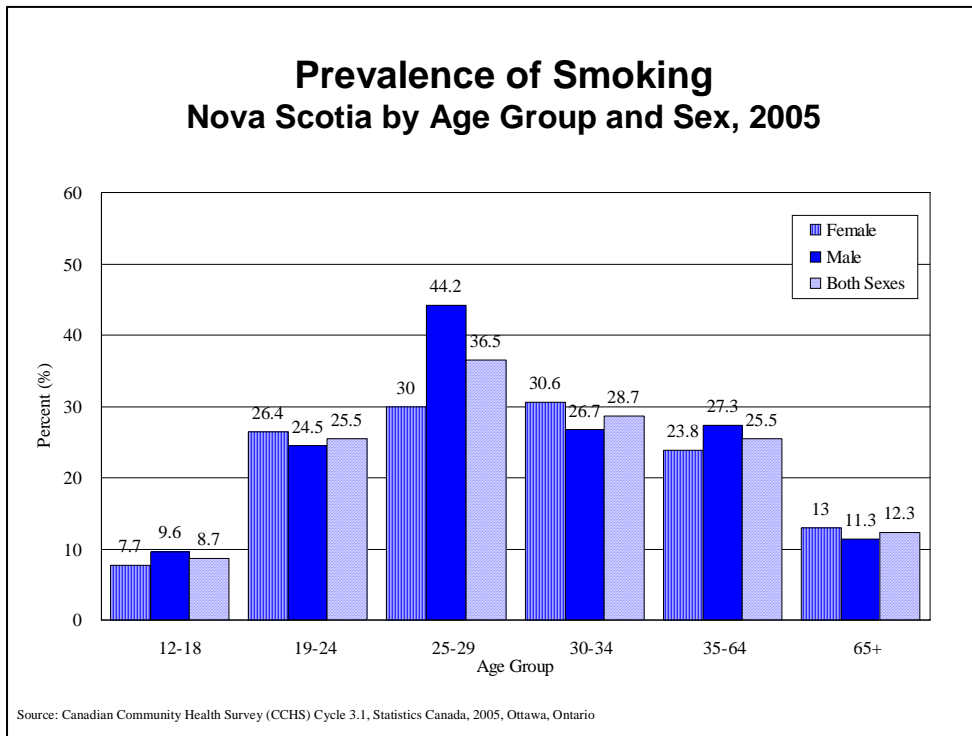
Technical Specifications

Calculation:

1. $\left(\frac{\text{The number of people aged 12 years or older, who were either active, moderately active, or inactive; [based on energy expenditure of physical activity (amount and duration)]}}{\text{The total number of people aged 12 years or older}} \times 100\right)$ for each of Nova Scotia's nine District Health Authorities and Nova Scotia.
2. $\left(\frac{\text{The number of males and females aged 12 to 19, who were either active, moderately active, or inactive; [based on energy expenditure of physical activity (amount and duration)]}}{\text{The total number of males and females aged 12 to 19}} \times 100\right)$ for all of Nova Scotia.

Source: Canadian Community Health Survey (CCHS) Cycle 3.1, Statistics Canada, 2005, Ottawa, Ontario.





Prevalence of Smoking by Age Group and Sex

Definition

The percentage of survey respondents who answered 'yes' when asked if they smoked. Population aged 12 and over who report being smokers.

Significance – Rationale and Notes for Interpretation

Tobacco use is the leading cause of preventable illness and death in Canada. Health Canada estimates that smoking is responsible for more than 45,000 deaths per year. This indicator represents the proportion the total population who report current smoking habits. Because of the addictive nature of nicotine, youth smoking is of particular concern. Nova Scotia aims to decrease the percentage of youth who smoke. Strategies to achieve this target include continued implementation of all components of the Comprehensive Tobacco Strategy.

This indicator is designed to assist policy makers in determining where tobacco policies should be directed. By looking at prevalence of smoking by both age and sex, it is easier to identify which populations' policies and programs should be targeted towards.

In 2003, Nova Scotia implemented a province-wide Comprehensive Tobacco Strategy. The strategy addresses seven key components: taxation, smoke-free places legislation, treatment/cessation, community-based programs, youth

prevention, media awareness, and monitoring and evaluation. Through this comprehensive approach, by 2004-2005 the province hopes to decrease the provincial smoking rate to the Canadian average or less. Nova Scotia's rate has decreased from 23.1 in 2003 to 22.6 in 2005, but has not yet reached the 2005 Canadian average of 21.8.

Technical Specifications

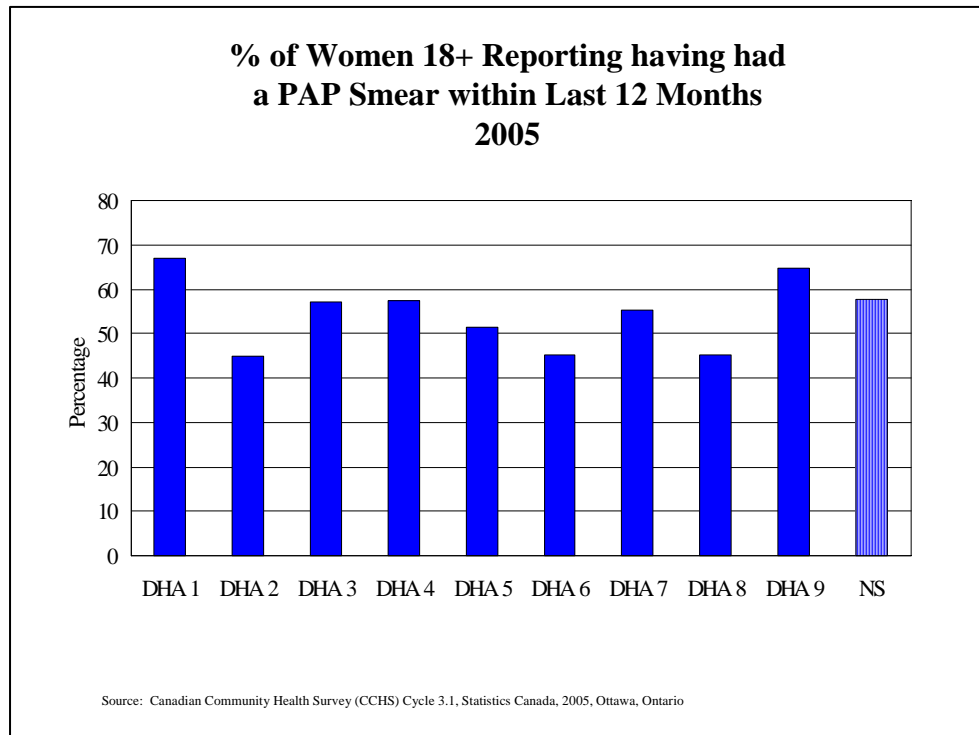
The data are based on the question: At the present time do you smoke cigarettes daily, occasionally or not at all?

Numerator: Weighted number of individuals aged 12+, by sex, who report smoking

Denominator: Total population

Calculation: (Numerator/Denominator) x 100

Source: Canadian Community Health Survey (CCHS) Cycle 3.1, Statistics Canada, 2005, Ottawa, Ontario.



PAP Smear Testing

Definition

The percentage of females aged 18 and over who have had a PAP smear in the last 12 months

Significance - Rationale and Notes for Interpretation

Pap Smear Tests are used to screen for cervical cancers. These cancers can be better treated with early detection and managed quite effectively. Early and regular testing for these cancers, in the populations at risk, leads to earlier detection and treatment as well as better health outcomes. Measuring the percentage of females having been treated, and the frequency of screening, provides an estimate of health services resources used and perhaps the target areas that education and further testing needs to be focused on.

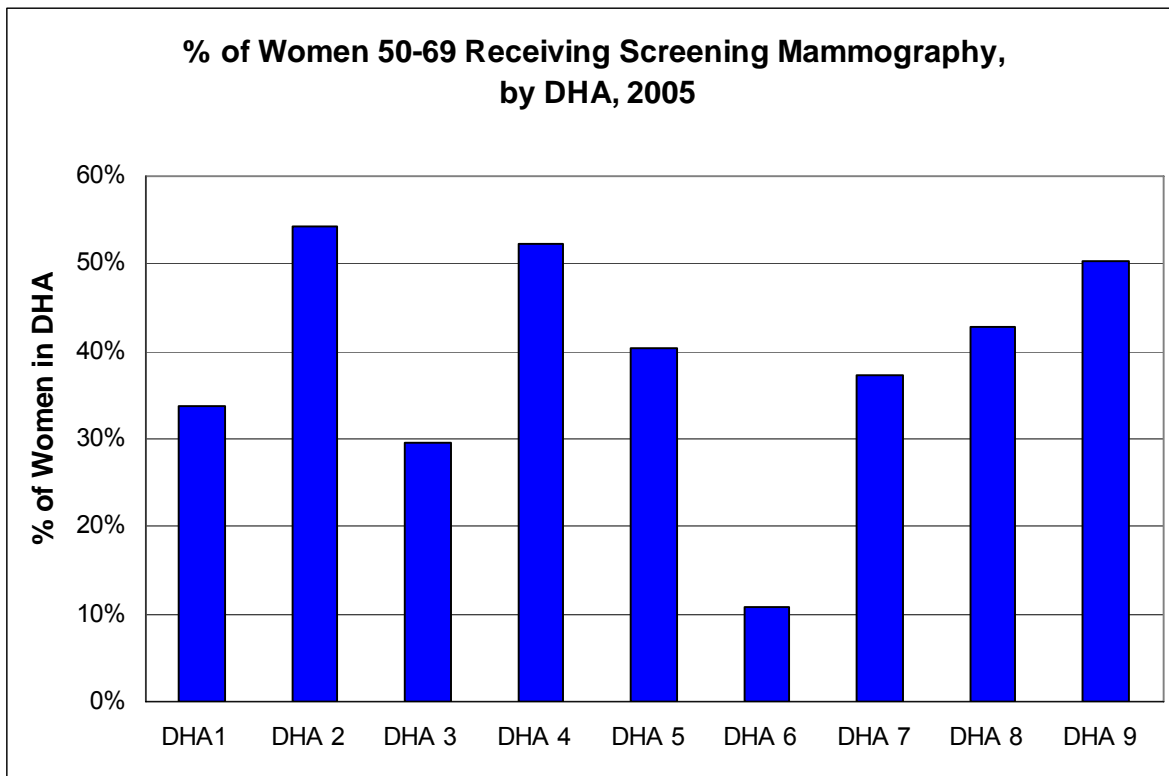
DHA 2 and 8 are significantly lower than the Provincial rate.

Technical Specifications

Calculation:

$$\left(\frac{\text{The number of females aged 18 and over who have had a PAP smear test within the last 12 months}}{\text{The total number of females aged 18 and over}} \right) \times 100$$
for each of Nova Scotia's nine District Health Authorities and Nova Scotia.

Source: Canadian Community Health Survey (CCHS) Cycle 3.1, Statistics Canada, 2005, Ottawa, Ontario.



**Mammography Screening
Percentage of Women Screened (Aged 50 to 69 Years)**

Definition

This indicator measures the percentage of women ages 50 to 69 who have had at least one mammogram screening for breast cancer in a given fiscal year, as administered by the Nova Scotia Breast Screening Program.

Significance – Rationale and Notes for Interpretation

The goal of the Nova Scotia Breast Screening Program (NSBSP) is to reduce the mortality from breast cancer in Nova Scotia women aged 50-69 years of age by 30% within ten years following province wide program status. Women aged 50-69 are more at risk for breast cancer making adequate screening measures imperative for this age group. Examining and reporting the number of first time breast screening women and the number of women returning to the program enables the NSBSP to monitor screening promotion and use in each DHA and indicate where extra resources may be needed. Since the establishment of the NSBSP in 1991, 119,200 women have been registered in the provincial breast screening database and 375,641 mammograms have been done. By the end of 2007 it is predicted that all mammography in the province will

be done under the umbrella of the NSBSP making it the first province in Canada to accomplish this.

Vision

To provide quality standardized mammography access with timely assessment, informed patient navigation and appropriate follow-up of women who have abnormal mammograms on screening, through diagnostic work-ups in accredited work-up centers, before consideration of surgical alternatives.

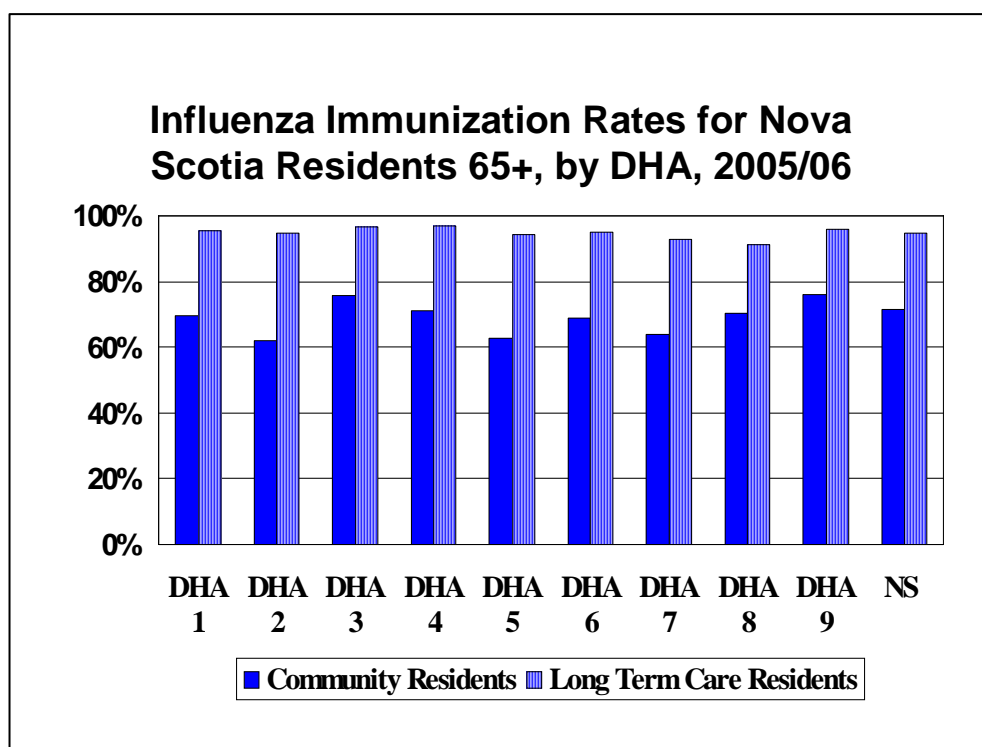
NSBSP Biennial Participation and Cancer Detection Rate by District ages 50-69

District Health Authority (DHA)	Target Population	Women screened biennially 2005+2006	Participation Rate 2005+2006	Invasive Cancers	In situ Cancers	All Cancers	Cancer Rate per woman screened per district
Unknown	-	3,226	7%	9	2	11	
DHA1	7,555	2,551	33.8%	7	1	8	3.1
DHA 2	7,241	3,930	54.3%	10	2	12	2.8
DHA 3	9,312	2,756	29.6%	2	0	2	0.7
DHA 4	7,439	3,882	52.2%	8	3	11	2.8
DHA 5	4,043	1,629	40.3%	5	1	6	3.7
DHA 6	5,406	590	10.9%	1	0	1	1.7
DHA 7	5,434	2,019	37.2%	6	0	6	3.0
DHA 8	15,762	6,761	42.8%	22	7	29	4.3
DHA 9	38,114	19,208	50.4%	47	10	57	3.0
Invalid Postal Codes	-	8	-				
Total	100,306	46,560	46.4%	117	26	143	3.0

Definition

This table measures the number of women ages 50-69 who have had at least one mammogram for breast cancer screening in a given year as administrated by the Nova Scotia Breast Screening Program. This is not an accurate representation of the breast screening participation rate in each district due to ad hoc screening still going on in the diagnostic sector in some districts.

Source: Nova Scotia Breast Screening Program database, Nova Scotia Department of Health.



Influenza Immunization Rates for Nova Scotia Residents 65+

Definition

1. The proportion of adults 65 years of age and older who received an influenza vaccination in the last year by DHA.
2. The proportion of adults 65 years of age and older who received an influenza vaccination 1998-2006.

Significance – Rationale and Notes for Interpretation

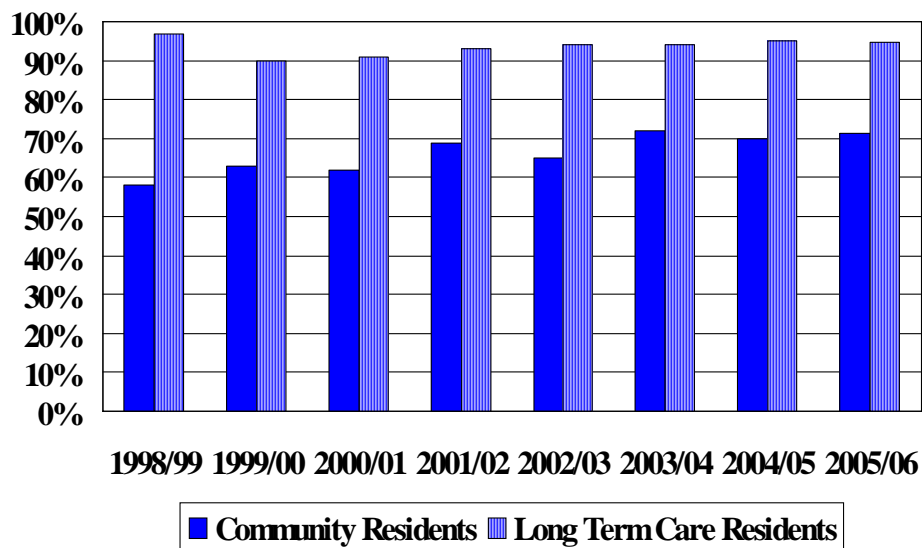
The *Canadian Consensus Conference on Influenza* (1993) recommended that by the 2000/01 flu season 70% of individuals in high-risk groups (such as those aged 65+) should receive flu shots. Nova Scotia has a comprehensive strategy for the promotion of flu immunizations.

Technical Specifications

Calculation: (Total number of people immunized)/(Total population (for community resident this is based on mid-year population projection from the 1996 census)) x 100 for each of Nova Scotia's nine District Health Authorities and Nova Scotia.

Source: Influenza Surveillance and Immunization Annual Report, 2005-2006, Office of the Chief Medical Officer of Health, Nova Scotia Department of Health.

Influenza Immunization Rates for Nova Scotia Residents 65+, 1998/99 – 2005/06



Section 2 Disease Prevalence / Incidence

Unlike health promotion and population health indicators, disease incidence and mortality indicators tell us how healthy our population currently is and at what rate it is experiencing and dying from disease. Incidence is a measure of the rate at which new cases of disease occur in a population previously without disease. In this section, three types of disease are examined: communicable diseases, cancers and diabetes.

Often when looking at disease incidence and disease mortality rates, statisticians use a method of analysis called age standardization. Age standardization is a way of looking at the rate of illness in a specific place and asking, "What would we expect the rate of illness to be if this place had the same age structure as the rest of Canada?" Therefore, the rates shown do not cite the actual number of observed cases, but the numbers of expected cases in the standard population.

Using this method allows for valid comparisons across different parts of the province/country and allows us to see if health problems are actually more serious in one place than in another. Age standardized statistics must be standardized to the same census population data. Data are not comparable if, for instance, some data (for a particular variable) are standardized to 1996 population data and some are standardized to 1991 population data. In this report, 1991 Canadian population data are used.

Age-standardized cancer incidence rates measure the appearance of new cases of cancer. This incidence rate is influenced by two main groups of factors: (1) the underlying rate of cancer incidence, which reflects, in part, the prevalence of risk factors such as smoking, and, in turn, the success of primary prevention efforts, and (2) the rate of detection and diagnosis of cancers, which can be influenced by the intensity and effectiveness of cancer screening programs.

Unfortunately, from the viewpoint of interpreting this indicator, these two factors work in opposite directions. For example, an increase in measured cancer incidence could reflect either deterioration in healthy life style or an improvement in screening. However, this latter kind of "screening artefact" is unlikely to carry on for a long period so that generally, a declining incidence of cancer suggests a positive change in population health. This interpretation is being addressed by the addition of staging data to the cancer registry systems. Cancer staging provides information on how advanced (serious) the cancer is at the time of diagnosis.

As a general comment on using incidence figures, there is an increasing awareness that a successful decrease in one disease may simply lead to an increase in the incidence of

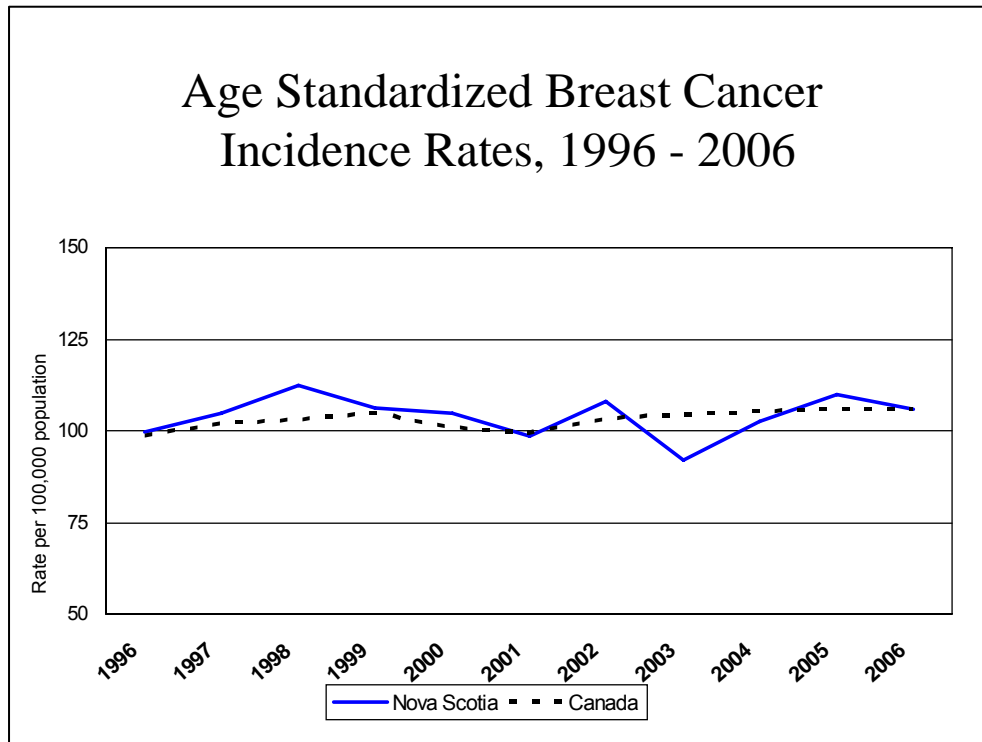
some other conditions, with no net benefit. Therefore, when one cause of death or disability is replaced by another, it is important to know if there is a net increase in life span or if there is a significant gap in time between the decrease in mortality for one cause and increased mortality for another. Quality of health during the remaining years is also crucial.

Age-standardized cancer mortality rate trends may indicate long-term success in reducing deaths from these diseases. Lower death rates could indicate success in cancer screening, treatment. However cardio-vascular disease prevention, detection, and treatment could also be responsible.

More information on cancer incidence and mortality and cancer programs can be obtained at Cancer Care Nova Scotia's website: <http://www.cancercare.ns.ca> or at the national Cancer Care Society website: www.cancer.ca.

Communicable diseases pass between people through bodily contact, exchange of bodily fluids or gases, or through contact with an infected agent such as food or water. Communicable diseases are often preventable and treatable.

More information on communicable diseases can be obtained through the Nova Scotia Department of Health website: www.gov.ns.ca health or through Health Canada's website: www.hc-sc.gc.ca.



Female Breast Cancer Incidence Rate

Definition

The reported number of newly diagnosed primary breast cancer cases in a given year per 100,000 population that would have occurred in the standard population if the observed age-specific rates in a given population had occurred in the standard population.

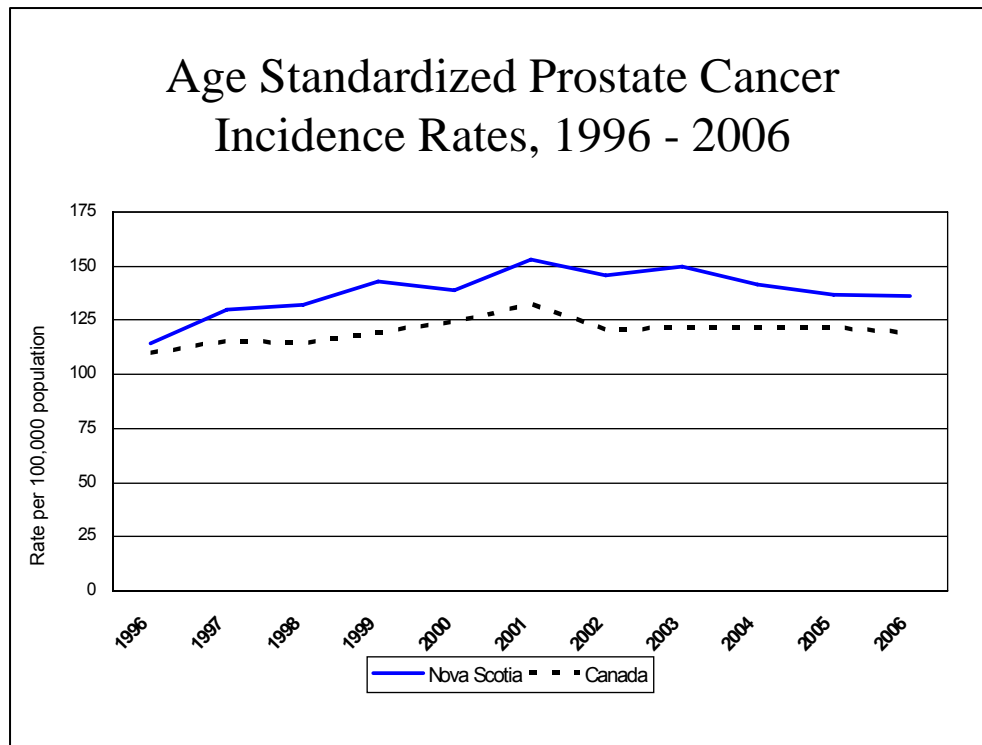
Significance – Rationale and Notes for Interpretation

Incidence rate trends associated with breast cancer can provide important planning information regarding treatment and prevention programs, especially as death from chronic conditions becomes more prevalent.

Technical Specifications

Codes: Malignant neoplasm of the female breast (ICD-9 174), (ICD-10 C50), (ICDO-3)
Calculation: The age-standardized rate for each cancer site is calculated by multiplying each observed age-specific incidence rate by the standard population in the corresponding age and sex group, summing the results, multiplying the sum by 100,000. The 1991 Canadian population is used as the standard population. (Non-residents of Canada are excluded from the calculation.)

Source: Canadian Cancer Statistics 2006, National Cancer Institute of Canada



Prostate Cancer Incidence Rate

Definition

The reported number of newly diagnosed primary prostate cancer cases in a given year per 100,000 male population that would have occurred in the standard population if the observed age-specific rates in a given population had occurred in the standard population.

Significance – Rationale and Notes for Interpretation

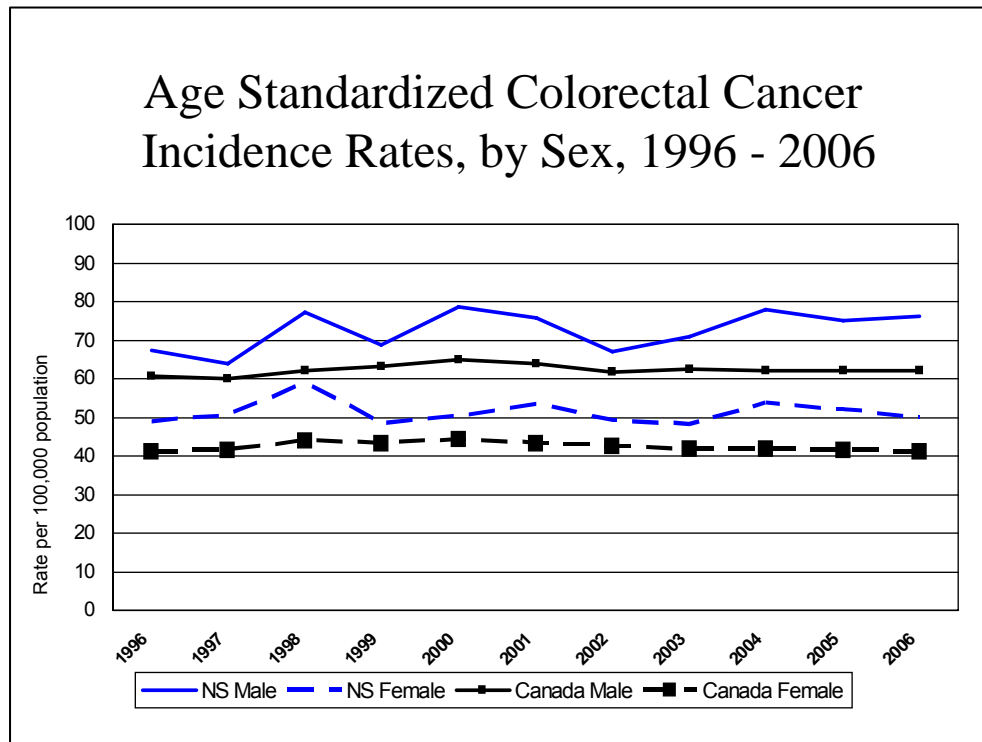
Incidence rate trends associated with prostate cancer can provide important planning information regarding treatment and prevention programs, especially as death from chronic conditions becomes more prevalent. The risk of prostate cancer increases with age, so it is important (in our aging population) for men over 50 to have regular prostate-specific antigen (PSA) tests.

Technical Specifications

Codes: Malignant neoplasm of the prostate (ICD-9 185) (ICD-10 C61) (ICDO-3)

Calculation: The age-standardized rate for each cancer site is calculated by multiplying each observed age-specific incidence rate by the standard population in the corresponding age and sex group, summing the results, multiplying the sum by 100,000. The 1991 Canadian population is used as the standard population. (Non-residents of Canada are excluded from the calculation.)

Source: Canadian Cancer Statistics 2006, National Cancer Institute of Canada



Colorectal Cancer Incidence Rate

Definition

The reported number of newly diagnosed primary colorectal cancer cases in a given year per 100,000 population that would have occurred in the standard population if the observed age-specific rates in a given population had occurred in the standard population.

Significance – Rationale and Notes for Interpretation

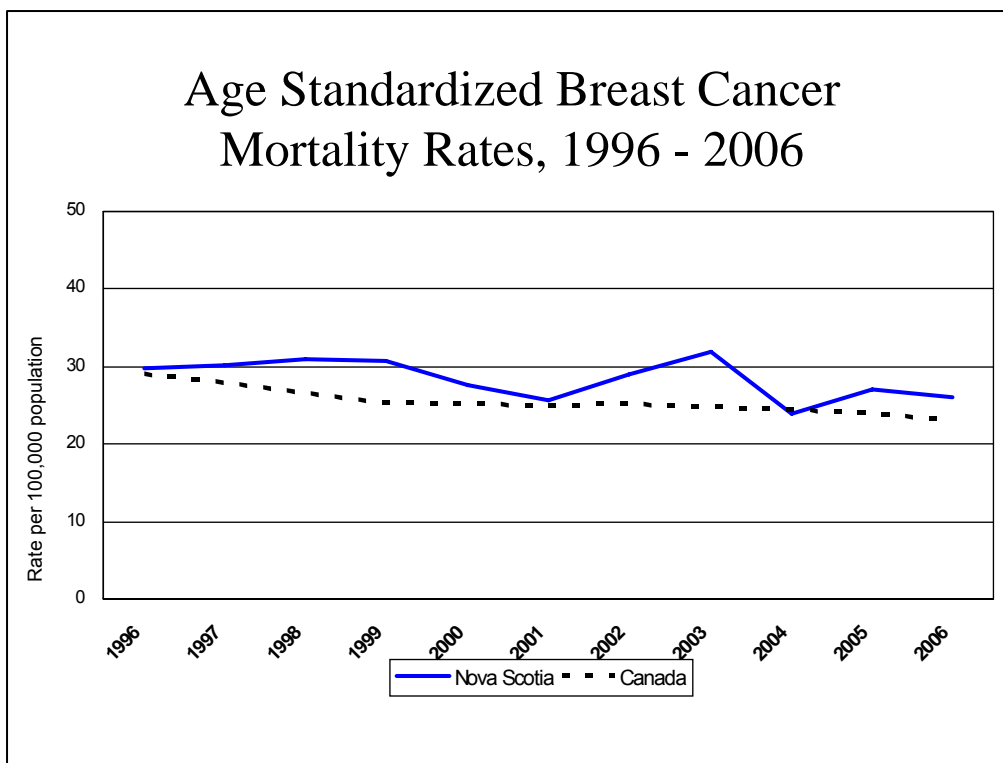
Incidence rate trends associated with colorectal cancer can provide important planning information regarding treatment and prevention programs, especially as chronic diseases become more prevalent.

Technical Specifications

Codes: Malignant neoplasm of the colon/rectum (ICD-9 153-154) (ICD-10 C18, C19, C20) (ICDO-3)

Calculation: The age-standardized rate for each cancer site is calculated by multiplying each observed age-specific incidence rate by the standard population in the corresponding age group, summing the results, multiplying the sum by 100,000. The 1991 Canadian population is used as the standard population. (Non-residents of Canada are excluded from the calculation.)

Source: Canadian Cancer Statistics 2006, National Cancer Institute of Canada



Breast Cancer Mortality Rate

Definition

The reported number of deaths of individuals where the underlying cause of death is breast cancer, per 100,000 female population, that would have occurred in the standard population if the observed age-specific rates in a given population had occurred in the standard population.

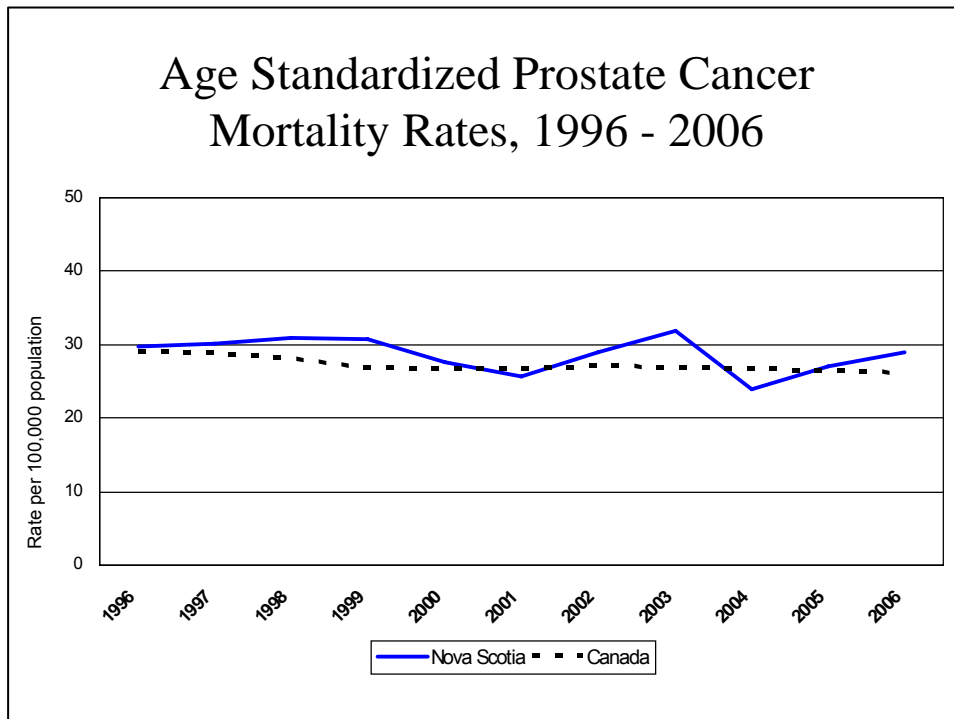
Significance – Rationale and Notes for Interpretation

Age-standardized cancer trends may indicate long-term success in reducing deaths from these diseases, compared with other provinces and countries. Lower death rates indicate success in cancer prevention, detection, and treatment.

Technical Specifications

Calculation: The age-standardized rate for each cancer site female breast (ICD-9 174 or ICD-10, ICDO-3, C50), is calculated by multiplying each observed age-specific death rate by the standard population in the corresponding age-group, summing the results, multiplying the sum by 100,000. The 1991 Canadian population is used as the standard population. (Non-residents of Canada are excluded from the calculation.)

Source: Canadian Cancer Statistics 2006, National Cancer Institute of Canada



Prostate Cancer Mortality Rate

Definition

The reported number of deaths of individuals where the underlying cause of death is prostate cancer, per 100,000 male population, that would have occurred in the standard population if the observed age-specific rates in a given population had occurred in the standard population.

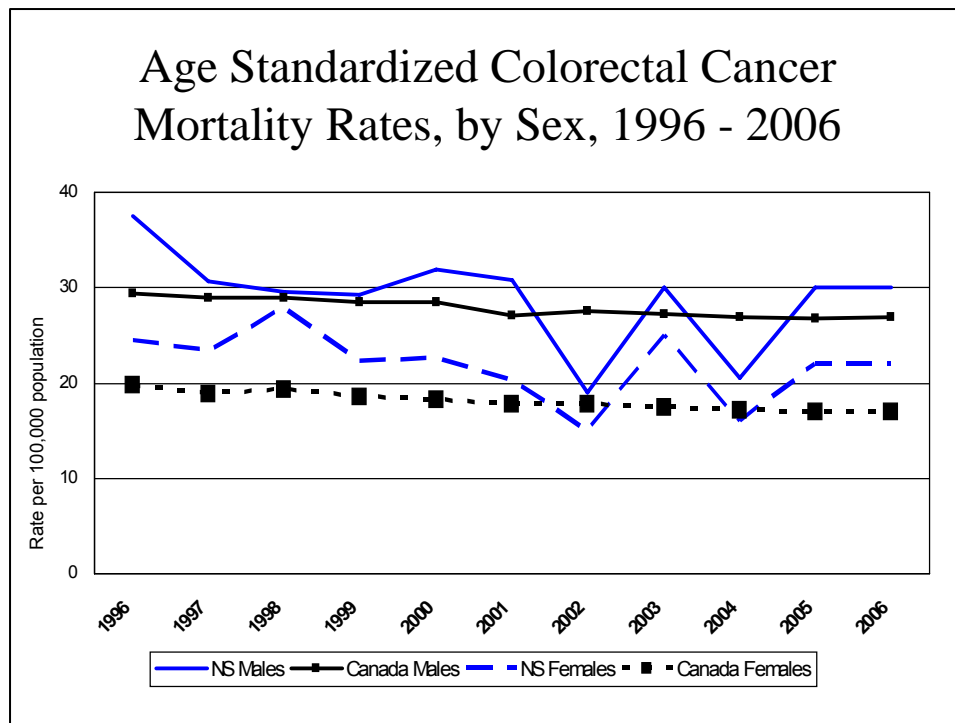
Significance – Rationale and Notes for Interpretation

Age-standardized cancer death rate trends may indicate long-term success in reducing deaths from these diseases, compared with other provinces and countries. Lower death rates indicate success in cancer prevention, detection, and treatment.

Technical Specifications

Calculation: The age-standardized rate for cancer of the prostate (ICD-9 185 or ICD-10, ICDO-3 C61) is calculated by multiplying each observed age-specific death rate by the standard population in the corresponding age-group, summing the results, multiplying the sum by 100,000. The 1991 Canadian population is used as the standard population. (Non-residents of Canada are excluded from the calculation.)

Source: Canadian Cancer Statistics 2006, National Cancer Institute of Canada



Colorectal Cancer Mortality Rate

Definition

The reported number of deaths of individuals where the underlying cause of death is colorectal cancer, per 100,000 population, that would have occurred in the standard population if the observed age-specific rates in a given population had occurred in the standard population.

Significance – Rationale and Notes for Interpretation

Age-standardized cancer death rate trends may indicate long-term success in reducing deaths from these diseases, compared with other provinces and countries. Lower death rates indicate success in cancer prevention, detection, and treatment.

Technical Specifications

Calculation: The age-standardized rate for cancer of the colon/rectum (ICD-9 153-154 or ICD-10, ICDO-3 C18-20) is calculated by multiplying each observed age-specific death rate by the standard population in the corresponding age group, summing the results, multiplying the sum by 100,000. The 1991 Canadian population is used as the standard population. (Non-residents of Canada are excluded from the calculation.)

Source: Canadian Cancer Statistics 2006, National Cancer Institute of Canada

Incidence and Mortality Rates for Selected Cancers Nova Scotia by DHA - 2005

Incidence rates¹ of invasive cancers, by gender and District Health Authority (DHA), common cancer sites, Nova Scotia 2005

FEMALES	Age-Standardized Incidence Rate ² per 100,000							
DISTRICT HEALTH AUTHORITY	BREAST	95% CI ³	COLORECTAL	95% CI	LUNG	95% CI	ALL SITES	95% CI
South Shore Health	87.8	[60.3 - 115.2]	53.1	[33.3 - 73.0]	46.4	[27.2 - 65.6]	333.3	[279.1 - 387.5]
South West Health	71.7	[48.1 - 95.4]	58.0	[36.8 - 79.1]	37.4	[19.4 - 55.4]	317.8	[264.4 - 371.3]
Annapolis Valley Health	112.1	[83.8 - 140.4]	53.3	[35.0 - 71.6]	29.0	[15.8 - 42.2]	336.5	[287.8 - 385.2]
Colchester East Hants Health Authority	106.0	[76.0 - 135.9]	64.4	[40.8 - 87.9]	56.0	[33.8 - 78.2]	374.5	[317.8 - 431.2]
Cumberland Health Authority	100.7	[60.0 - 141.4]	61.9	[31.8 - 91.9]	96.6	[58.3 - 134.9]	480.2	[388.5 - 571.9]
Pictou County Health Authority	76.8	[46.0 - 107.7]	65.5	[39.8 - 91.2]	48.5	[25.0 - 72.1]	397.8	[330.2 - 465.4]
Guysborough Antigonish Strait Health Authority	104.9	[70.1 - 139.7]	45.4	[22.9 - 67.9]	40.0	[16.8 - 63.3]	392.7	[319.8 - 465.6]
Cape Breton District Health Authority	139.4	[114.4 - 164.3]	53.8	[39.8 - 67.9]	50.1	[36.1 - 64.1]	420.5	[377.3 - 463.7]
Capital Health	118.6	[104.6 - 132.7]	50.6	[41.6 - 59.7]	64.0	[53.5 - 74.5]	396.9	[371.1 - 422.7]
All Nova Scotia 2005	101.4	[93.3 - 109.4]	52.9	[47.3 - 58.5]	52.1	[46.4 - 57.8]	374.3	[358.8 - 389.8]
Canada ⁴ 2001	98.7	[90.9 - 107.1]	53.3	[47.9 - 59.3]	56.8	[50.9 - 63.2]	374.0	[358.5 - 390.1]

¹ Rates are provisional as 2004 population data were used in place of 2005.

² Rates are standardized to the age distribution of the 1991 Canadian population.

³ The 95% confidence interval (range within which a value is expected to fall with a given probability).

⁴ Age-standardized incidence rates obtained from Cancer Surveillance Online, Health Canada, Oct. 26, 2006.

MALES DISTRICT HEALTH AUTHORITY	Age-Standardized Incidence Rate ² per 100,000						ALL SITES	95% CI
	PROSTATE	95% CI	COLORECTAL	95% CI	LUNG	95% CI		
South Shore Health	134.7	[100.5 - 169.0]	70.3	[45.8 - 94.7]	72.7	[47.4 - 97.9]	468.7	[403.5 - 534.0]
South West Health	191.9	[148.6 - 235.1]	67.6	[41.2 - 94.1]	102.0	[70.5 - 133.5]	575.0	[499.6 - 650.5]
Annapolis Valley Health	112.2	[83.3 - 141.1]	63.5	[41.7 - 85.3]	99.8	[72.6 - 127.0]	499.5	[437.2 - 561.9]
Colchester East Hants Health Authority	103.7	[71.7 - 135.6]	117.7	[83.9 - 151.5]	64.1	[39.7 - 88.6]	454.8	[388.4 - 521.2]
Cumberland Health Authority	158.6	[106.0 - 211.2]	74.0	[38.2 - 109.7]	127.6	[81.8 - 173.3]	572.6	[471.5 - 673.7]
Pictou County Health Authority	236.5	[179.2 - 293.8]	73.3	[42.3 - 104.2]	78.9	[45.7 - 112.1]	630.8	[536.6 - 725.1]
Guysborough Antigonish Strait Health Authority	141.4	[99.3 - 183.5]	79.8	[48.2 - 111.4]	84.1	[51.5 - 116.6]	496.2	[415.9 - 576.5]
Cape Breton District Health Authority	122.4	[98.4 - 146.3]	84.9	[65.0 - 104.7]	98.7	[77.0 - 120.4]	509.0	[459.6 - 558.3]
Capital Health	122.9	[107.1 - 138.7]	68.6	[56.6 - 80.5]	79.1	[66.2 - 91.9]	487.8	[456.2 - 519.4]
All Nova Scotia 2005	136.2	[126.2 - 146.1]	76.2	[68.7 - 83.7]	87.3	[79.3 - 95.3]	510.3	[490.9 - 529.7]
Canada ⁴ 2001	151.2	[140.6 - 162.4]	75.8	[68.4 - 83.8]	87.5	[79.5 - 96.1]	528.6	[508.6 - 549.3]

¹ Rates are provisional as 2004 population data were used in place of 2005.

² Rates are standardized to the age distribution of the 1991 Canadian population.

³ The 95% confidence interval (range within which a value is expected to fall with a given probability).

⁴ Age-standardized incidence rates obtained from Cancer Surveillance Online, Health Canada, Oct. 26, 2006.

Source: Cancer Care Nova Scotia

**Mortality counts and rates¹, by gender and District Health Authority (DHA),
common cancer sites, Nova Scotia 2005**

FEMALES						Age-Standardized Incidence Rate ² per 100,000	
DISTRICT HEALTH AUTHORITY	BREAST	COLORECTAL	LUNG	OTHER	TOTAL MORTALITY	ALL CANCERS	95% CI ³
South Shore Health	6	7	17	32	62	118.4	[87.2 - 149.6]
South West Health	10	17	10	38	75	142.5	[108.0 - 177.1]
Annapolis Valley Health	13	24	21	37	95	142.1	[112.3 - 172.0]
Colchester East Hants Health Authority	9	5	13	28	55	115.2	[83.7 - 146.7]
Cumberland Health Authority	7	4	19	28	58	180.7	[131.6 - 229.8]
Pictou County Health Authority	7	8	13	23	51	129.9	[91.8 - 168.1]
Guysborough Antigonish Strait Health Authority	14	5	9	23	51	143.3	[101.3 - 185.3]
Cape Breton District Health Authority	20	10	49	73	152	136.1	[113.5 - 158.7]
Capital Health	46	50	105	160	361	142.9	[127.7 - 158.2]
All Nova Scotia 2005	132	130	256	442	960	137.9	[128.8 - 147.0]

¹ Rates and counts are provisional as mortality data may not be complete and 2004 population data were used in place of 2005.

² Rates are standardized to the age distribution of the 1991 Canadian population.

³ The 95% confidence interval (range within which a value is expected to fall with a given probability).

MALES						Age-Standardized Incidence Rate ² per 100,000	
DISTRICT HEALTH AUTHORITY	PROSTATE	COLORECTAL	LUNG	OTHER	TOTAL MORTALITY	ALL CANCERS	95% CI ³
South Shore Health	6	13	22	55	96	216.6	[173.1 - 260.1]
South West Health	9	13	29	41	92	229.2	[181.4 - 277.0]
Annapolis Valley Health	15	15	43	47	120	230.2	[188.8 - 271.5]
Colchester East Hants Health Authority	12	15	22	34	83	203.4	[159.3 - 247.5]
Cumberland Health Authority	7	3	28	18	56	238.3	[175.2 - 301.5]
Pictou County Health Authority	8	8	25	30	71	248.4	[190.1 - 306.7]
Guysborough Antigonish Strait Health Authority	11	10	12	22	55	186.5	[137.1 - 235.9]
Cape Breton District Health Authority	15	29	63	86	193	239.9	[205.7 - 274.2]
Capital Health	38	47	102	196	383	206.8	[185.8 - 227.8]
All Nova Scotia 2005	121	153	346	529	1149	218.4	[205.7 - 231.1]

¹ Rates and counts are provisional as mortality data may not be complete and 2004 population data were used in place of 2005.

² Rates are standardized to the age distribution of the 1991 Canadian population.

³ The 95% confidence interval (range within which a value is expected to fall with a given probability).

Source: Cancer Care Nova Scotia

Incidence of Invasive Meningococcal Disease

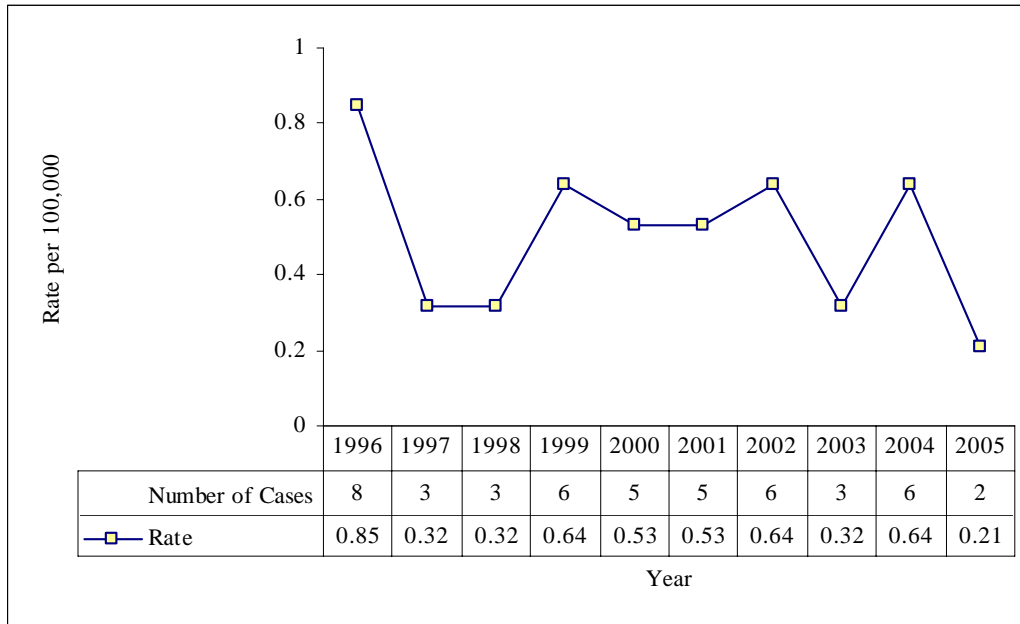


Figure 1

Definition

The rate per 100,000 population of reported new cases of invasive meningococcal disease reported annually in Nova Scotia. A confirmed case is defined as invasive disease (e.g. meningitis and /or Septicaemia with possible progression to purpura fulminans, shock, and death) with laboratory confirmation of infection through isolation of *Neisseria meningitidis* from a normally sterile site (blood, cerebrospinal fluid, joint, pleural or pericardial fluid) or demonstration of *N. meningitidis* antigen in cerebrospinal fluid.¹

Significance – Rationale and Notes for Interpretation

Invasive meningococcal disease (IMD) is an acute bacterial disease caused by the meningococcus, *Neisseria meningitidis*. The disease is spread by direct contact and droplet infection from the nose and throat of infected individuals. The prevalence of those who carry the bacteria in the absence of meningitis or invasive disease may be 25% or more but the invasion of bacteria sufficient to cause systemic disease is uncommon. Serogroups A, B, C and Y are responsible for most cases of disease but groups W-135, X and Z have also been recognized as pathogens.

¹ Advisory Committee on Epidemiology and Division of Disease Surveillance, Bureau of Infectious Diseases, Laboratory Centre for Disease Control, Health Protection Branch, Health Canada. Case Definitions for Diseases Under National Surveillance. Minister of Public Works and Government Services Canada, 2000.

Following an outbreak in 1992, overall incidence of IMD in Nova Scotia has remained consistently low (Figure 1, previous page). The highest incidence is reported in children and youth less than 20 years of age, an average rate of 2 cases per 100,000 annually since 1998.

A total of 53 laboratory-confirmed and clinical cases of IMD were reported between 1996 and 2005 in Nova Scotia, including 5 deaths (Table 1). An incidence has been shown to be highest among young children and to decline with increasing age, immunization programs generally focus on those less than 20 years of age. Tables 1 and 2 summarize the reported cases of laboratory-confirmed IMD from 1996 to 2005 with confirmed serogroups (B,C,Y,W-135, unknown) by age group.

Source: Office of the Chief Medical Officer of Health, Nova Scotia Department of Health.

Table 1: Number of reported cases of Invasive Meningococcal Disease (Laboratory confirmed and clinical) by serogroup and outcome, Nova Scotia, 1996-2005

YEAR	TOTAL NUMBER CASES	CASE							OUTCOME	
		Confirmed with Serogroup					Clinical	Rate 100,000/Year	Recovered	Died
		B	C	Y	W-135	Unknown				
1996	8	3	3	1	-	1	-	0.8	8	-
1997	3	1	-	-	-	2	-	0.3	1	2
1998	4	3	-	-	-	-	1	0.3	4	-
1999	6	5	-	1	-	-	-	0.6	5	1
2000	5	2	-	1	-	2	-	0.5	4	1
2001	7	1	-	2	-	2	2	0.5	7	-
2002	8	3	1	2	-	-	2	0.6	7	1
2003	3	1	1	1	-	-	-	0.3	3	-
2004	6	4	-	-	1	1	-	0.6	6	-
2005	3	1	1	-	-	-	1	0.3	3	-
Total	53	24	6	8	1	8	6		48	5

Table 2: Number of reported cases of laboratory confirmed Invasive Meningococcal Disease by age group and serogroup, Nova Scotia, 1996-2005

Year	Age-Group	CASE						
		Confirmed with Serogroup						
		B	C	Y	W135	Unknown	Total	Rate/100,000
1996	0-4	3	2	1	-	-	6	12.4
	5-9	-	-	-	-	1	1	1.8
	15-19	-	1	-	-	-	1	1.6
1997	0-4	1	-	-	-	1	2	4.1
	15-19	-	-	-	-	1	1	1.6
1998	0-4	2	-	-	-	-	2	4.1
	10-14	1	-	-	-	-	1	1.6
1999	0-4	1	-	-	-	-	1	2.1
	5-9	1	-	-	-	-	1	1.8
	10-14	1	-	-	-	-	1	1.6
	15-19	1	-	-	-	-	1	1.5
	40-59	1	-	1	-	-	2	0.7
2000	0-4	1	-	-	-	-	1	2.1
	5-9	-	-	-	-	1	1	1.8
	15-19	1	-	1	-	-	2	3.1
	20-24	-	-	-	-	1	1	1.6
2001	5-9	-	-	1	-	-	1	1.8
	10-14	-	-	1	-	1	2	3.2
	15-19	1	-	-	-	1	2	3.1
2002	0-4	2	-	-	-	-	2	4.1
	10-14	-	-	1	-	-	1	1.6
	15-19	1	1	-	-	-	2	3.1
2003	0-4	1	-	-	-	-	1	2.1
	15-19	-	1	-	-	-	1	1.5
	60+	-	-	1	-	-	1	0.6
2004	0-4	1	-	-	1	-	2	4.1
	15-19	2	1	-	-	-	3	4.7
	60+	1	-	-	-	-	1	0.6
2005	10-14	-	1	-	-	-	1	1.6
	30-39	1	-	-	-	-	1	0.7

Figure 2: Incidence of Verotoxigenic *E Coli*, Nova Scotia, 1996-2005

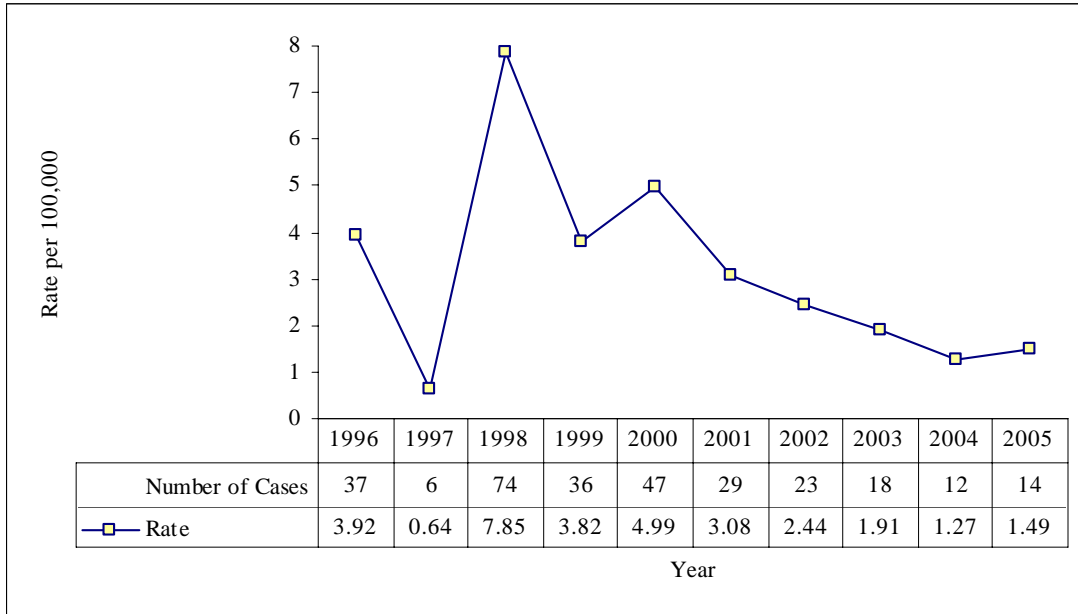
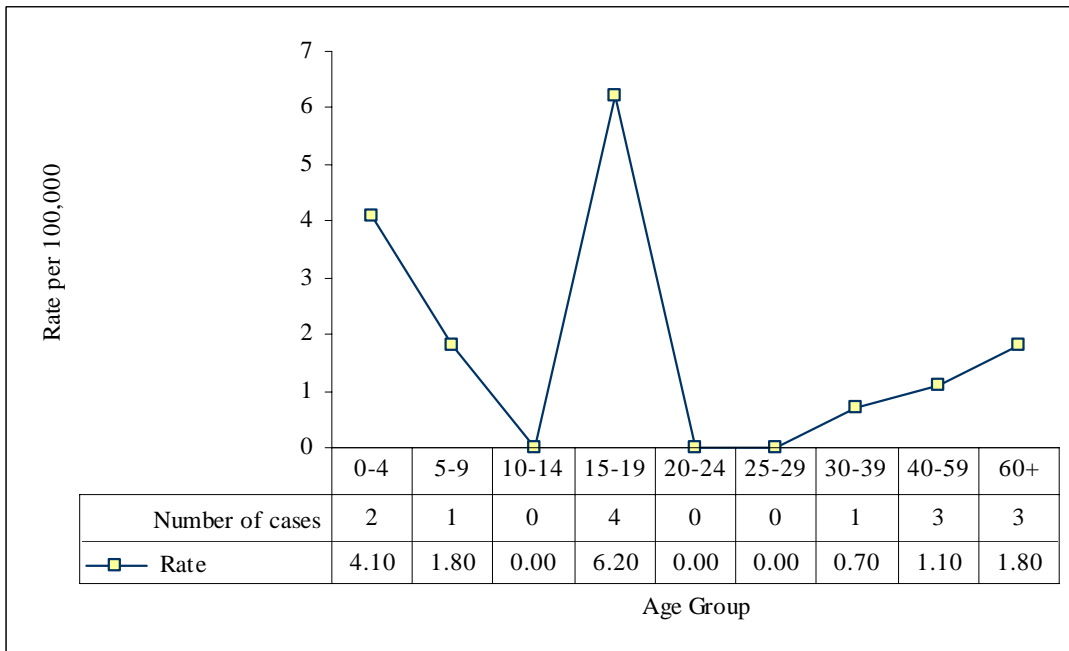


Figure 3: Age specific incidence of Verotoxigenic *E. Coli*, Nova Scotia, 2005



Incidence of Verotoxigenic *Escherichia coli* Infection

Definition

The rate per 100,000 of reported new cases of verotoxigenic *Escherichia coli* infection reported annually in Nova Scotia. A confirmed case is defined as laboratory confirmation of *E. coli* infection with or without symptoms including isolation of verotoxin producing *Escherichia coli* or other toxigenic strains from an appropriate clinical specimen.²

Significance – Rationale and Notes for Interpretation

Infection with Verotoxigenic/Shigatoxigenic *E. coli* (VTEC/STEC) may lead to hemorrhagic colitis and potentially the more severe Hemolytic Uremic Syndrome (HUS), a serious complication of the infection. A common serotype in North America is *E. Coli* 0157:H7. Transmission may be through water but commonly the infection is transmitted through contaminated food. Inadequately cooked beef (particularly ground beef), raw milk and fruits or vegetables that have been contaminated with feces from ruminants are commonly responsible. The bacteria may also be passed person-to-person through direct contact in families, childcare centres, and institutions.

The incidence of verotoxigenic *E. coli* infection in Nova Scotia peaked at 7.9 cases per 100,000 population in 1998 followed by an apparent decrease to 1.3 and 1.5 cases per 100,000 population in 2004 and 2005 respectively (Figure 2). Reported cases in 2005 were equally split between female and male (50%). Half of the reported cases in 2005 were in children <20 years of age. The highest age-specific incidence occurred in those 15-19 years of age at 6.2 cases per 100,000 population (Figure 3).

Technical Specifications

Numerator: Number of reported cases of Verotoxigenic *E. coli*

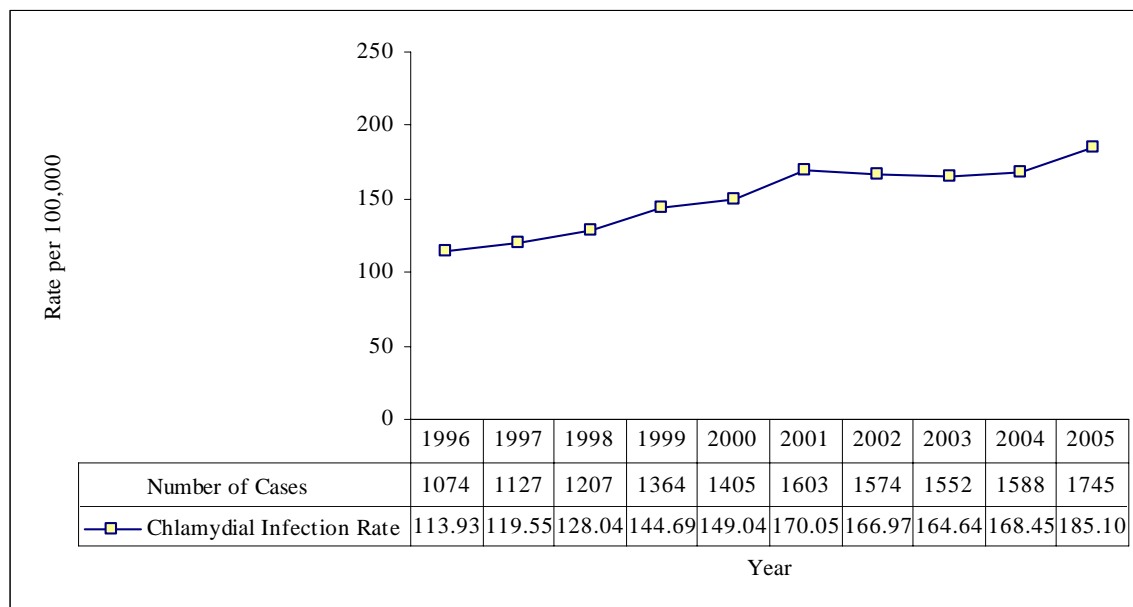
Denominator: Total population of Nova Scotia

Calculation: Numerator/denominator x 100,000

Source: Office of the Chief Medical Officer of Health, NS Department of Health

² Advisory Committee on Epidemiology and Division of Disease Surveillance, Bureau of Infectious Diseases, Laboratory Centre for Disease Control, Health Protection Branch, Health Canada. Case Definitions for Diseases Under National Surveillance. Minister of Public Works and Government Services Canada, 2000

Figure 4: Incidence of Chlamydial infection, Nova Scotia, 1996-2005



Incidence of *Chlamydia trachomatis* Infection

Definition

The rate per 100,000 of new cases of Chlamydial infection (genital) reported annually in Nova Scotia. A confirmed case is defined as laboratory confirmation of *Chlamydia trachomatis* infection as detected using appropriate laboratory techniques in genitourinary specimens.⁴

Significance – Rationale and Notes for Interpretation

Chlamydiae cause a number of sexually transmitted infections and eye and lung infections of infants consequent to maternal genital infection. Genital chlamydial infection is a sexually transmitted disease caused by the bacterium *Chlamydia trachomatis*, manifested in males mainly as a urethritis and in females primarily as a mucopurulent cervicitis.

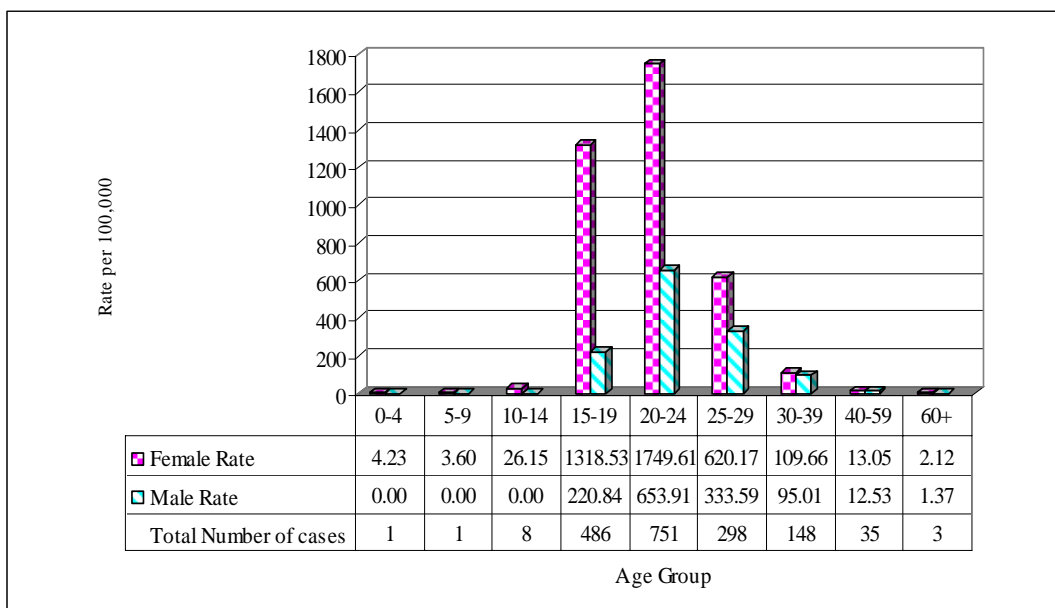
⁴ Advisory Committee on Epidemiology and Division of Disease Surveillance, Bureau of Infectious Diseases, Laboratory Centre for Disease Control, Health Protection Branch, Health Canada. Case Definitions for Diseases Under National Surveillance. Minister of Public Works and Government Services Canada, 2000

Recent increasing incidence rates of chlamydial infection probably reflect to a large degree, changes in testing methodology. The number of *Chlamydia trachomatis* infections in Capital Health Region showed a marked increase in 2001 coincidental with the replacement of an enzyme immunoassay (EIA) method of testing with a more sensitive polymerase chain reaction (PCR) method at the Microbiology Laboratory of the Queen Elizabeth II Health Sciences Centre. Therefore, while rates may have increased (Figure 4), much of this increase can be attributed to more sensitive testing.

The incidence of reported new cases of genital chlamydial infection in females far exceeded the rates in males for those 15-39 years age in 2005 (Figure 5) and seventy-two percent of all reported new cases were diagnosed in females. This may be reflective of more females undergoing testing. The greatest proportion of cases in 2005 (71%) were reported in the 15 to 24 year age group and DHA 9 (Capital) reported the highest age-standardized incidence of 247.7 cases per 100,000 population. Females in Capital had an age-standardized incidence of 340.5 per 100,000 population (Figure 6).

Source: Office of the Chief Medical Officer of Health, NS Department of Health

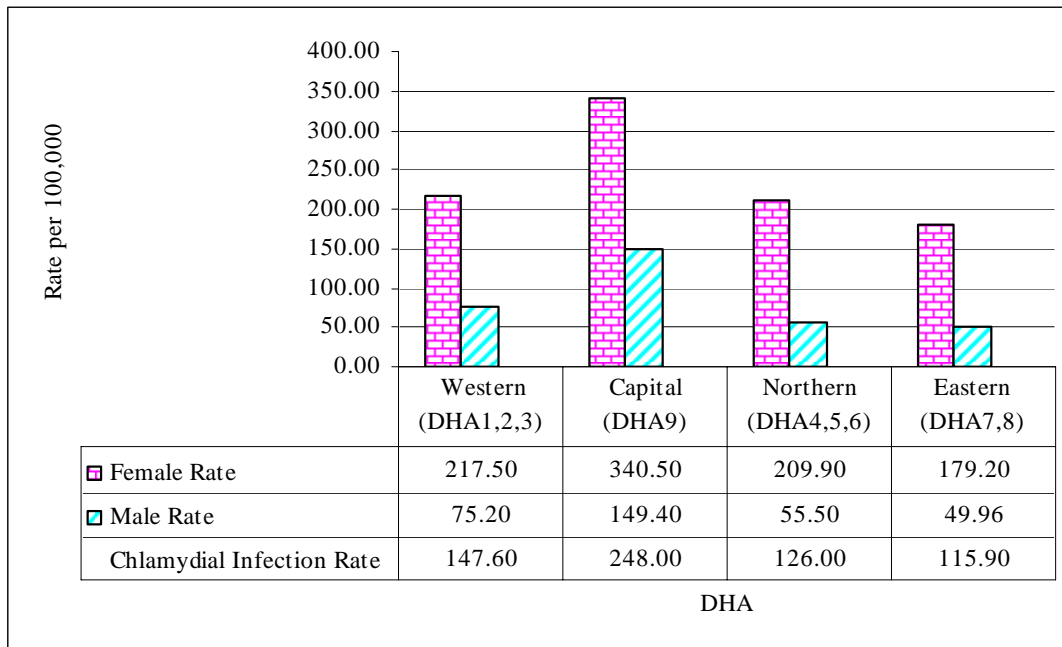
Figure 5: Age specific incidence of Chlamydial infection by gender, Nova Scotia, 2005



* 14 cases age was not specified

Source: Office of the Chief Medical Officer of Health, NS Department of Health

Figure 6: Age standardized incidence of Chlamydial infection by gender and District Health Authority (DHA), Nova Scotia, 2005



Source: Office of the Chief Medical Officer of Health, NS Department of Health

Chlamydia trachomatis (Genital Chlamydia)

Table 3: Reported number of new cases of *Chlamydia trachomatis* by age, gender, District Health Authority (DHA), Nova Scotia, 2005

DHA	Sex	0-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+	N.SP.	Total
1,2,3 (Western)	Female	0	0	0	86	85	31	16	4	0	0	222
	Male	0	0	0	14	31	16	10	3	0	1	75
	Total	0	0	0	100	116	47	26	7	0	1	297
4,5,6 (Northern)	Female	0	0	3	53	67	17	11	1	2	0	154
	Male	0	0	0	11	15	12	3	2	0	1	44
	Total	0	0	3	64	82	29	14	3	2	1	198
7,8 (Eastern)	Female	0	0	0	69	77	20	9	1	0	1	177
	Male	0	0	0	7	25	5	7	1	0	0	45
	Total	0	0	0	76	102	25	16	2	0	1	222
9 (Capital)	Female	1	1	5	203	317	127	44	12	0	1	711
	Male	0	0	0	41	134	70	48	11	1	1	306
	Unkn	0	0	0	2	0	0	0	0	0	9	11
	Total	1	1	5	246	451	197	92	23	1	11	1028
Nova Scotia	Female	1	1	8	411	546	195	80	18	2	2	1264
	Male	0	0	0	73	205	103	68	17	1	3	470
	Unkn	0	0	0	2	0	0	0	0	0	9	11
	Total	1	1	8	486	751	298	148	35	3	14	1745

Source: Office of the Chief Medical Officer of Health, NS Department of Health

Table 4: Age and gender specific, crude and age standardized* rates per 100,000 of *Chlamydia trachomatis* by District Health Authority (DHA), Nova Scotia, 2005

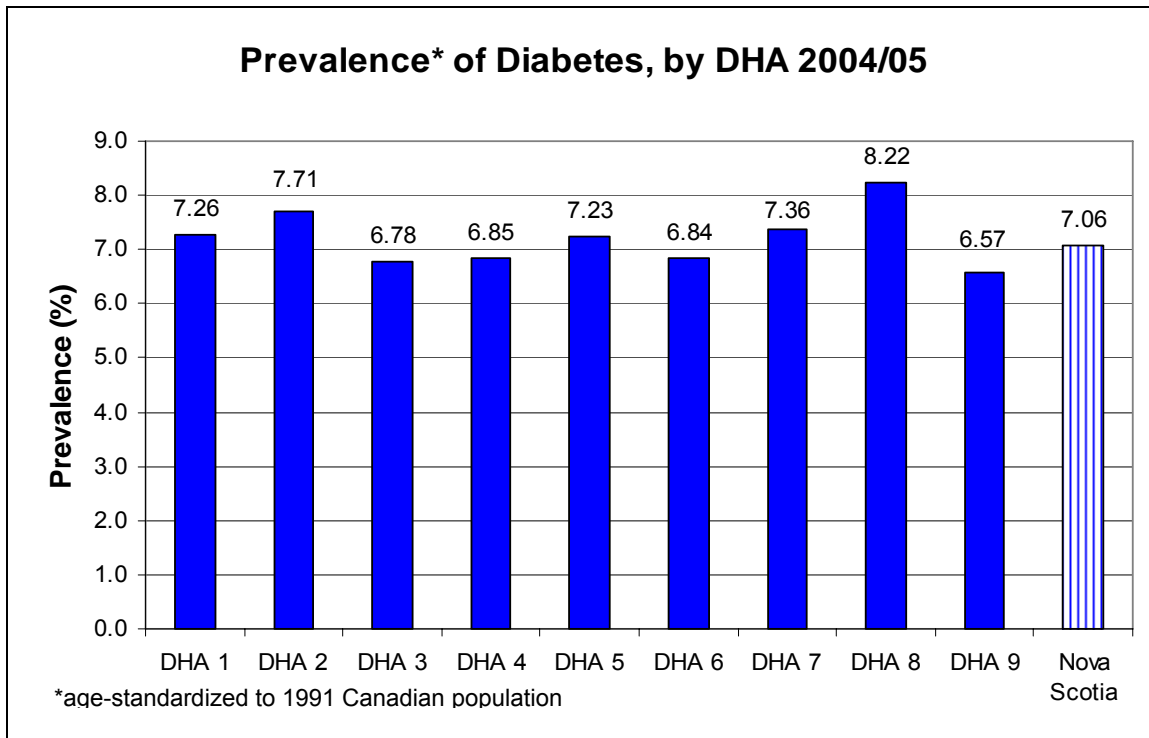
DHA	Sex	0-4	5-9	10-14	15-19	20-24	25-29	30-39	40-59	60+	Crude Rate	Age-Standardized Rate
1,2,3 (Western)	Female	0.0	0.0	0.0	1239.2	1300.7	541.5	104.0	13.0	0.0	207.5	217.5
	Male	0.0	0.0	0.0	194.9	464.9	276.0	63.4	9.8	0.0	72.0	75.2
	Total	0.0	0.0	0.0	708.0	878.6	407.9	83.5	11.4	0.0	140.7	147.6
4,5,6 (Northern)	Female	0.0	0.0	59.9	989.7	1402.7	347.4	97.7	4.5	11.7	194.2	209.9
	Male	0.0	0.0	0.0	186.9	284.3	258.4	27.1	8.7	0.0	57.1	55.5
	Total	0.0	0.0	28.9	569.3	815.5	304.1	62.7	6.6	6.6	126.6	126.0
7,8 (Eastern)	Female	0.0	0.0	0.0	1008.3	1189.7	399.8	74.2	3.7	0.0	187.7	179.2
	Male	0.0	0.0	0.0	96.8	393.3	97.4	61.4	3.7	0.0	50.3	49.9
	Total	0.0	0.0	0.0	540.0	795.1	246.6	68.0	3.7	0.0	120.8	115.9
9 (Capital)	Female	9.5	8.5	39.6	1687.0	2361.9	802.7	128.7	20.9	0.0	354.7	340.5
	Male	0.0	0.0	0	321.4	1027.0	457.5	144.0	19.9	4.1	160.2	149.4
	Total	4.6	4.1	19.2	992.4	1703.9	633.0	136.3	20.4	1.7	262.6	248.0
Nova Scotia	Female	4.2	3.6	26.1	1318.5	1749.6	620.2	109.7	13.0	2.1	262.8	261.8
	Male	0.0	0.0	0.0	220.8	653.9	333.6	95.0	12.5	1.4	101.8	99.2
	Total	2.1	1.8	12.7	756.7	1200.5	478.2	102.4	12.8	1.8	185.1	181.1

*Rates adjusted to the age distribution of the 2001 census population of Canada.

Source: Office of the Chief Medical Officer of Health, NS Department of Health

Prevalence of Diabetes

Percentage of Population with the disease (Aged 20 + Years)



Definition

This indicator measures the age standardized prevalence rate of diabetes mellitus for Nova Scotians age 20 and over. Prevalence rates are calculated as the proportion of new and existing diabetes cases for a given jurisdiction. Diabetes cases are determined from the National Diabetes Surveillance System (NDSS) annual person-level summary file as any individual with a date of diagnosis on or before March 31, 2005.

Significance - Rationale and Notes for Interpretation

The Diabetes Care Program of Nova Scotia (DCPNS) is one of seven provincial programs funded by the Nova Scotia Department of Health (DoH). Working closely with all Diabetes Centres in the Province, this Program advises the Ministry on service delivery models; establishes, promotes, and monitors adherence to diabetes care guidelines; provides support, services, and resources to diabetes healthcare providers; and collects, analyzes, and distributes diabetes-related data for Nova Scotia.

According to the most recent figures, diabetes has been diagnosed in approximately 7.06% of the adult population (age standardized) in Nova Scotia. This percentage varies across the District Health Authorities (DHAs) with the highest rates reported in South West Health (DHA 2) and Cape Breton (DHA 8). This new figure (7.05%) represents an absolute increase of 8% in the prevalence rates since last reported for 2002/03. The increase in prevalence is somewhat expected due to the aging of our population and the chronic nature of this condition (long duration). Inactivity, poor nutrition, and overweight/obesity also contribute to the growing prevalence numbers. Prevalence is noted to increase with age for both sexes, peaking in the 70-79 age group with one in four people in this age group having a diagnosis of diabetes and decreases slightly in the oldest age group 80+. The slight decrease in diabetes prevalence may be due to the mortality or increased co-morbidity at older ages. Strong support should be given to risk factor reduction through both targeted and population health initiatives aimed at the broader determinants of health.

Information for the under 19 population is derived from the DCPNS Registry inclusive of all new referrals to Nova Scotia's Diabetes Centres (DCs) since Jan 1, 1992. This data highlights, with concern, the growth in type 2 diabetes in this age population.

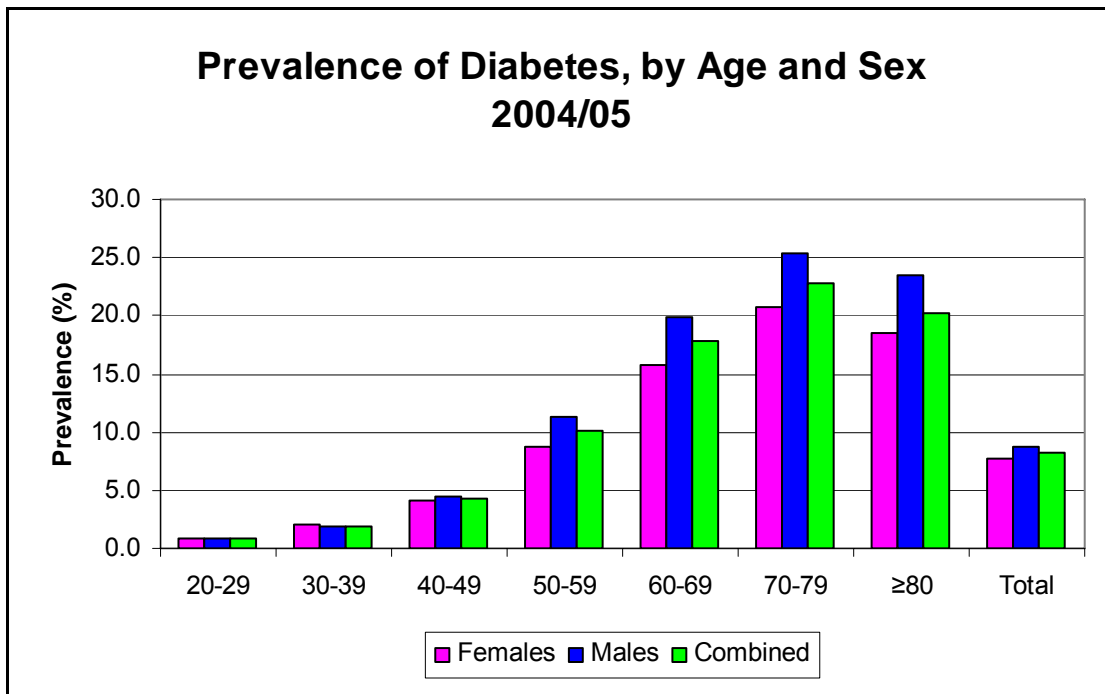
Technical Specifications

Standardized rates are used when comparing populations as they account for differences in the age and sex distribution in each jurisdiction.

NDSS algorithm: a person is identified as having diabetes with one hospital or two physician visits within two years coded with a diagnosis of diabetes mellitus.

Calculation: (The total number of people ages 20 and above who have been diagnosed with diabetes during a fiscal year/ the yearly Nova Scotia population estimate ages 20 and above) X the age-standardizing process) X 100 per fiscal year.

Source: Diabetes Care Program of Nova Scotia, Halifax, NS; National Diabetes Surveillance System, Health Canada.



*Based on 1991 census population estimates

Nova Scotia Incident Cases of Diabetes in the Population Under 19 Years

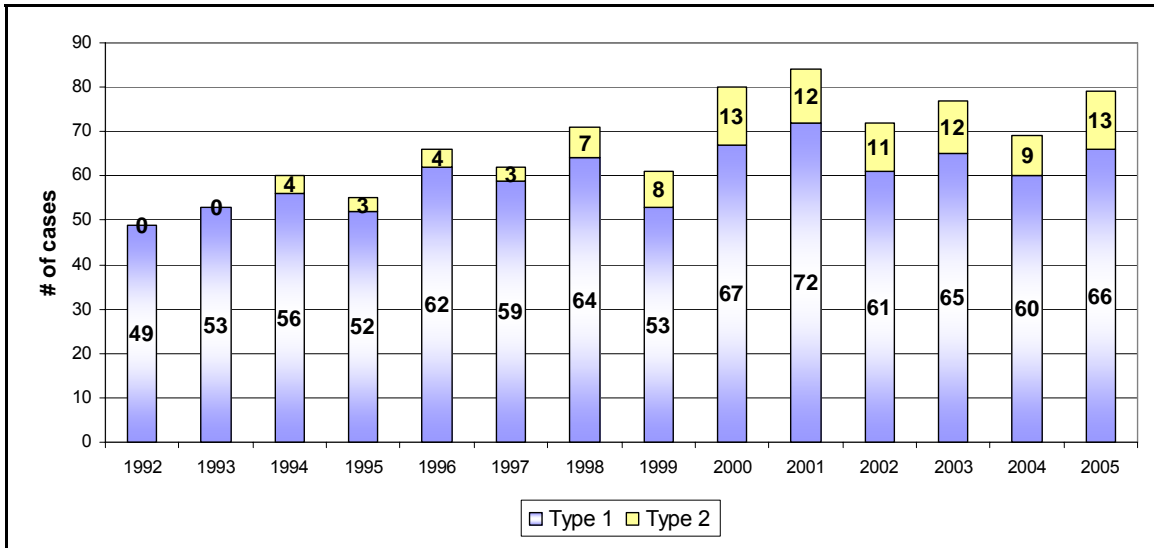
Definition

The incidence of disease is defined as the number of new cases of disease occurring in a population during a defined time interval for a given jurisdiction. Incident diabetes cases are determined from the DCPNS Registry as any individual with a date of diagnosis on or before December 31, 2005.

Type 1 Diabetes: Absolute deficiency of insulin secretion as a result of pancreatic b-cell destruction; prone to ketoacidosis. Usual onset is under age 35 years. Management includes insulin and nutrition therapy.

Type 2 Diabetes: Resistance to insulin and/or inadequate compensatory insulin secretory response. Usual onset is over age 35 years. Management includes nutrition therapy only; and/or oral antihyperglycemic agents/insulin.

Nova Scotia Incident Cases of Diabetes Mellitus (Type 1 & 2) for Ages <19



The incident cases for type 1 diabetes showed a slow but steady increase from 1992 (mean of the first 7 years, 56 cases) through to 2005 (mean of the last 7 years, 64 cases).

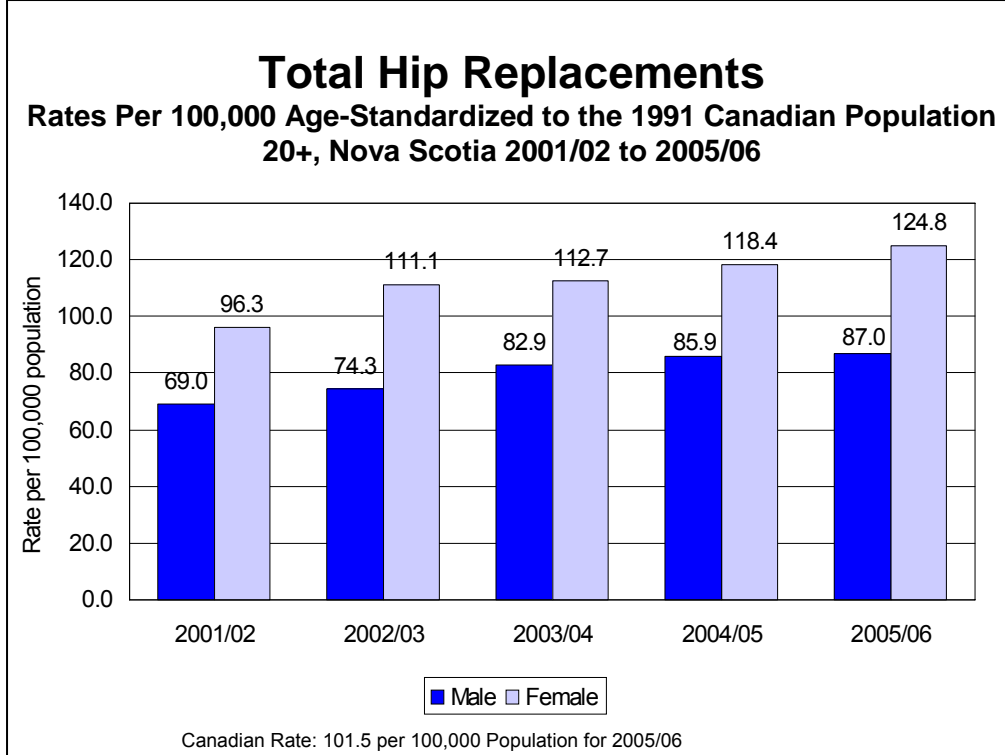
Type 2 diabetes now accounts for approximately 15% (average last five years) of new cases in this age group (< age 19 years). Type 2 diabetes was virtually unreported in Nova Scotia the early 1990's.

Section 3 Surgical Interventions

Often, as a result of disease, surgical interventions are required as part of a treatment care plan. Measuring the number of surgical interventions performed provides an indication of accessibility, health care system responsiveness, service provision, and disease incidence.

The rates of surgical interventions are analyzed using age-standardized data. By using this method, we can make valid comparisons of surgery rates across different parts of the province/country. These data must be standardized to the same population census data. Data are not comparable if, for instance, some data are standardized to 1996 population data and some is standardized to 1991 population data.

Please note that all results only reflect surgeries performed in Nova Scotia hospitals.



Total Hip Replacements

Definition

The surgical removal of the hip joint and replacement with a synthetic hip joint.

Significance – Rationale and Notes for Interpretation

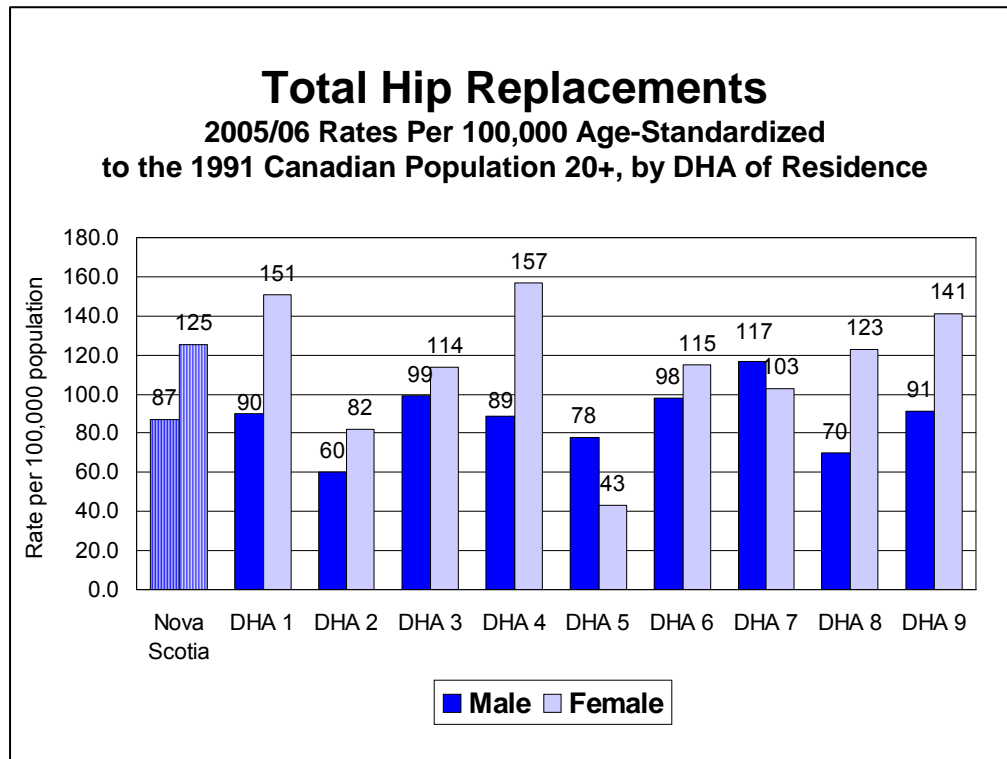
The intended outcome of most elective surgery is improved health-related quality of life. Increases in hip replacements may reflect increased access to orthopedic care and result in improved population health status or could reflect bone degeneration in the population. Over 94% of those receiving a hip replacement reported significant improvement in pain, stiffness and overall functioning.⁶

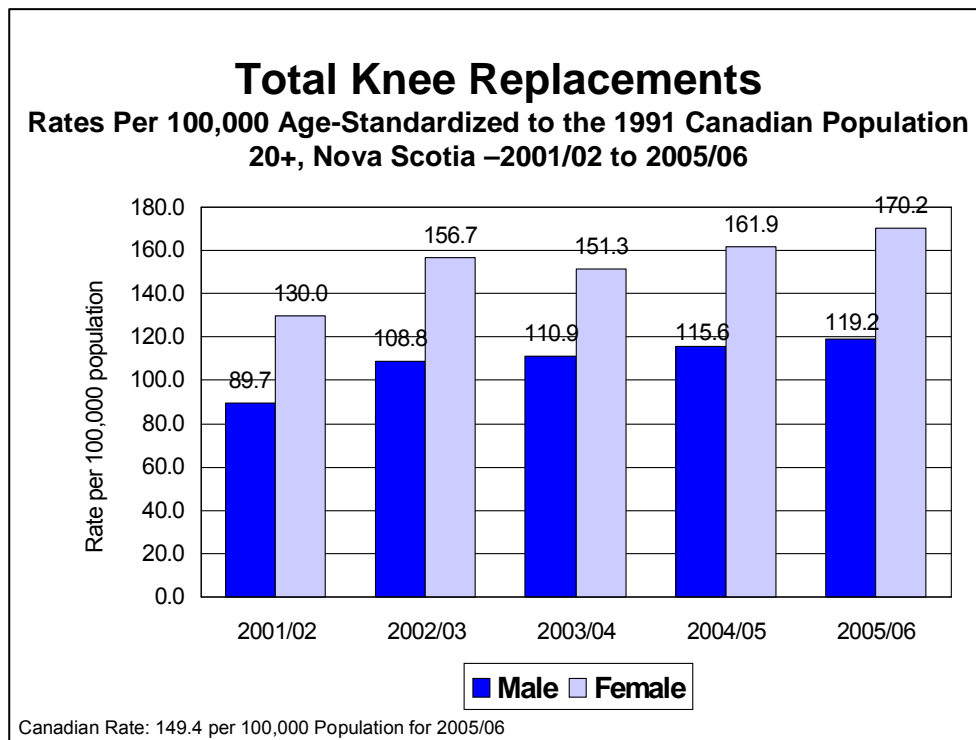
Technical Specifications

Calculation: Using the CCI (Canadian Classification of Health Interventions) codes 1.VA.53-LA-PN^ and 1.VA53-PN-PN^ ((The number of total hip replacements performed on Individuals over 20 yrs old as principal intervention per district of residence)/(the population for the district) X Standardizing Process) X 100,000.

⁶ as reflected in SF-36 and WOMAC results, Reporting to Nova Scotians on Comparable Health and Health Systems Indicators, 2001

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database





Total Knee Replacements

Definition

Surgical removal of the entire knee joint and replacement with a synthetic knee joint.

Significance – Rationale and Notes for Interpretation

The intended outcome of most elective surgery is improved health-related quality of life. Increases in knee replacements may reflect increased access to orthopedic care and result in improved population health status or may reflect bone degeneration in the population.

Technical Specifications

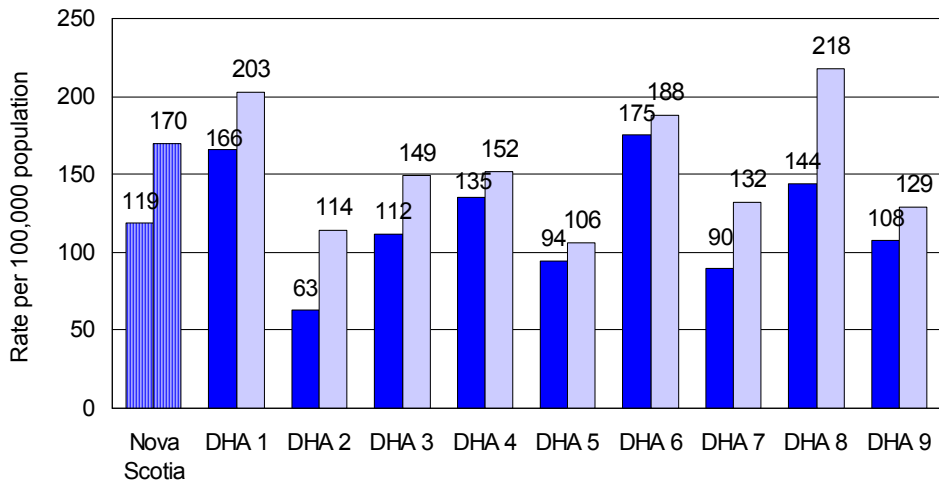
Calculation: Using CCI (Canadian Classification of Health Interventions) code 1.VG.53^^. $((\text{The number of total knee replacements on Individuals 20+ as principal interventions per District of residence}) / (\text{the population for the District}) \times \text{Standardizing Process}) \times 100,000$.

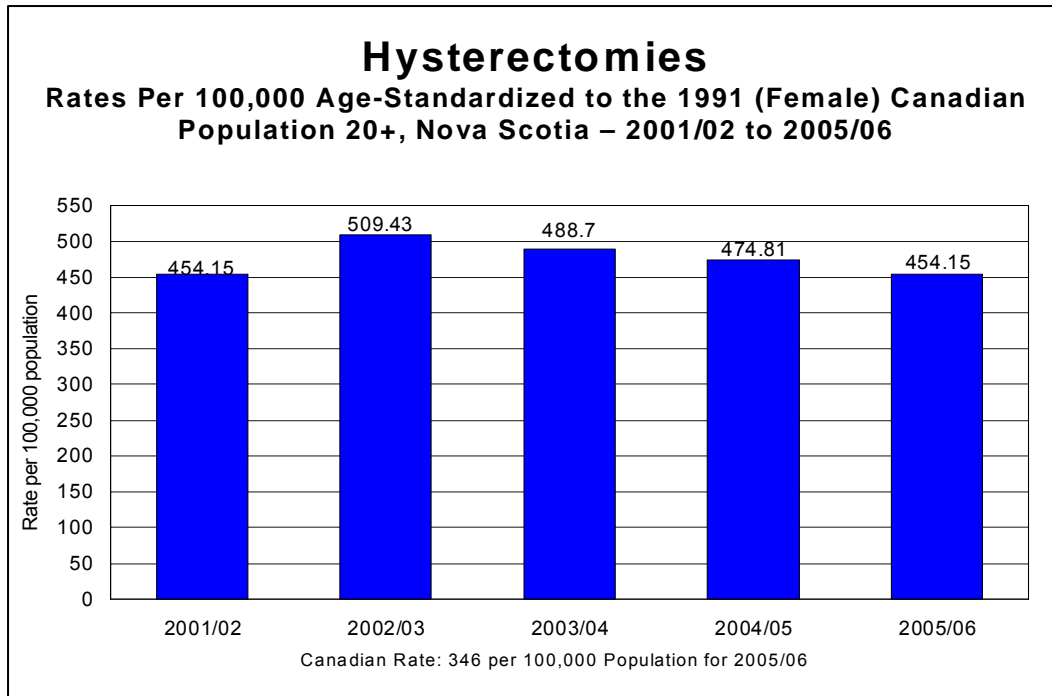
Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database

Total Knee Replacements

**2005/06 Rates Per 100,000 Age-Standardized
to the 1991 Canadian Population 20+, by DHA of Residence**

■ Males ■ Female





Hysterectomies

Definition

Surgical removal of the uterus.

Significance – Rationale and Notes for Interpretation

Medical debate surrounds the need for hysterectomy for reasons other than cancer. Traditionally, hysterectomy procedures have also been used for the treatment of diseases such as fibroids and menorrhagia. With new treatment alternatives, the need for hysterectomies for non-cancer diagnoses should decrease. Canada has one of the highest rates of hysterectomy procedures in the world, second only to the United States. Differences in rates often reflect the debate over appropriate use of this procedure and the variation in physician practice.

Technical Specifications

Calculation: Using CCI (Canadian Classification of Health Interventions) codes 1.RM.89.^{^^} and 1.RM.91.^{^^} for total and radical hysterectomies. **((The number of hysterectomies performed as any intervention per District of residence for women over 20)/(the population estimate per District) X Standardizing Process) X 100,000.**

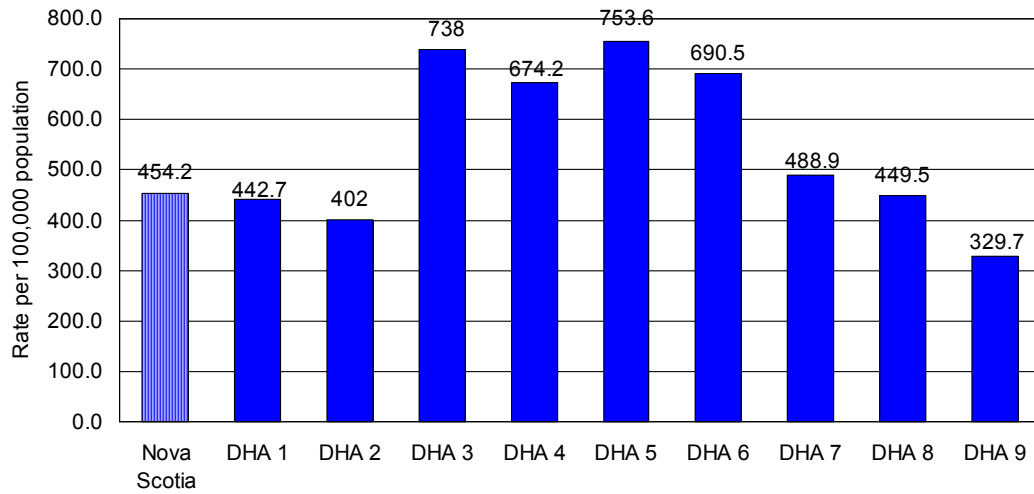
Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database

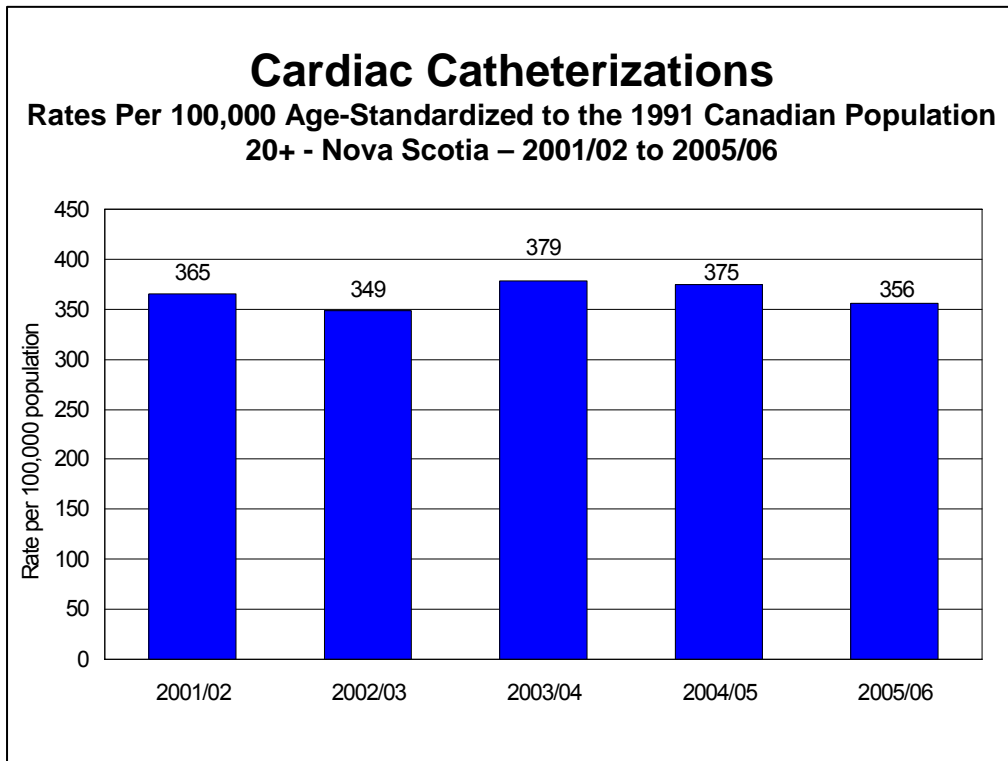
Disclosures

Excludes: Subtotal and partial hysterectomies

Hysterectomies

2005/06 Rates Per 100,000 Age-Standardized to the 1991 Canadian Population 20+, by DHA of Residence





Cardiac Catheterizations

Definition

A diagnostic procedure in which a tube is inserted into a blood vessel under local anesthetic and threaded through to the chambers of the heart to monitor blood flow, blood pressure and blood chemistry, and possibly to take a sample of heart tissue. The technique is often used to diagnose congenital heart disease and coronary artery disease.

Significance – Rationale and Notes for Interpretation

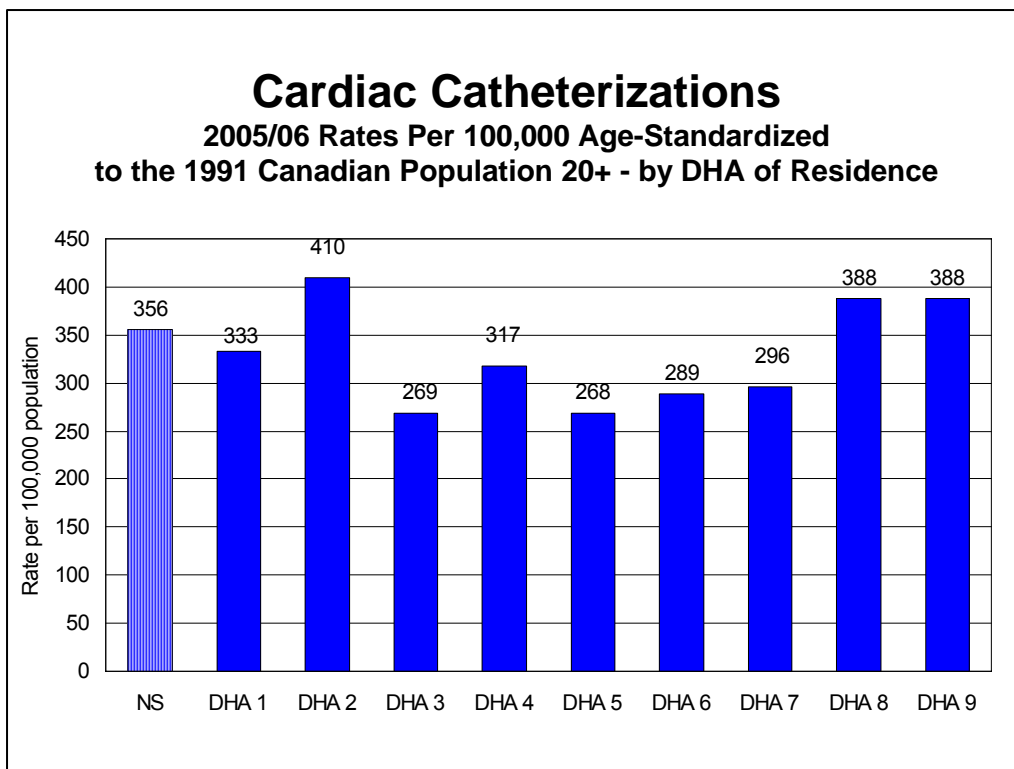
Cardiac catheterizations are a diagnostic procedure used for determining heart disease. Measuring the number of cardiac catheterizations performed provides an indication of how many people in the population are experiencing symptoms of heart disease.

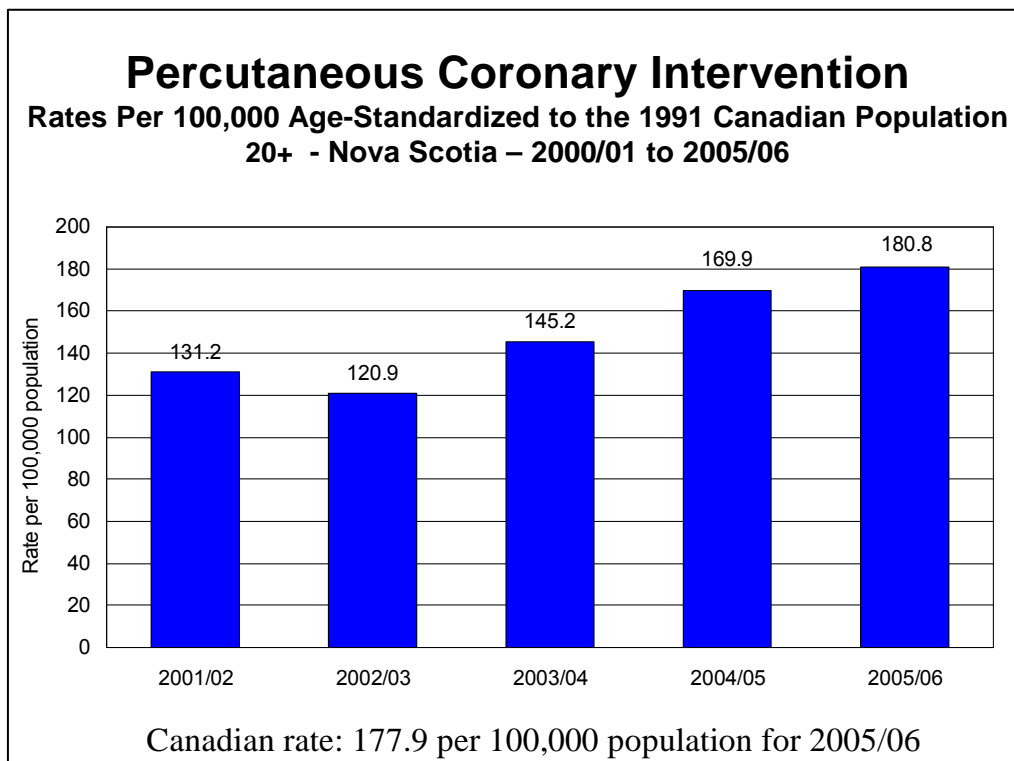
Technical Specifications

For Acute care and Day surgery and for the population aged 20 and over Calculation:

$$\text{CCI principal intervention code 3.IP.10}^{^^} \left(\left(\frac{\text{The number of cardiac catheterizations done as principal intervention per DHA of Residence}}{\text{the population for the province (each DHA)}} \right) \times \text{Standardizing Process} \right) \times 100,000$$

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database





Percutaneous Coronary Intervention

Definition

PCI encompasses several techniques, angioplasty is the procedure most frequently provided. Dilation of an obstructed coronary artery or the procedural removal of a thickened coronary arterial intima (using a balloon-tipped catheter) inserted through the femoral or other artery, with or without infusion of a thrombus-destroying substance.

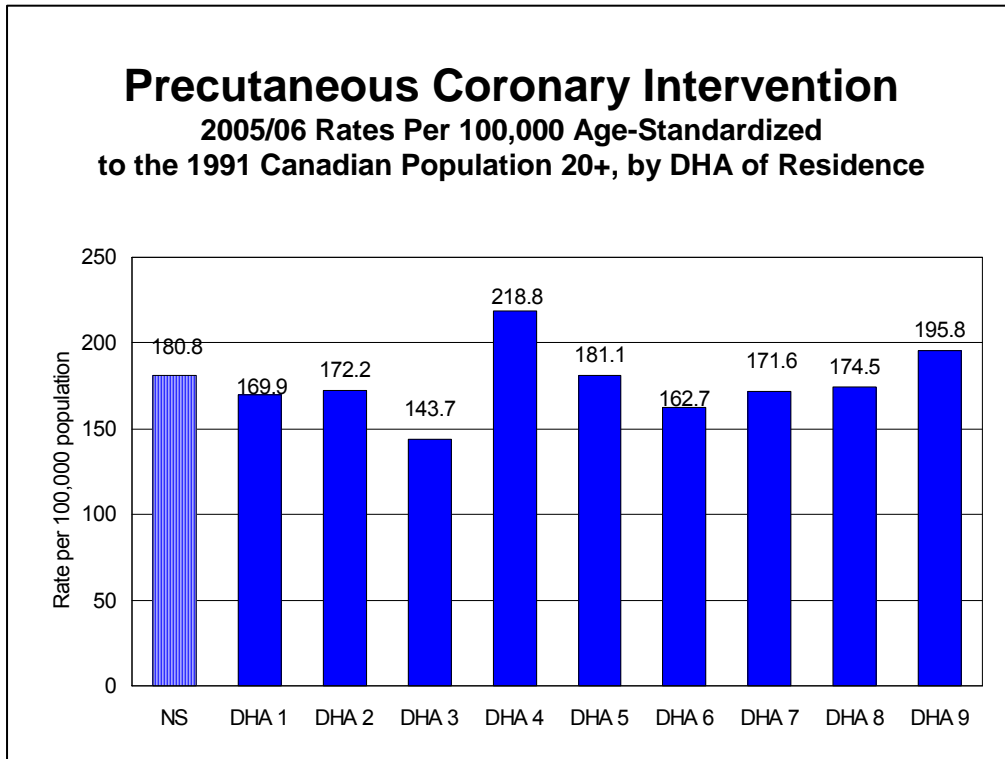
Significance – Rationale and Notes for Interpretation

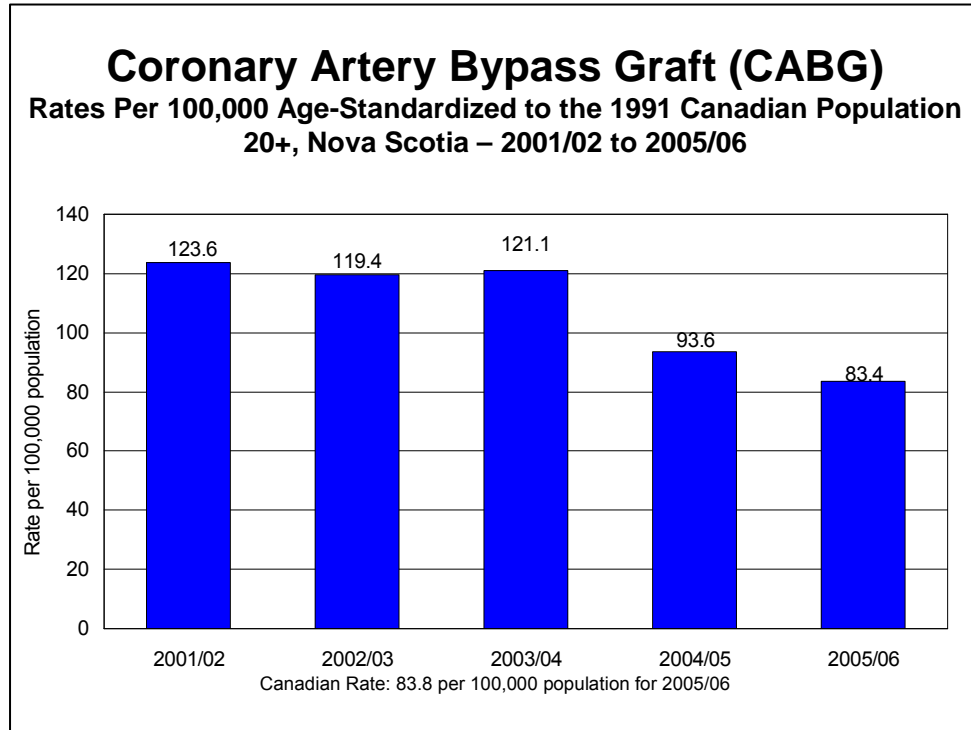
In many cases, PCI serves as a non-surgical alternative to coronary artery bypass graft (CABG) surgery and is undertaken for the purpose of opening obstructed coronary arteries. The choice of revascularization mode (that is, PCI or CABG) depends on numerous factors, including physician preferences, availability of services, referral patterns and differences in population health and socio-economic status.

Technical Specifications

For Acute care and Day surgery and for the population aged 20 and over Calculation: Intervention CCI code 1.IJ.50 and 1.IJ.57^^ . ((The number of coronary angioplasties done per DHA of Residence / the population aged 20 and over for the province (DHA's)) X Standardizing Process)) X 100,000

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database.





Coronary Artery Bypass Graft (CABG)

Definition

Restoration of coronary blood flow by a tubular surgical bypass (grafted mammary artery or saphenous vein) of an occluded coronary artery.

Significance – Rationale and Notes for Interpretation

Coronary artery bypass grafts are performed to restore blood flow to the heart. CABG's are performed to prevent future heart complications (for example heart attack), as well as a therapeutic intervention to restore function post heart attack and may be representative of a patients' access to care.

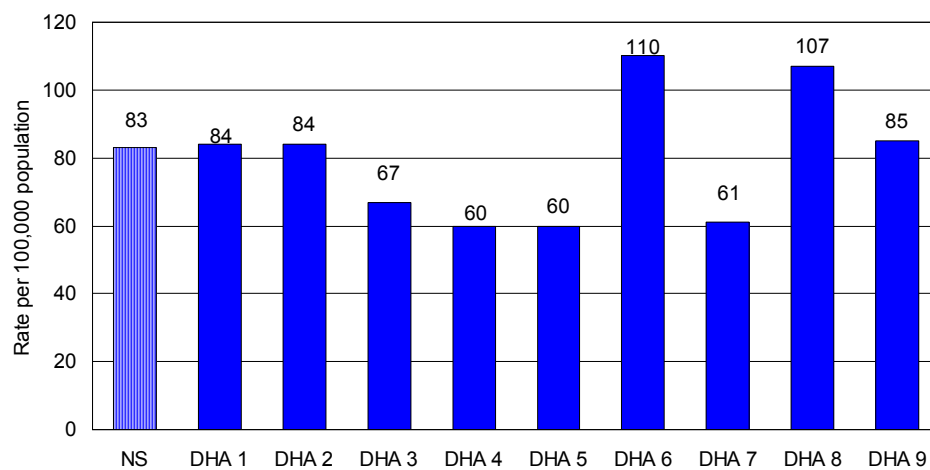
Technical Specifications

For the population aged 20 and over

Calculation: Intervention CCI code 1.IJ.76.^ used. ((The number of coronary artery bypass grafts performed per District of Residence) / (the population for the province (DHA's)) X Standardizing Process) X 100,000

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database

Coronary Artery Bypass Graft (CABG) 2005/06 Rates Per 100,000 Age-Standardized to the 1991 Canadian Population 20+, by DHA of Residence



Section 4 Provincial Services

In Nova Scotia, a number of programs work together to provide the health care services our communities require. Many of these programs provide specialized services offered outside of the hospital environment. These programs help to facilitate and provide appropriate care and develop disease prevention and promotion programs.

The data these programs collect provide information on the health care needs of specific communities and age groups and allows effective planning and funding of services in these areas.

Mental Health Programs

1. Inpatient Separations – Adults (≥ 19 years) Nova Scotia, 2005/06
2. Patient Days – Adults (≥ 19 years) Nova Scotia, 2005/06
3. Inpatient Separations - Children (<19 years) Nova Scotia, 2005/06
4. Patient Days – Children (<19 years) Nova Scotia, 2005/06
5. Ambulatory Care Number of People Served - Mental Health Outpatient Information System (MHOIS) - Unique Clients 2001/02 to 2005/06
6. Ambulatory Care, Average Visits Per Client and Active Clients Per 1000 Population – 2005/06
7. Ambulatory Care, Average Visits Per Client and Active Clients (Adults ≥ 19) Per 1000 Population – 2005/06
8. Ambulatory Care, Average Visits Per Client and Active Clients (Child and Youth <19) Per 1000 Population – 2005/06
9. Percentage of Adult Clients with Serious Mental Illness and the Percentage of Visits dealing with Serious Mental Illness, 2005-2006

Definitions

1 & 3 Inpatient Separations - Adults (≥ 19 Years) and Children (<19 Years) Separations from designated psychiatric units in Nova Scotia hospitals.

2 & 4. Patient Days - Adults (≥ 19 Years) and Children (<19 Years)
The number of days accumulated by separations from designated psychiatric units in Nova Scotia hospitals.

5. Ambulatory Care - Number of People Served - Mental Health Outpatient Information System (MHOIS) Unique Clients – 2001/02 to 2005/06

This is a unique count of the number of people served by the outpatient Mental Health Programs in Nova Scotia.

6, 7 & 8 Ambulatory Care – Average Visits per Client and Active Clients per 1000 Population 2001/02 to 2005/06 Visits per Client: average visits per client is an indicator of service intensity. Unlike the active client rate (discussed below) the visits per client indicator represents the number of total visits (as defined by MIS guidelines) not unique clients, and is divided by the number of clients whose files were open during the reporting period. (Adults ≥ 19 Yrs and Child and Youth < 19 Yrs)

Active Client Rate: Active unique clients per 1000 population (refers to unique Health Card numbers). 'Active unique clients' is a count of unique individuals treated within a given period, in this case, one year. The 1991 Statistics Canada Census population for Nova Scotia is used for the denominator.

9. Percentage of Adult Clients with Serious Mental Illness and the Percentage of Visits dealing with Serious Mental Illness, 2005-2006

Significance - Rationale and Notes for Interpretation

The Mental Health Program provides a range of services across the life span to residents of Nova Scotia. These services include inpatient, outpatient and outreach services, community support and other specialty services. Information on utilization of these services is necessary to establish priorities, allocate resources, design prevention and rehabilitation programs and improve health outcomes.

Technical Specifications

Calculation:

1 & 3: The sum of in-patient separations from each patient service (64 - psychiatry and 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

2 & 4: The sum of in-patient days from each patient service (64 - psychiatry and 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

5: Number of active unique clients served within a specified time period (as captured by the Mental Health Outpatient Information System)

6, 7 & 8: Visits per Client: the total number of visits / the number of clients with open cases during the time period under study for DHA of residence. (Adults ≥ 19 Yrs and Child and Youth < 19 Yrs)

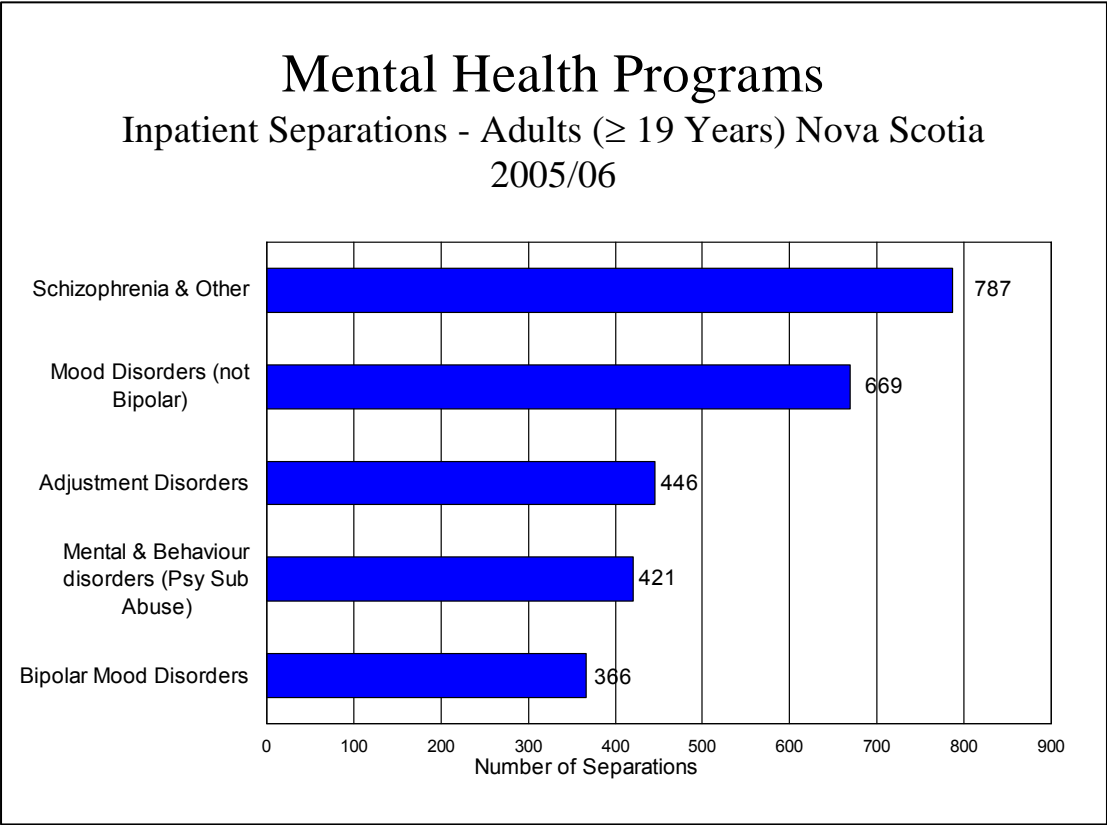
Active Client Rate: (the number of active unique clients / the 1991 Statistics Canada Census population for Nova Scotia) X 1000.

9. Clients with serious mental illness (Schizophrenia, Mood (not bipolar), and Mood (bipolar) / total adult clients x 100 and Visits dealing with serious mental illness / total adult visits x 100 by DHA of residence.

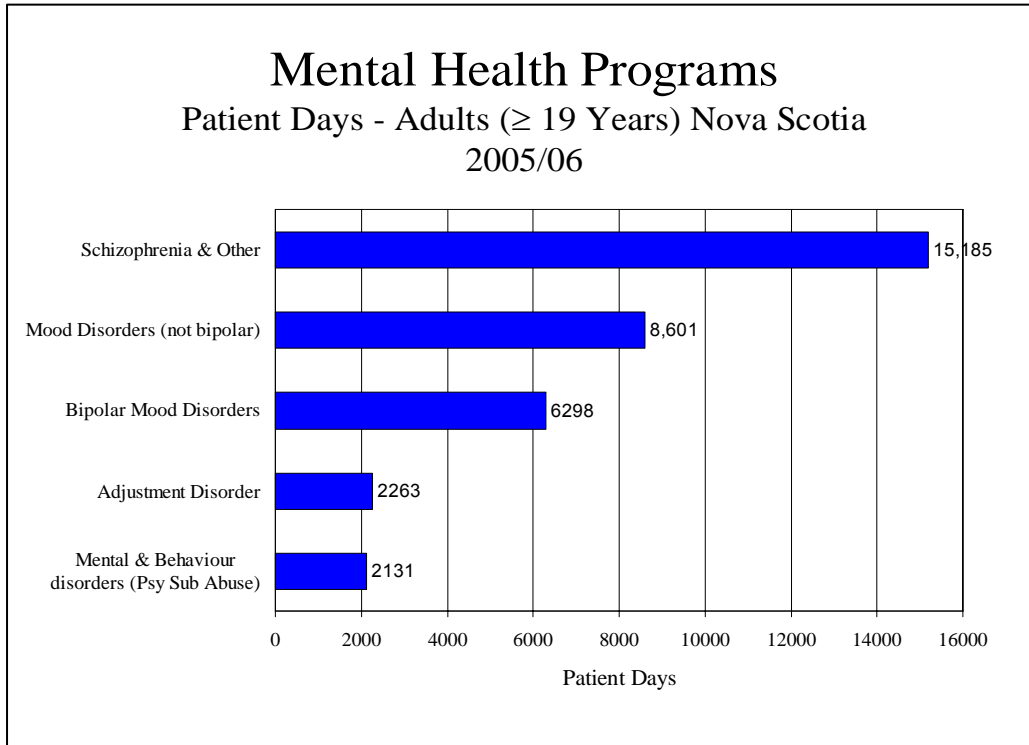
Source:

1 – 4 Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database
5 – 9 Mental Health Outpatient Information System, Annual Reports, Nova Scotia Department of Health

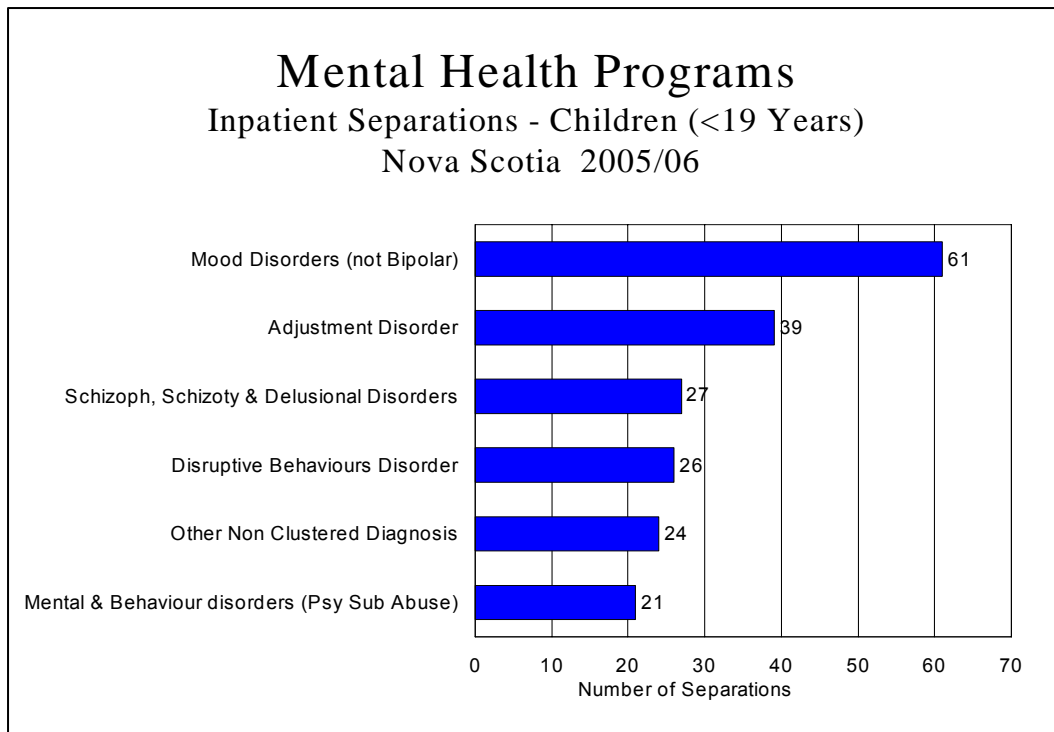
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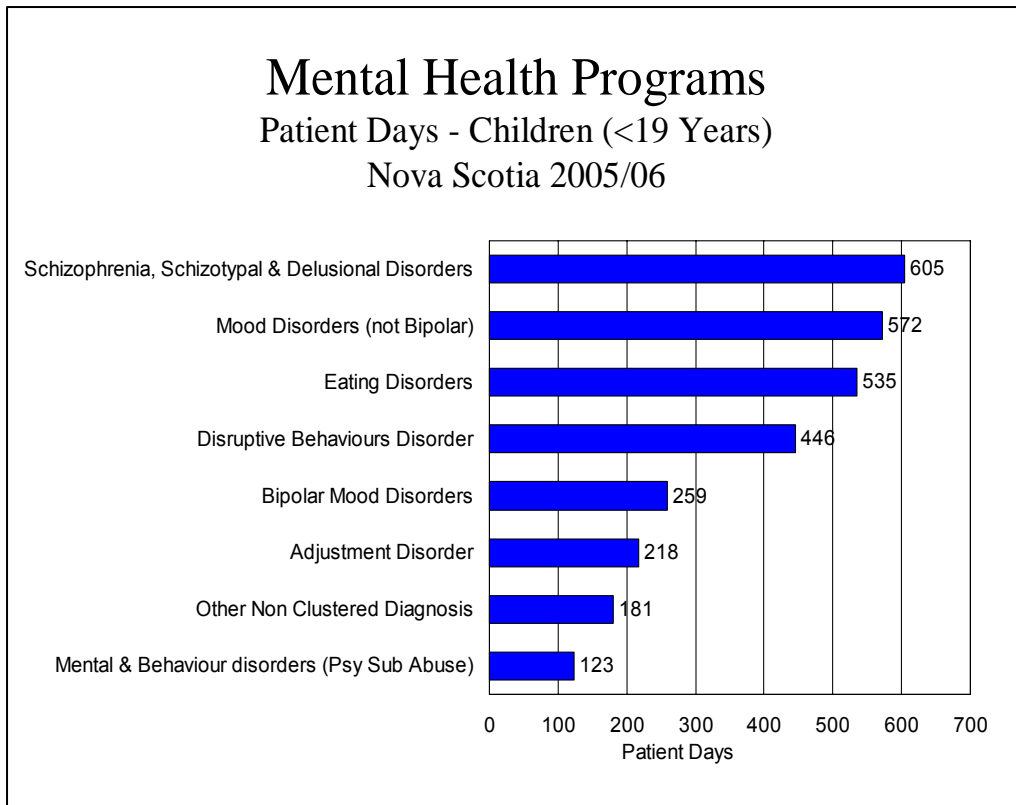
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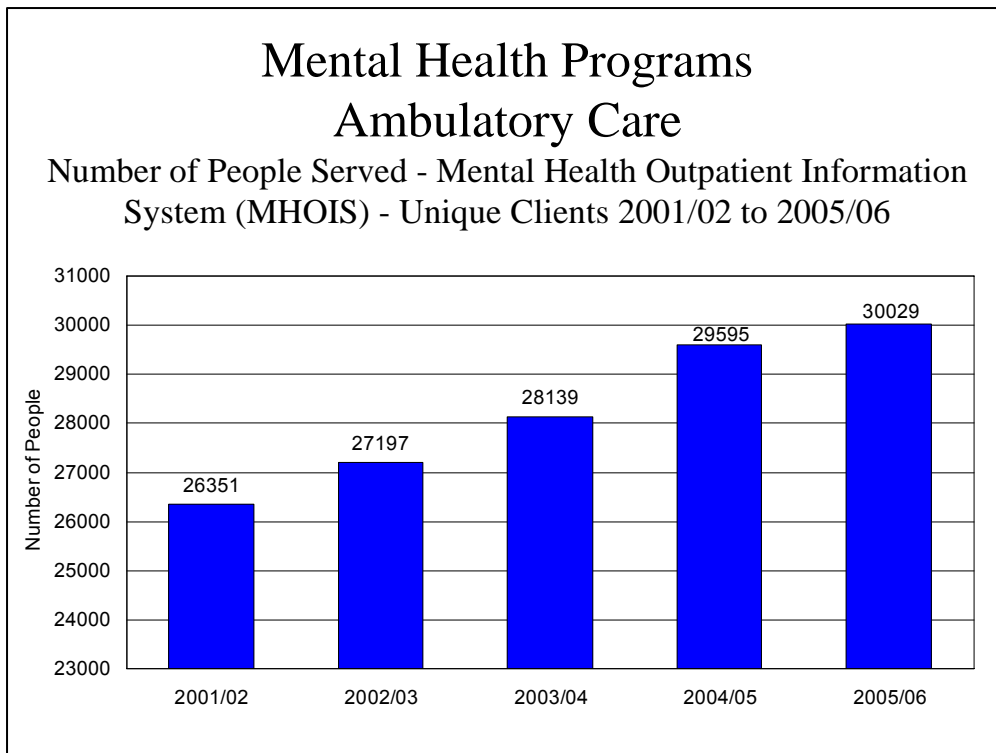
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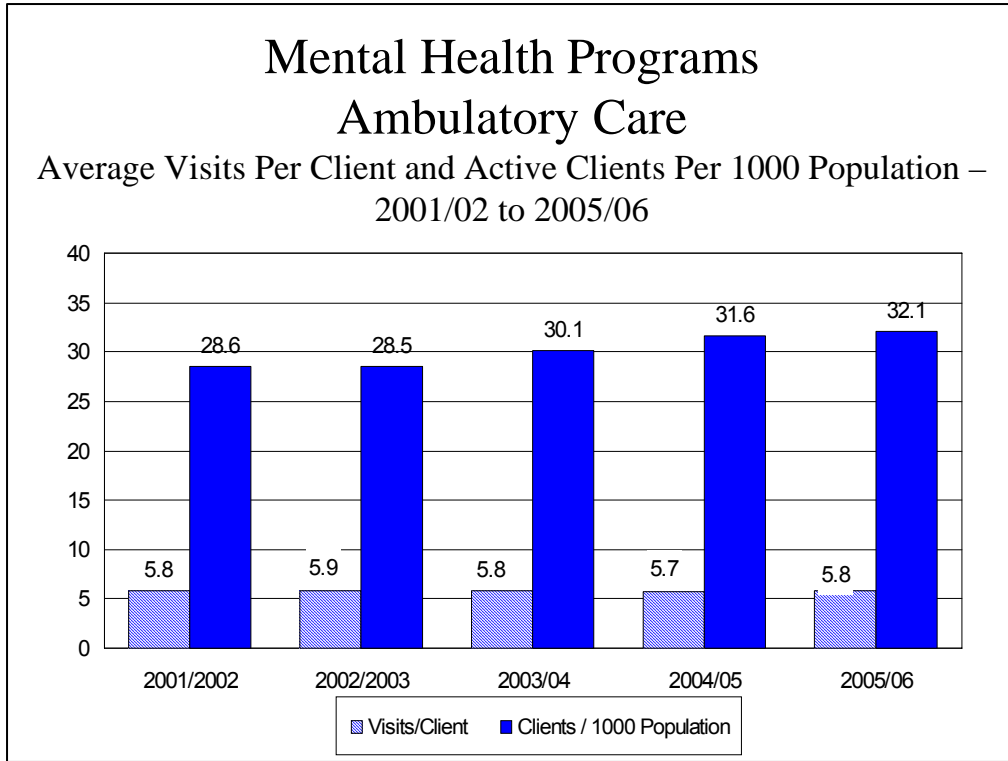
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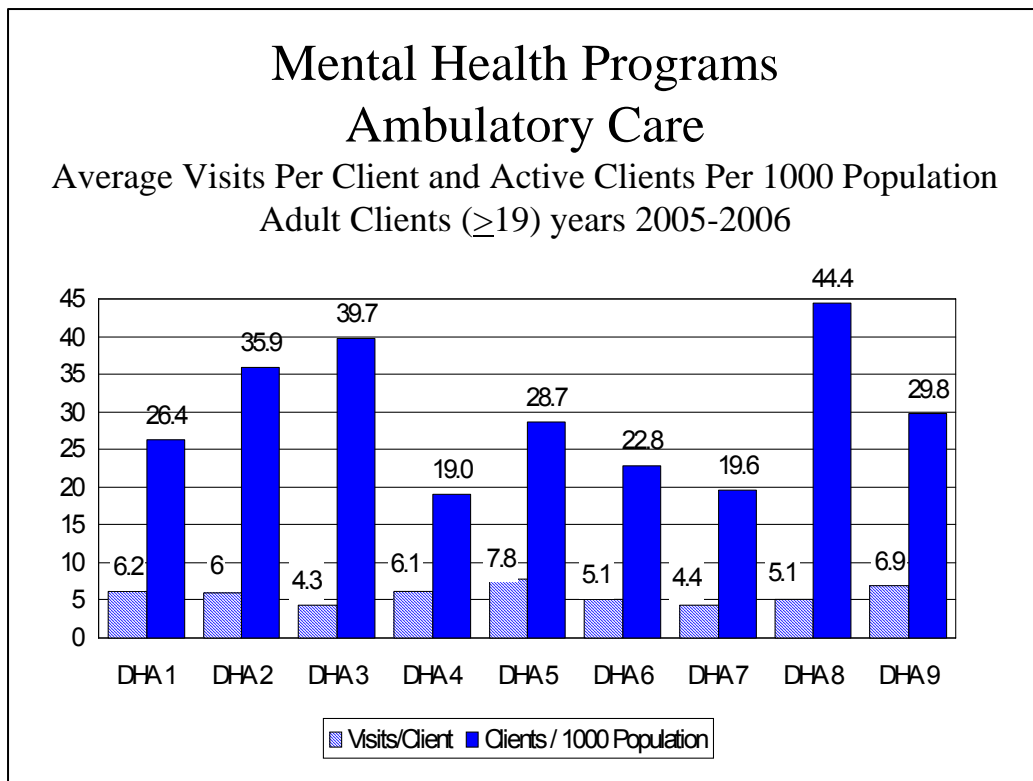
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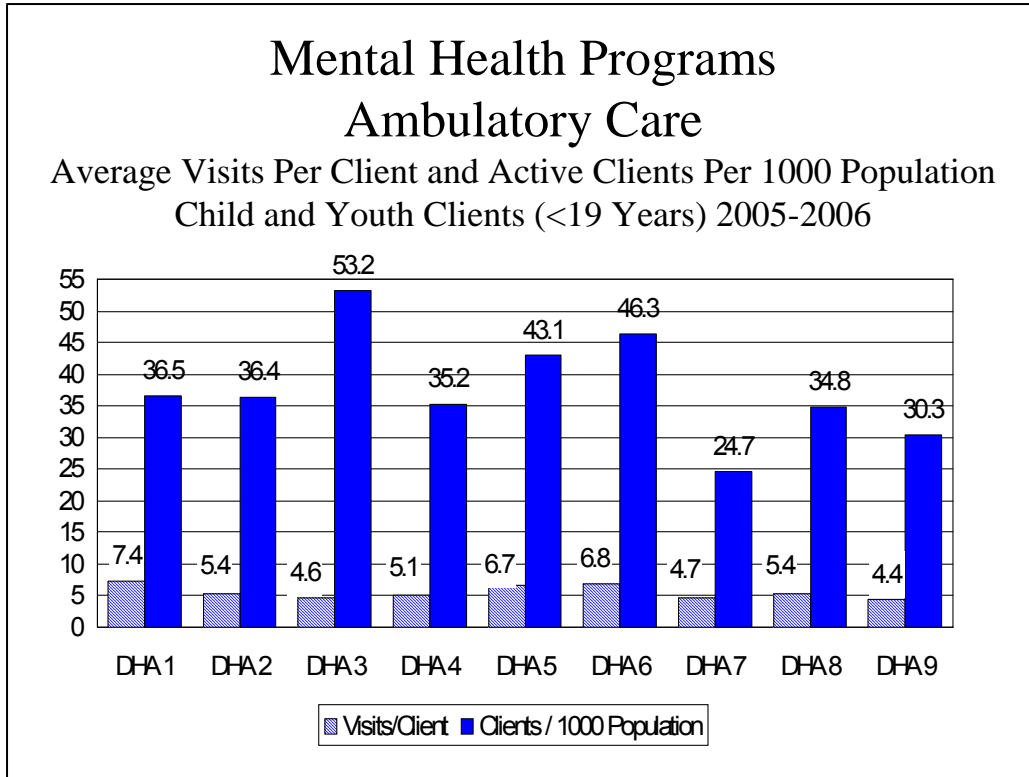
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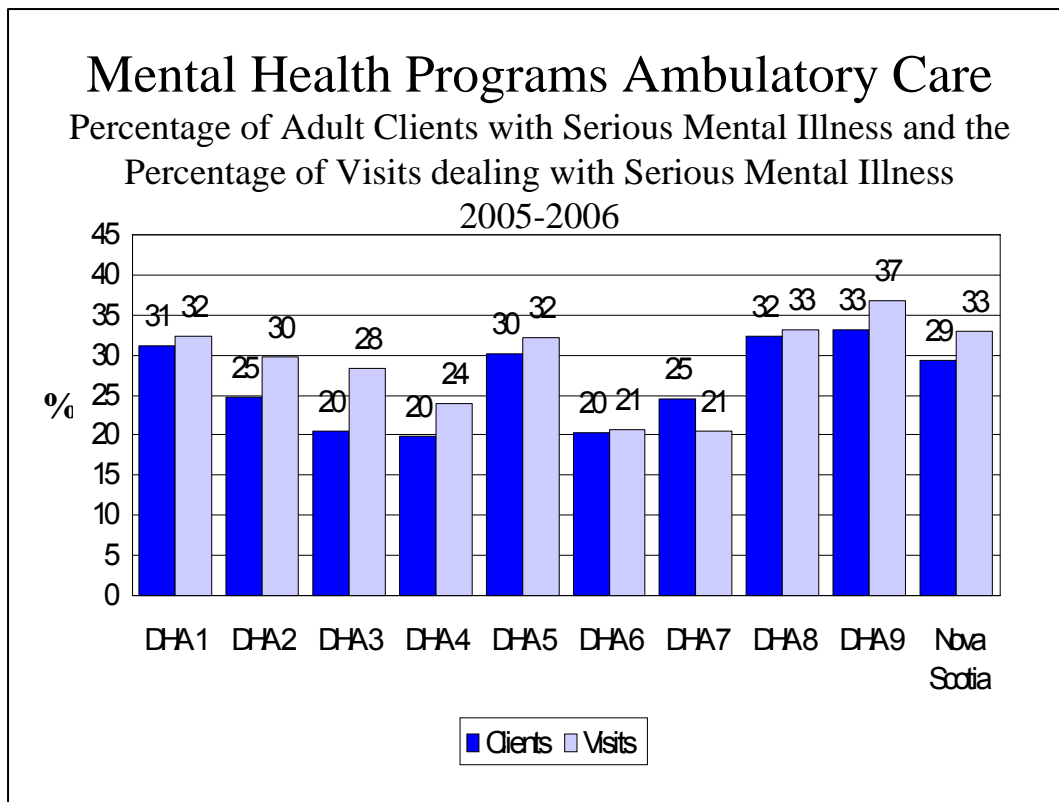
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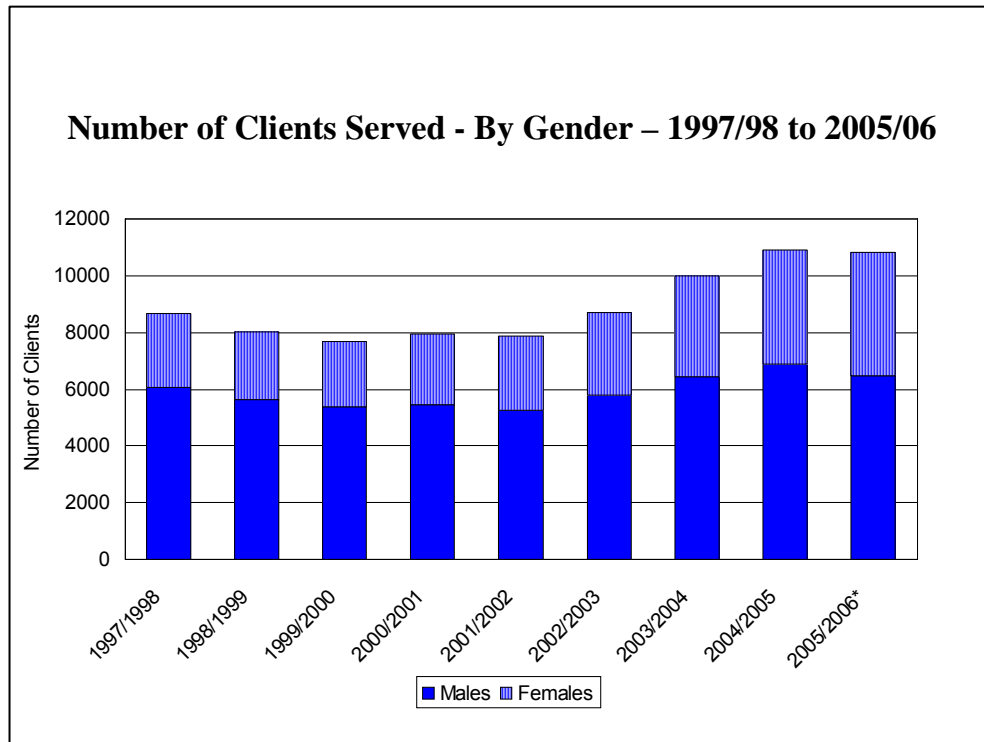
9.



Addiction Services

Introduction

Addiction Services includes various program areas: Primary Care Services (which includes Withdrawal Management, Addiction Education Program and Methadone Maintenance Treatment), Community Based Services, Community Oriented Recovery Environment (CORE), and Structured Treatment Services (which includes the 21 day program). The programs offered vary by District Health Authority.



Number of Clients Served by Gender

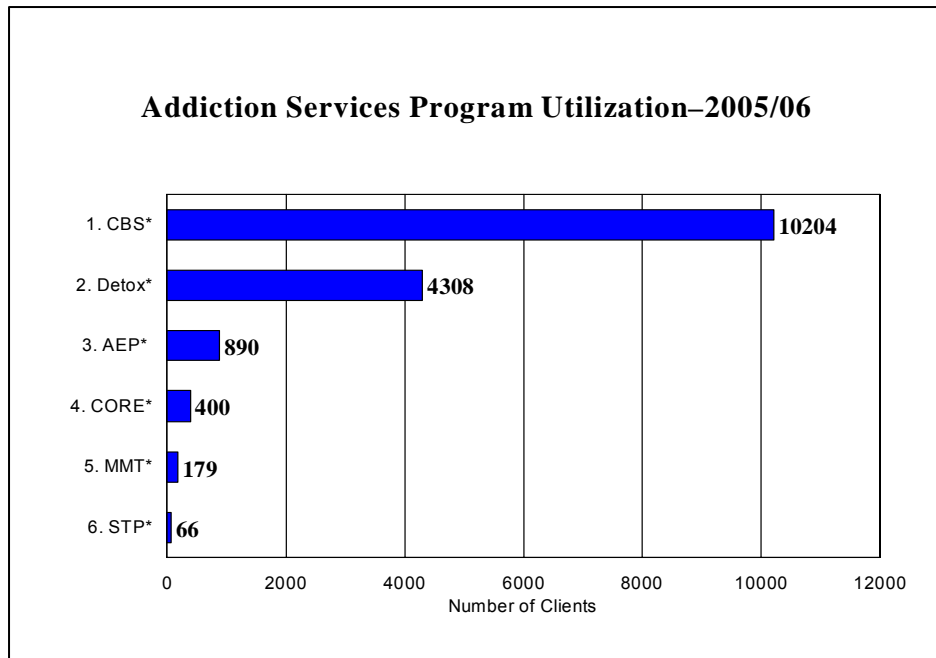
Definition

1. The total number of male and female clients who utilized Addiction Services programs in a given fiscal year.

Limitations

*In November 2005 CEHHA, CHA, PCHA, GASHA and CBDHA implemented a new information system (Addiction Services Statistical Information System Technology-ASsist). Reports are under development for ASsist and are not available at this time.

Due to the unavailability of reports from ASsist, CEHHA, CHA, and PCHA did not submit data for November 2005 to March 2006. Therefore total provincial counts are underrepresented. Alternatively, GASHA and CBDHA resubmitted the 2004-2005 fiscal year data as an approximation for the 2005-2006 fiscal year.



Addiction Services Program Utilization- 2005/06

Definition

2. The number of clients in Community Based Services. The total number of clients discharged from other programs including: Withdrawal Management (Detox), Addiction Education Program (AEP), Structured Treatment Program (STP), Methadone Maintenance Treatment (MMT), and Community Oriented Recovery Environment (CORE).

Limitations

*In November 2005 CEHHA, CHA, PCHA, GASHA and CBDHA implemented a new information system (Addiction Services Statistical Information System Technology-ASsist). Reports are under development for ASsist and are not available at this time. Due to the unavailability of reports from ASsist, CEHHA, CHA, and PCHA did not submit data for November 2005 to March 2006. Therefore total provincial counts are

underrepresented. Alternatively, GASHA and CBDHA resubmitted the 2004-2005 fiscal year data as an approximation for the 2005-2006 fiscal year.

Notes

Specific to Programs offered by District Health Authorities (DHAs)

- Addiction Education Program is offered in all DHAs except CDHA.
- Methadone Maintenance Treatment is offered in GASHA, CBDHA and CDHA only.
- The 21-day Structured Treatment Program is offered in AVDHA only. Other DHAs offer various forms of Structured Treatment Programs.
- Community Oriented Recovery Education (CORE) is offered in CDHA only.

Specific to Guysborough Antigonish Strait and Cape Breton Health Authorities

- It should be noted that in GASHA & CBDHA the Methadone Maintenance Treatment program is a long term service; while only 18 were discharged in the 2004-2005 fiscal year, a total of 108 clients were treated.
- With the revised structure of Structured Treatment Programs (STP) in GASHA and CBDHA routine residential programs are no longer offered. As a result no clients were discharged in the 2005-2006 fiscal year; however, there were 403 “visits” as per CIHI definition to STP in this period.

Significance – Rationale and Notes for Interpretation

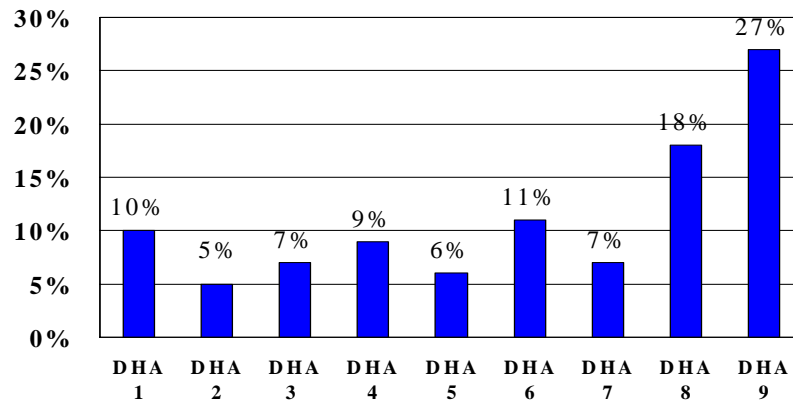
Addiction Services Program data assist service planners and providers in developing and maintaining effective, efficient and appropriate services by examining the number of, and characteristics of, clients using services (e.g. type of services used by gender, age category, place of residence). Addiction services program data monitors the use of services. These services are intended to minimize the harms associated with substance use and/or gambling, thereby improving the health of Nova Scotians.

All District Health Authorities are expected to be using the new information system (ASsist) and will have the capacity to provide detailed reports to fulfill future requests.

Source

Addiction Services Statistical Information System (StatIS), Nova Scotia Department of Health

Adult Protection Services Intakes: % of total provincial intakes by DHA, Fiscal 2005/06



The % of the population treated per DHA is a cumulative count totaling the number of all clients serviced by the Adult Protection Services Intake

Adult Protection Services

Definition

Adult Protection Services provides protection from abuse (mental, physical, or sexual) and neglect (self-neglect or caregiver neglect) of vulnerable adults, of the ages 16 and over, as mandated by the Adult Protection Act, 1985. In Nova Scotia, it is mandatory for all people who believe a person may be in need or protection to report to Adult Protection Services.

Significance – Rationale and Notes for Interpretation

Adult Protection data are gathered to enable effective service planning and provision. This data also enables service providers to recognize increases and decreases in the number of cases reported, and trends in the age of victims, which can indicate a need for health promotion and education strategies targeted at certain areas and/or age groups.

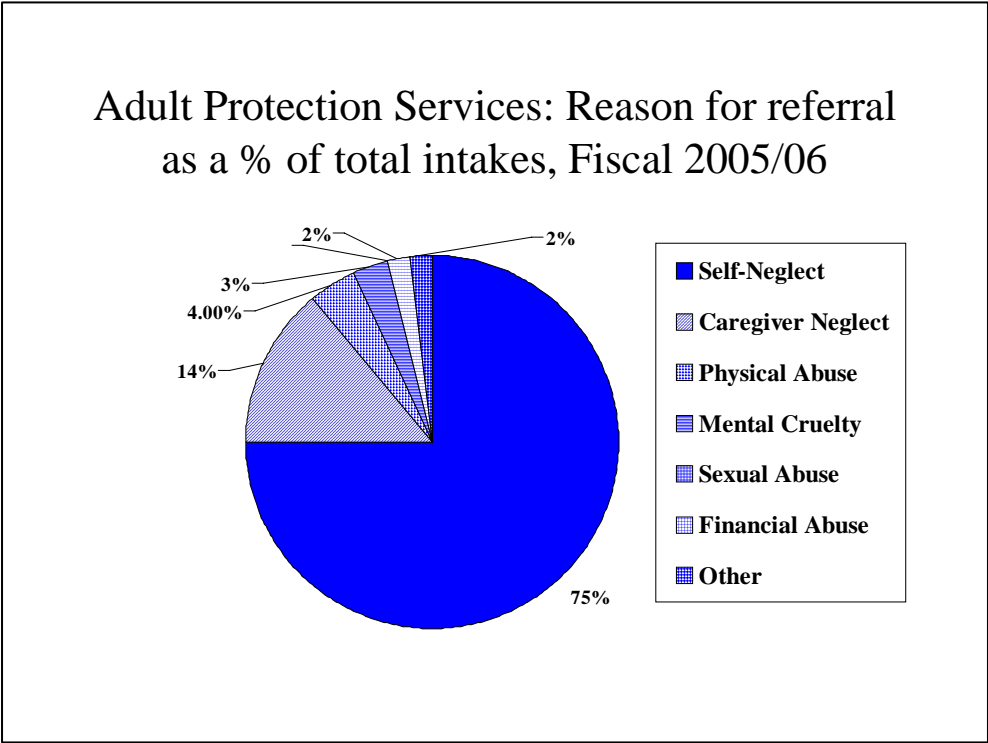
Technical Specifications

The total number of Adult Protection Intakes for 2005/06 is 1,212. An Intake is defined as a referral that has been received and for which there is a reasonable and probable ground to believe the person may be in need of protection.

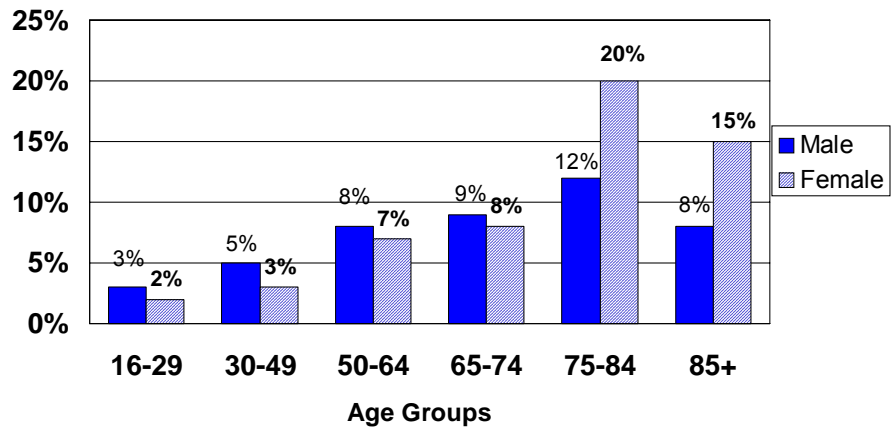
Calculation:

- 1. District adult protection intakes as a percentage of the provincial intake total
- 2. Reason for Referral as a percentage of the provincial intake total
- 3. Percent of provincial intake total, in one of 6 age categories and as male or female.

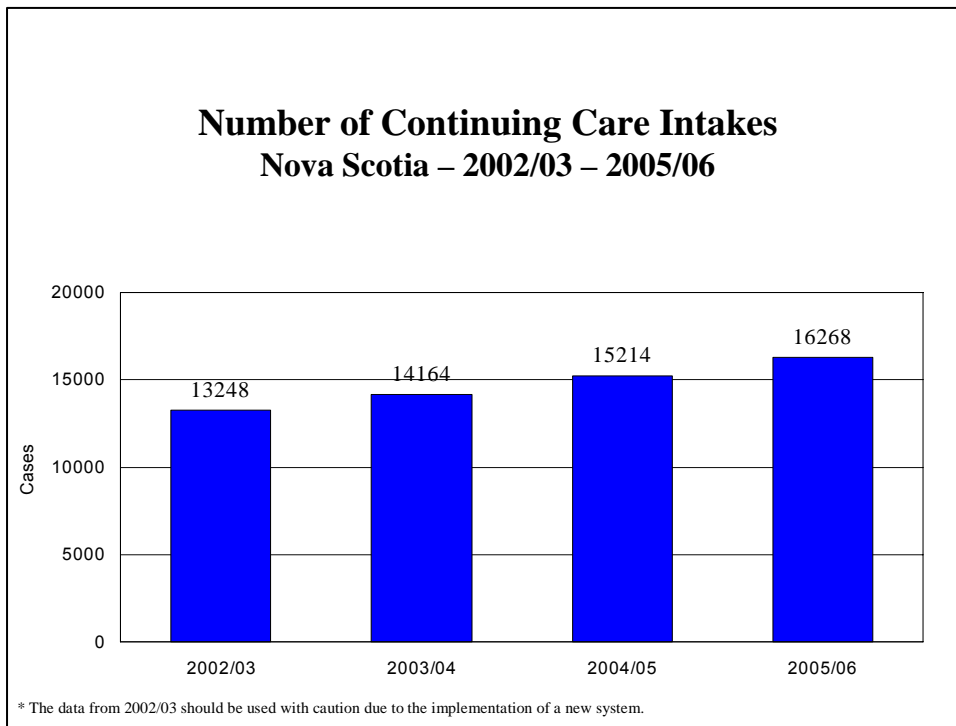
Source: Adult Protection Services Program, Continuing Care Branch, Nova Scotia Department of Health



Adult Protection Services: % of total intakes by age group and sex, Fiscal 2005/06



* Unknown age – 1%



Continuing Care Intakes

Definition

Intakes are referrals to Continuing Care services. A referral can be made by a potential clients, physician, family member, or member of the public. People are referred so they can be assess for Continuing Care services, which include homes care services, long term care services, and Adult Protection services.

Significance – Rationale and Notes for Interpretation

Data on Continuing Care services are collected in order to: measure utilization levels, assist with budgeting efforts, and to provide identification of service trends for program planning purposes.

Technical Specifications

Calculation: The total number of intake assessments conducted during the fiscal years of 2002/03 – 2005/06.

Source: Nova Scotia Department of Health, Continuing Care, SEAscape Database.

Emergency Health Services Nova Scotia (EHS)

Emergency Health Services (EHS) is a division of the Nova Scotia Department of Health. As a regulator, EHS is responsible for the continuing development, implementation, monitoring and evaluation of pre-hospital emergency health services in the province.

EHS integrates various pre-hospital services and programs required to meet the needs of Nova Scotians across the province. The main components are:

- 1) The EHS Communications Center
- 2) The EHS Ground Ambulance System
- 3) EHS LifeFlight
- 4) The EHS Nova Scotia Trauma Program
- 5) The EHS Atlantic Health Training and Simulation Center
- 6) The EHS Medical First Response program

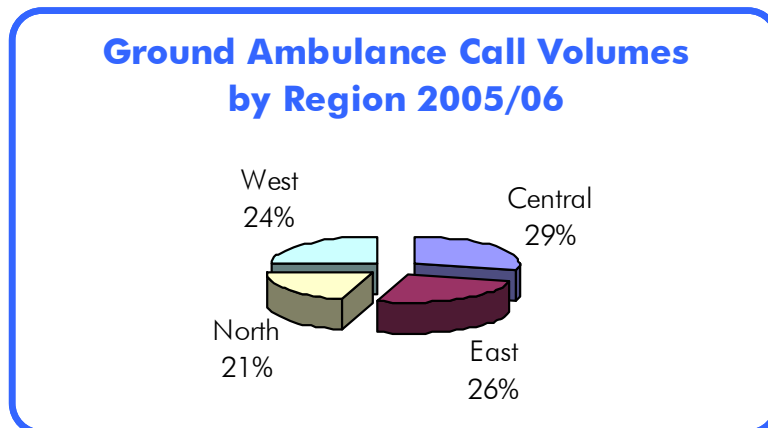
In addition, all system components are monitored by Medical Oversight of physicians specially trained in emergency and critical care.

For more detailed information on EHS, please visit www.gov.ns.ca/health/ehs

Approximately 140 ground ambulances, one rotary wing aircraft and one fixed wing aircraft are dedicated to meeting the direct patient care needs of Nova Scotia's citizens. For 2005/06, this resulted in approximately 104,000 requests for ground service with over 90,000 transports, and over 400 completed air ambulance missions.

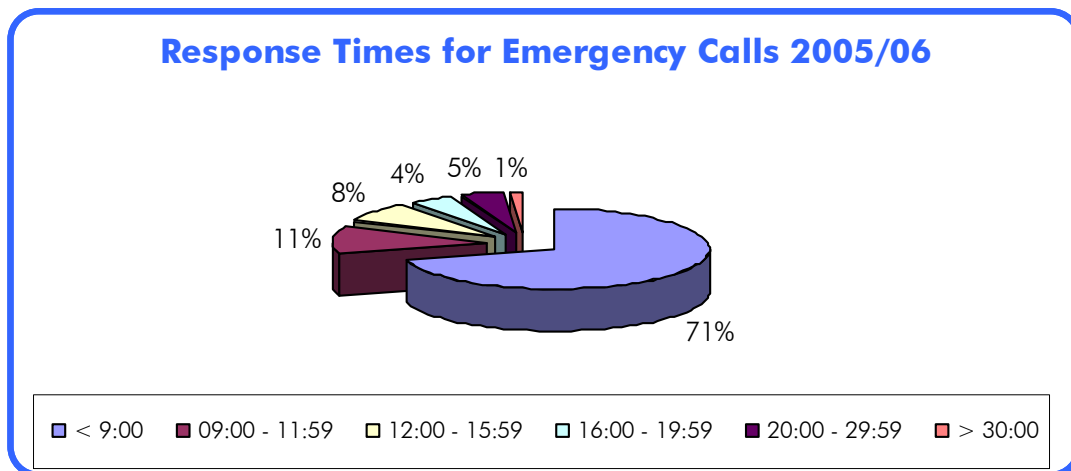
1.0 EHS Ground Ambulance

Figure 1.1 Ground Ambulance Call Volumes



EHS has defined minimum standards for response time reliability. Response time is the “actual elapsed time between when a call is received at the EHS communications center and the actual arrival of the ambulance at the location”. By setting these standards and evaluating compliance with them, EHS offers an effective emergency service to Nova Scotians. Figure 1.2 shows the response times for emergency calls for the entire province (urban and rural areas) during the year 2005/06.

Figure 1.2 Ground Ambulance Response Times

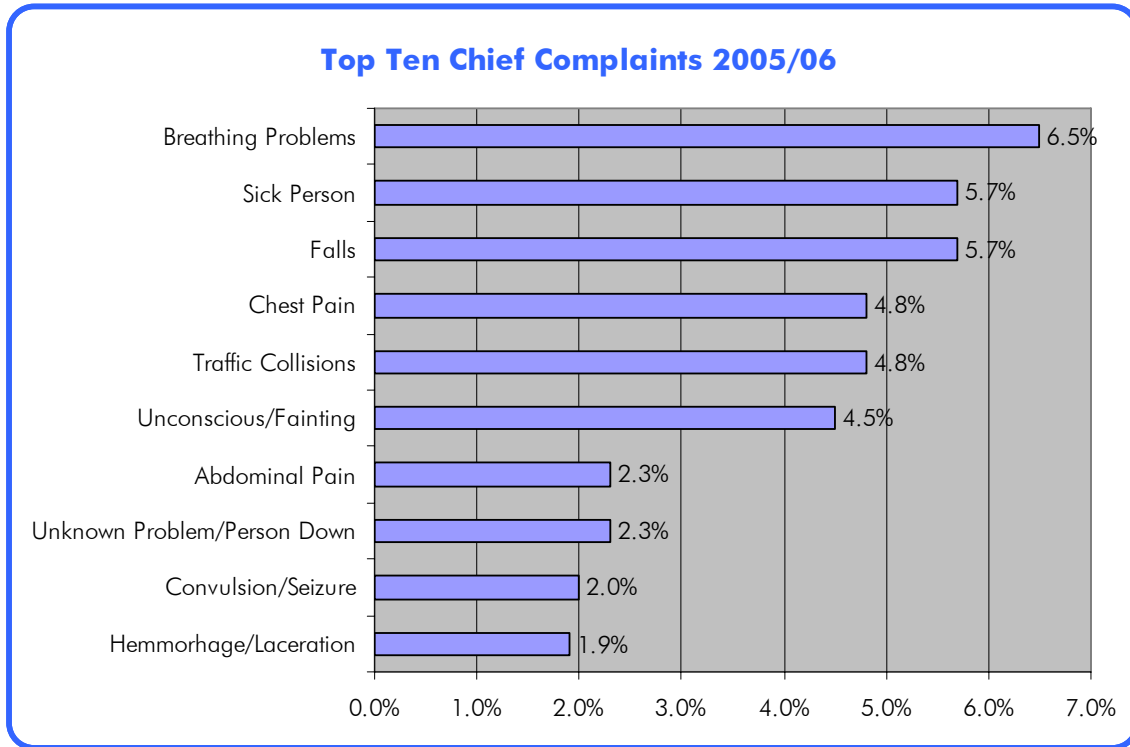


Source: *EHS CAD*

Response time: The actual elapsed time (in minutes and seconds) between when the call is received at the EHS communications center and the actual arrival of an ambulance at that location

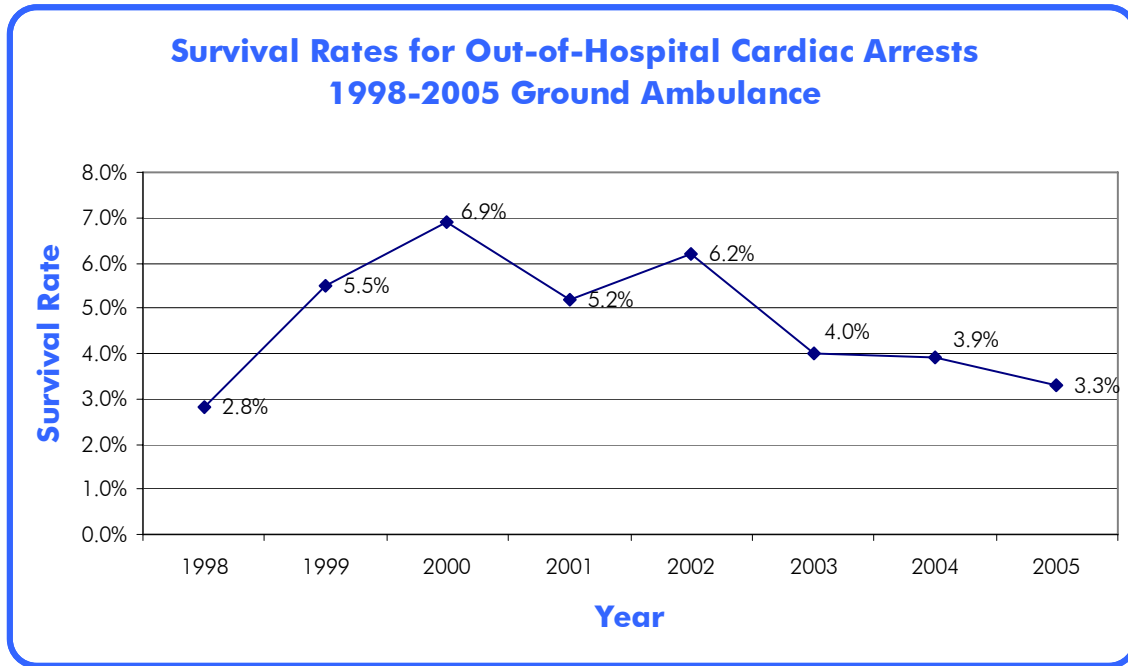
One way to determine the skills and equipment that paramedics require to do their job efficiently is to identify the most frequently requested types of emergency services. Figure 1.3 illustrates the “Top Ten” chief complaints received for the year 2005/06, as a percentage of total calls received.

Figure 1.3 Chief Complaints for Ground Ambulance Calls



One of the main clinical outcome measures for most EHS systems is cardiac arrest survival. During 2005, 559 cardiac arrest patients had resuscitations initiated in the field. Figure 1.4 presents the out-of-hospital cardiac arrest survival rates for Nova Scotia for the years 1998-2005. (Survival is defined as a patient being discharged from hospital neurologically intact after having an out-of-hospital cardiac arrest)

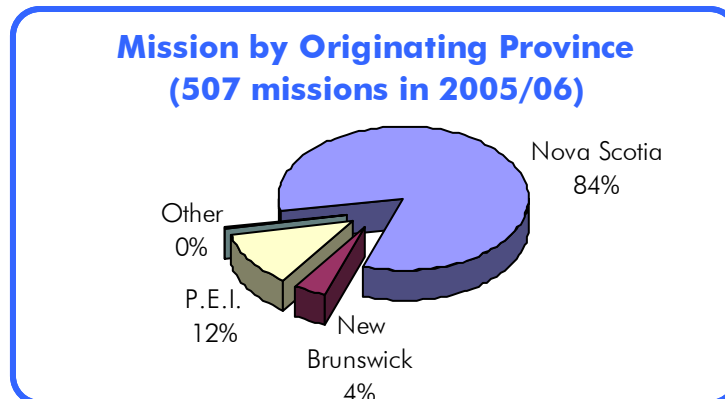
Figure 1.4 Cardiac Arrest Statistics



2.0 EHS LifeFlight

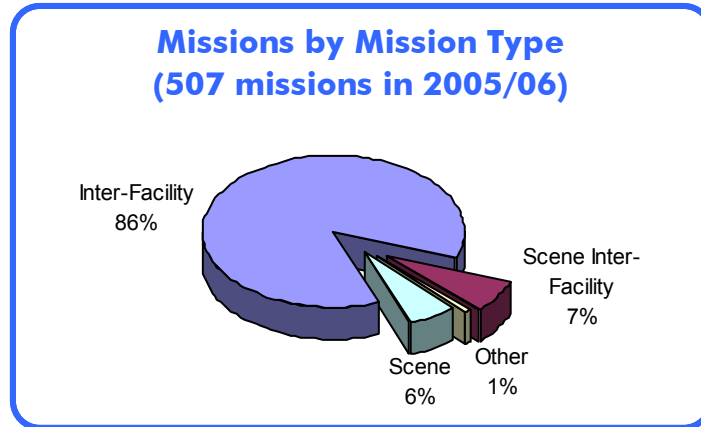
During the year 2005/06, EHS LifeFlight completed 507 missions. Of those, 421 (84%) originated in Nova Scotia and 86 (16%) missions originated in other provinces. Figure 2.1 shows the distribution of missions by location.

Figure 2.1 EHS LifeFlight Missions



Other: Other provinces of Canada or the United States

Figure 2.2 EHS LifeFlight Missions by Response Type



Source: EHS LifeFlight

Inter-Facility: The patient is transported between two approved health care facilities.

Scene: Request for a transport originates from a scene of injury or illness and the patient is picked up directly from the scene.

Scene Inter-Facility: Request for a transport originates from the scene of injury or illness and patient is picked up from a health care facility.

Other: Repatriation

Department of Health Promotion & Protection

In February 2006 Premier Rodney MacDonald announced the creation of the Department of Health Promotion and Protection.

The new department brings together Nova Scotia Health Promotion, the Public Health branch of the Department of Health, and the Office of the Chief Medical Officer of Health. By bringing together experts in promotion, prevention and protection, government is taking the next step forward in creating a healthier and safer Nova Scotia.

Tobacco use is one of Nova Scotia's primary preventable health risks. Many chronic diseases such as cancer, stroke and heart attacks can be prevented through the reduction of tobacco use.

Tobacco Enforcement Overall Compliance and Retailer Compliance Rates: Tobacco Sales to Minors by DHA, 2005/06

YEAR TO DATE										
	DHA 1	DHA 2	DHA 3	DHA 4	DHA 5	DHA 6	DHA 7	DHA 8	DHA 9	TOTAL
Retail Inspections	198	106	255	206	140	140	200	417	810	2472
Overall Warnings	32	21	51	64	43	18	21	37	242	529
Overall Compliance Rates (%)	83.8	80.2	80.0	68.9	69.3	87.1	89.5	91.1	70.1	78.6
Admin. compliance check	85	2	114	106	93	57	93	215	472	1237
Prosec. compliance check	2		7	1	3	9	3	13	22	60
Sales to Minors Warnings	8		18	40	31	14	9	27	121	268
Compliance Rates for sales to minors (%)	90.1	100.0	93.4	62.6	67.7	75.0	90.6	88.2	75.5	79.3

Compliance rates for sales to minors, province wide is 79.3%
Compliance rates for all other sections, province wide is 78.6%

Definition

The percentage of retailers complying with the requirements outlined in the Provincial *Tobacco Access Act* and the Federal *Tobacco Act*.

Significance – Rationale and Notes for Interpretation

Overall compliance is a measure of retailer compliance with the requirements outlined in the Provincial *Tobacco Access Act* and the Federal *Tobacco Act*, as opposed to Retailer Compliance: Sales to Minors being a measure strictly of retailers selling to minors. Tobacco sales are controlled by legislation making it illegal to sell to people less than 19 years of age.

Technical Specifications

Calculation:

$$\left(\left(\left(\text{The total number of inspections} + \text{Compliance checks} \right) - \left(\text{the number of retailers cited} \right) \right) / \left(\text{the total number of inspections} + \text{Compliance checks} \right) \right) \times 100.$$

Source: Dept of Health Promotion and Protection, Chronic Disease and Injury Prevention - Tobacco Control

Section 5 Health Care System Performance

Comparative health system performance indicators help health districts monitor their efficiency, effectiveness and improvements over time. This section provides typical health system performance indicators including a number of those discussed below.

Population by physician and registered nurse are useful indicators of the number of physicians and nurses relative to the population but cannot be used in isolation to assess the adequacy of provider resources. The population's access to hospitals, other health care facilities, technology; specific types of physician (primary care physicians vs. specialists), physician age and sex can influence whether the supply of provider resources is appropriate.

Hospital beds per 1000 population, patient days per 1000 population, and average length of stay are basic indicators of hospital access, utilization and efficiency.

It has been shown that preadmission testing and surgery on the day of admission helps to decrease the length of stay for a patient. This translates into reduced health care costs for hospitals.

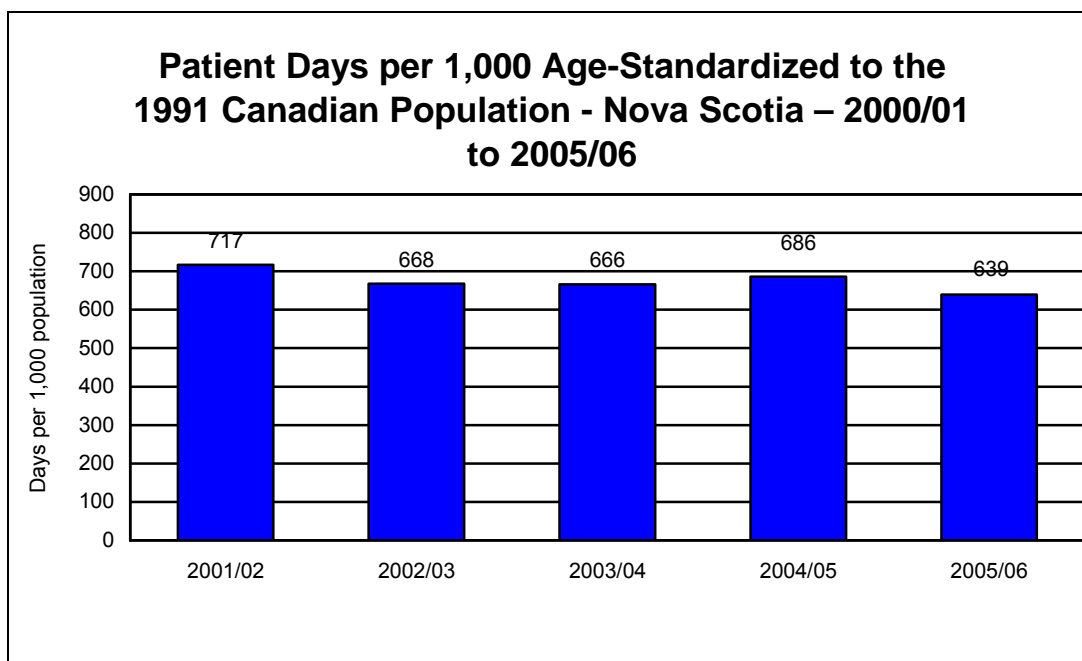
Readmission rates are often used to suggest the effect of bed closures and the shortening of hospital stays.

Ambulatory care sensitive conditions or ACSC is a CIHI indicator. The conditions this indicator focuses on are chronic diseases where it is felt that appropriate ambulatory care could either prevent or shorten hospitalization. Districts and/or hospitals can monitor the volume of cases and total days to see if better or more ambulatory care could be provided.

Inflow/outflow ratios compare hospital services given in a specific district to hospital services received by residents of that same district.

Caesarean sections (C-Sections) have long been monitored as an indicator of health system performance. Unnecessary Caesarean sections increase the risk for maternal morbidity and mortality and are associated with higher costs. Lower rates indicate more efficient care and are more appropriate. WHO has set a benchmark of 15%.

The Department of Health reports on a variety of wait times on its Wait Time Website. Monthly wait times for cardiovascular procedures and cardiac intervention have been collected and monitored by the Cardiovascular Division of the Queen Elizabeth II Health Sciences Centre and the Department of Health for several years. This is also an indicator of health system performance.



Patient Days per 1000 Population

Definition

Patient care days for acute care inpatient separations (by DHA of residence) expressed as a rate per 1000 population for a specified time period.

Significance – Rationale and Notes for Interpretation

Patient days per 1000 population is an indicator of resource use and service planning. Throughout the country, as well as Nova Scotia, patient days per thousand population have been decreasing since the mid 1990's. Standardizing removes the effects of age (and/or sex) in the population. The resulting standardized rate provides a more appropriate comparison between geographic areas and time periods than does the crude rate. Age standardized patient days per 1000 population range from a high of 853 in DHA 8 to a low of 499 in DHA 3. Patient days per 1000 have decreased in Nova Scotia from a high of 717 in 2001/02 to 639 in 2005/06.

Technical Specifications

Calculation:

(The total days stay for hospital inpatient separations per DHA of residence) X Standardizing Process /100

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database; Statistics Canada population estimates

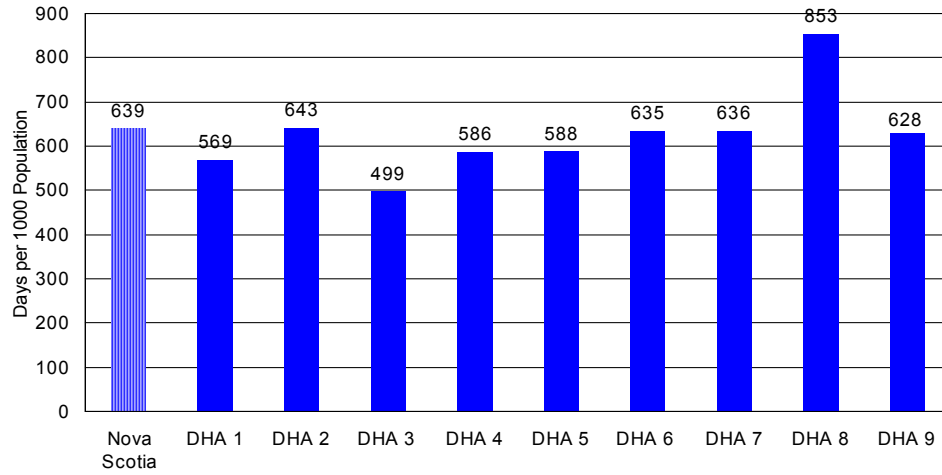
Disclosures

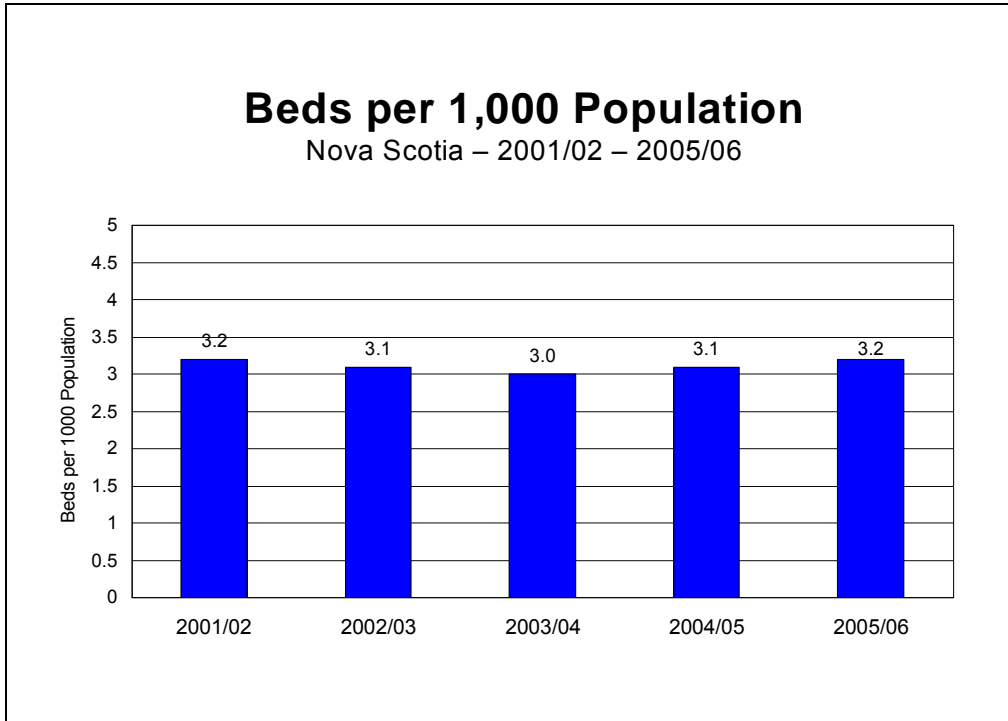
Exclusions: Veteran Affairs of Canada (VAC), newborns, out of province patients

Inclusions: Acute medical, surgical and psychiatric inpatient days

Patient Days per 1000 Population

Days Per 1000 Population Age-Standardized to the 1991 Canadian Population by DHA of Residence 2005/06
Excludes Newborns





Beds per 1000 Population

Definition

The number of acute care (including Med/surg, ICU, OBS, Paeds, Mental health, Rehabilitation inpatient beds and other acute) beds per 1000 population.

Significance – Rationale and Notes for Interpretation

We report the number of beds per 1000 population as a measure of hospital capacity and available resources.

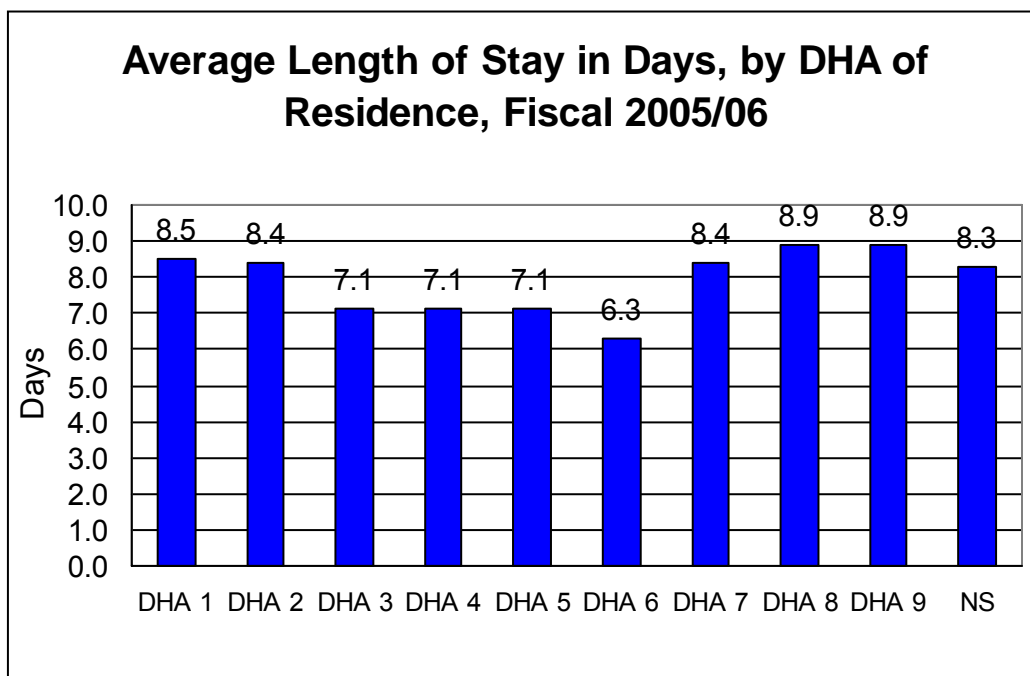
Technical Specifications

Calculation: (The total number of acute care beds / the Nova Scotia population) X 1000

Source: Information Analysis & Reporting, Nova Scotia
Department of Health

Disclosures

Exclusions: Veterans Affairs of Canada (VAC), Detoxification beds and Level 2 beds.



Average Length of Stay

Definition

The average length of a hospital stay for acute care inpatients by DHA of residence.

Significance – Rationale and Notes for Interpretation

There is debate about the usefulness of overall average length of stay (ALOS) as an indicator. Lengths of stay for particular patient groups, especially when compared with other facilities, are more commonly used for utilization management at the facility or inter-district level.

Technical Specifications

Calculation: (The total length of stay (in days) for acute inpatient separations by DHA of residence) / (the total acute inpatient separations DHA of residence)

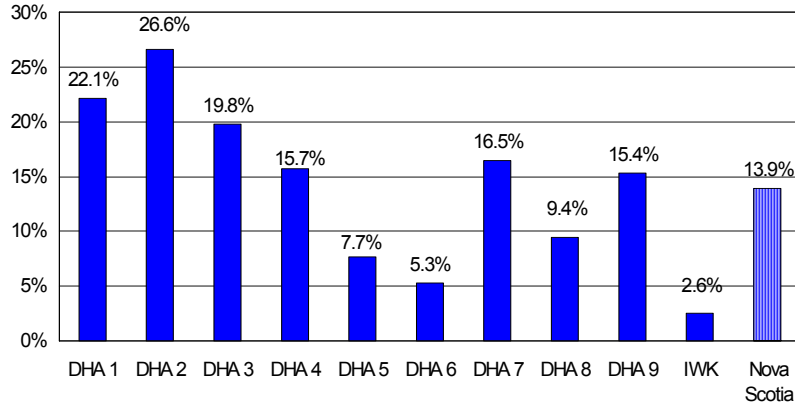
Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database.

Disclosures

Exclusions: newborns, forensic, and out-of-province patients

Inclusions: All days and separations for medical, surgical, and acute inpatient cases.

% Alternate Level of Care Days (ALC) by Institution DHA, Fiscal 2005/06



Alternate Level of Care

Definition

Alternate Level of Care (ALC) Days are days of care provided to inpatients who have finished the acute care phase of their treatment or who were admitted for non-acute medical care. ALC status is indicated by the physician or designated other.

Significance – Rationale and Notes for Interpretation

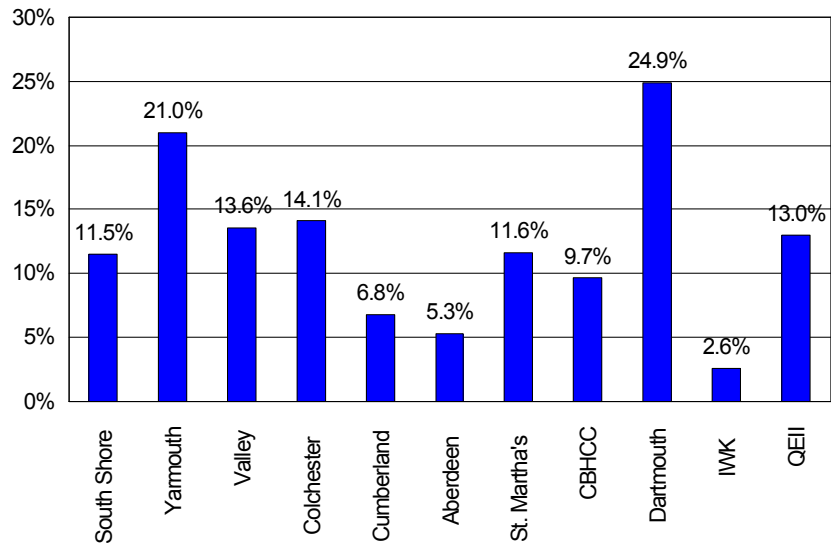
CIHI (Canadian Institute for Health Information) has provided the ALC designation in order to capture those hospital inpatients no longer receiving acute care. This indicator is designed to assess the processes that ensure the placement of patients in the most appropriate care setting. Differences in rates between facilities, districts and provinces may reflect differences in reporting practices rather than differences in hospital utilization or patient mix. ALC rates range from 26.6% in DHA 2 to 2.6% at the IWK.

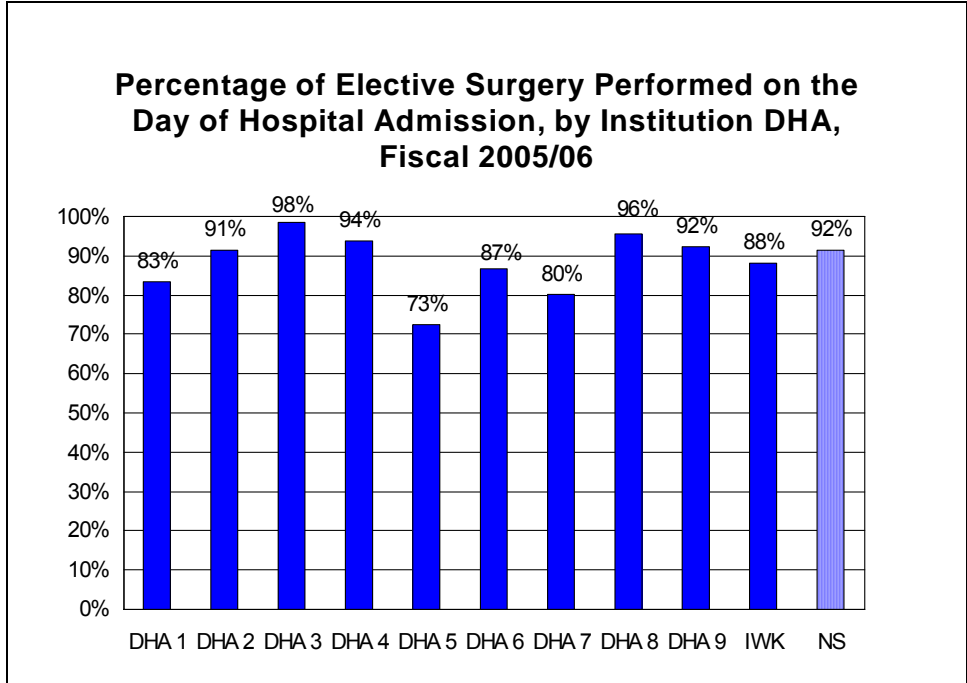
Technical Specifications

Calculation: 1: $((\text{The total ALC days per DHA of residence}) / (\text{total inpatient days})) \times 100$
 2: $((\text{The total ALC day per hospital}) / (\text{the total days stay per hospital})) \times 100$

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database.

% Alternate Level of Care Days by Institution, Fiscal 2005/06





Percentage Elective Surgery Performed On the Day of Hospital Admission

Definition

Same Day Admission surgery occurs when a patient’s elective surgery is performed on the same day he/she was admitted. In other words, the admission date is the same as the intervention date. All preparatory investigation is completed prior to admission. Only surgeries performed in an operating room or an endoscopy room are included. (Obstetrical procedures are excluded.)

Significance – Rationale and Notes for Interpretation

Preadmission testing followed by surgery on the day of admission help to decrease the length of stay for a patient. This translates into reduced health care costs. The percentage of elective surgeries done on the day of admission has increased steadily from 7% in 1990/91.

Technical Specifications

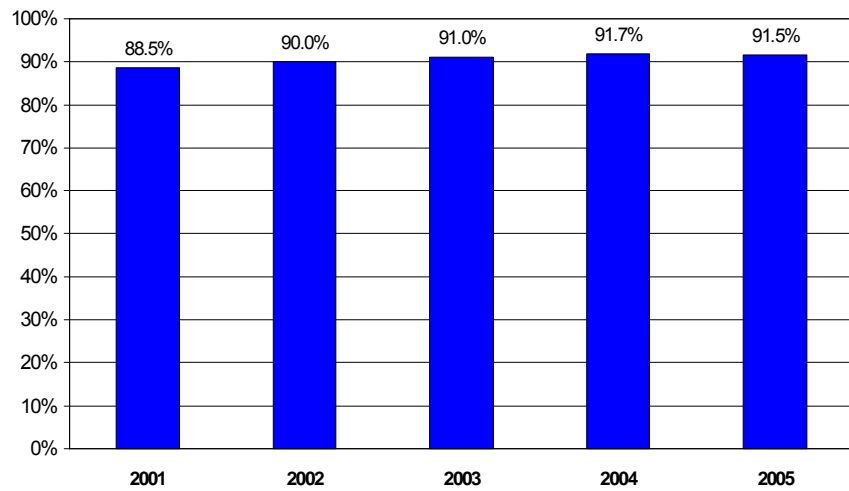
Calculation: ((The number of elective separations with surgery performed on the day of hospital admission by institutional DHA) / (the total number of elective separations having surgery)) X 100

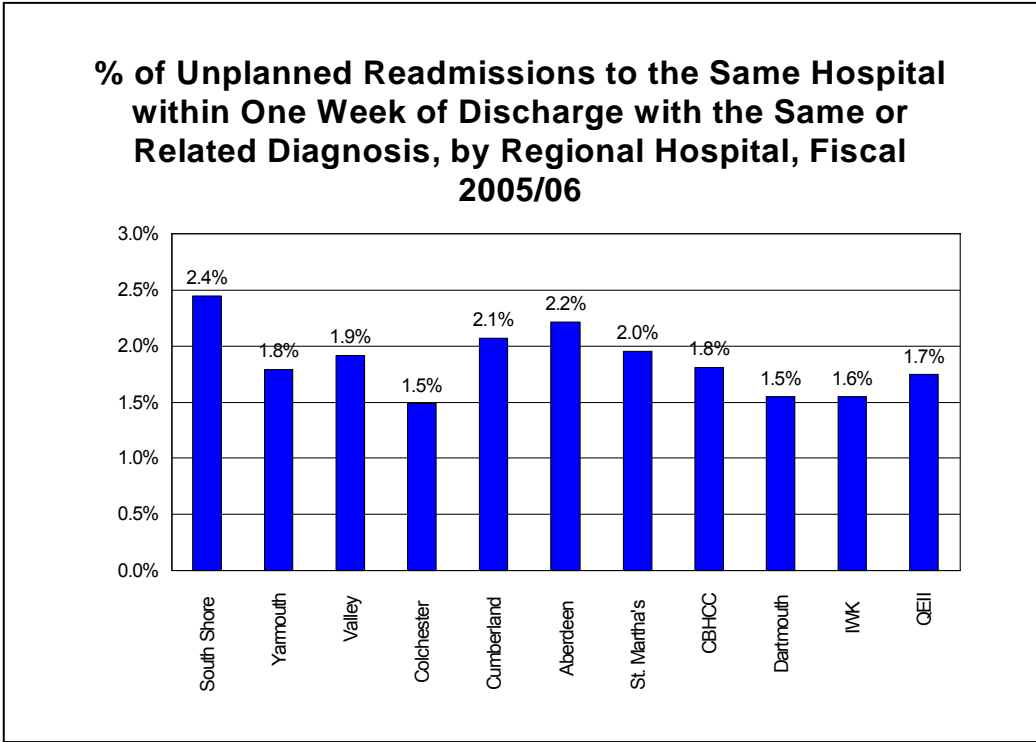
Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database

Disclosures

Inclusions: *Out-of-province patients and newborns*

Percentage of Elective Surgery performed on the Day of Hospital Admission, Nova Scotia, 2001-2005





Readmission to the same Hospital – Unplanned from previous Acute Admission within one week of discharge with the same or related diagnosis

Definition

Admission to acute care ≤ 7 days; unplanned from previous acute admission at the same facility with the same or related diagnosis inpatients only.

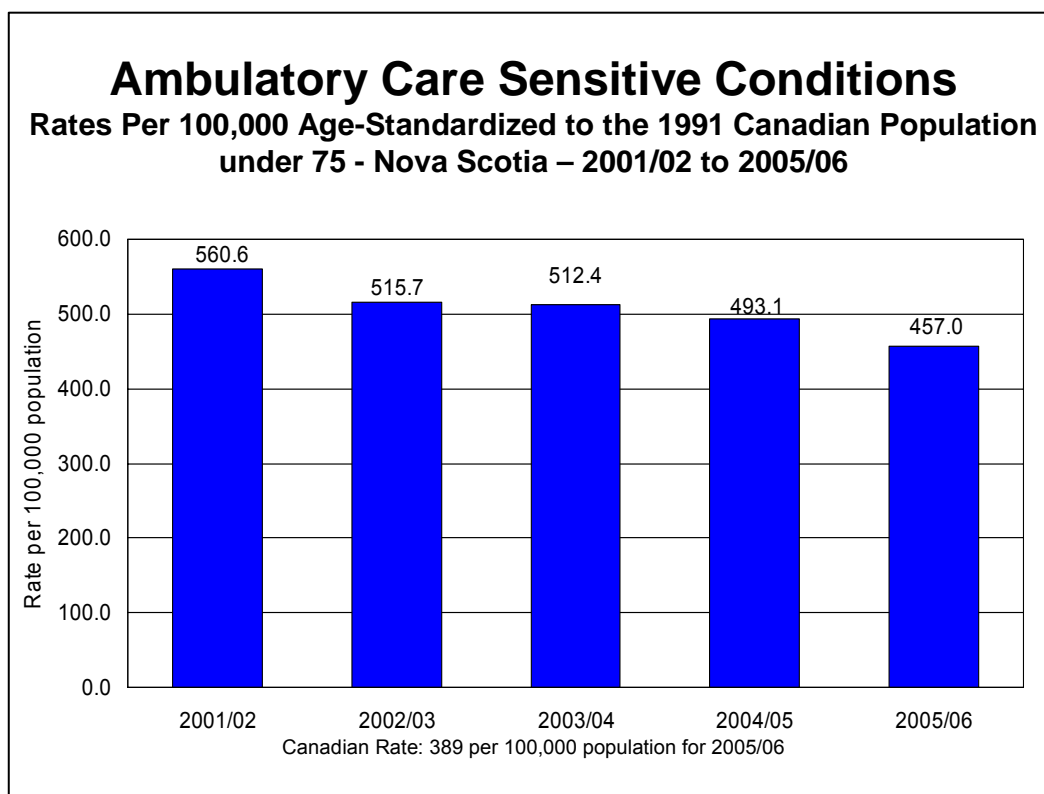
Significance – Rationale and Notes for Interpretation

Hospital readmission rates have been used to measure the effects of decreasing bed numbers and lengths of stay. Percentages of unplanned readmission are low for the province with the highest being 2.4% for South Shore Regional Hospital.

Technical Specifications

Calculation: $\left(\frac{\text{The number of readmissions } \leq 7 \text{ days; unplanned from previous acute admission}}{\text{total number of separations}} \right) \times 100$.

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database.



Ambulatory Care Sensitive Conditions

Definition

Age-standardized inpatient acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for hospitalization, per 100,000 population under age 75 years. – exclude Nova Scotia Hospital.

Most Responsible diagnosis ICD-10-CA code of: G40, G41, J41, J42, J43, J44, J47, J45, E10.1, E10.6, E10.7, E10.9, E11.0, E11.1, E11.6, E11.7, E11.9, E13.0, E13.1, E13.6, E13.7, E13.9, E14.0, E14.1, E14.6, E14.7, E14.9, J20 (only when secondary diagnosis of J41, J42, J43, J44, or J47 is also present), J12, J13, J14, J15, J16, J18 (only when secondary diagnosis of J41, J42, J43, J44 or J47 is also present), I50, J81 (excluding cases with CCI code of 1.IJ.50, 1.HZ.85, 1.IJ.76, 1.HB.53, 1.HD.53, 1.HZ.53, 1.HB.55, 1.HD.55, 1.HZ.55, 1.HB.54, or 1.HD.54), I10.0, I10.1, I11 (excluding cases with CCI code of 1.IJ.50, 1.HZ.85, 1.IJ.76, 1.HB.53, 1.HD.53, 1.HZ.53, 1.HB.55, 1.HD.55, 1.HZ.55, 1.HB.54, or 1.HD.54), and I20, I23.82, I24.0, I24.8, I24.9 (excluding cases with any one CCI code of 1*, 2*, or 5*)

Excluding: death before discharge

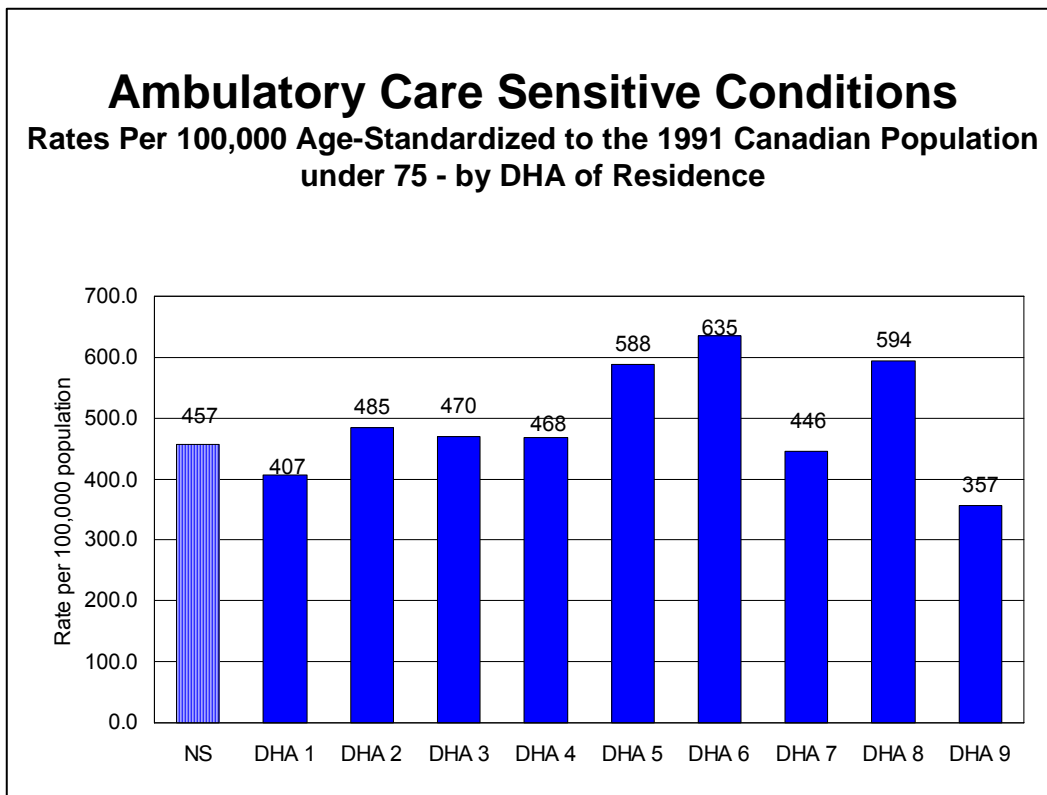
Significance – Rationale and Notes for Interpretation

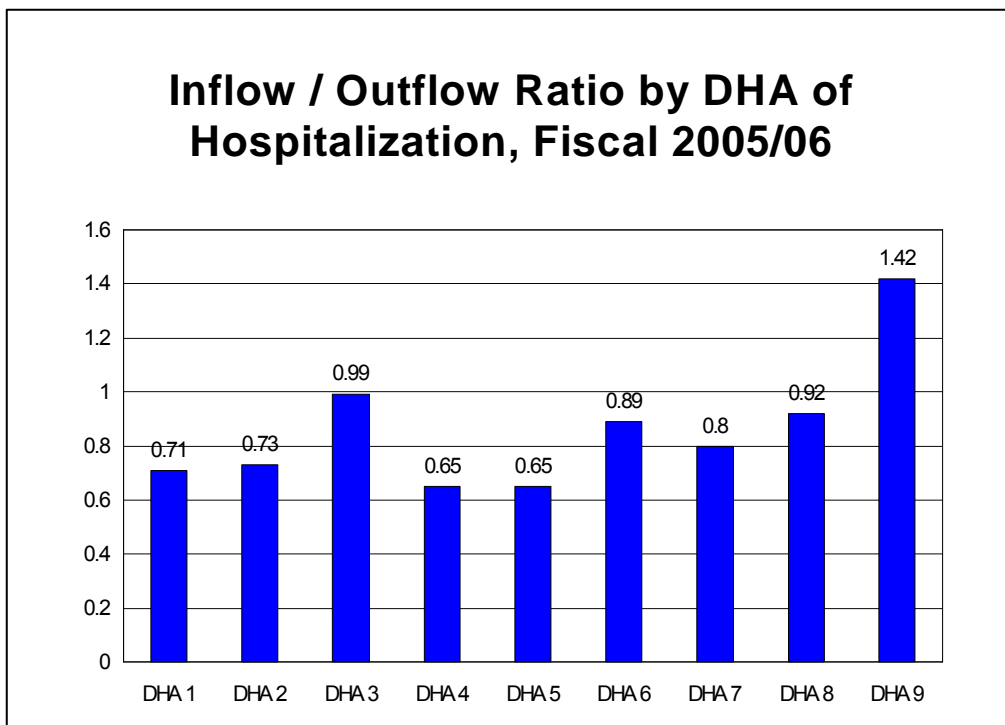
Hospitalizations for ambulatory care sensitive conditions are considered to be an indirect measure of access to appropriate medical care. While not all admissions for these conditions are avoidable, appropriate ambulatory care could potentially prevent the onset of this type of illness or condition, control an acute episodic illness or condition or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to primary care.

Technical Specifications

Calculation: ((The number of separations with an ACSC most responsible diagnosis done per DHA of Residence / the population for the province (DHA's)) X Standardizing Process)) X 100,000

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database.





Inflow/Outflow Ratio

Definition

This indicator is used for acute care inpatients separations only. It compares the number of separations from acute care hospitals within a DHA to the number of hospital separations of residents from the same DHA (all DHAs of hospitalization). The IWK is included in DHA 9 for this indicator.

Significance – Rationale and Notes for Interpretation

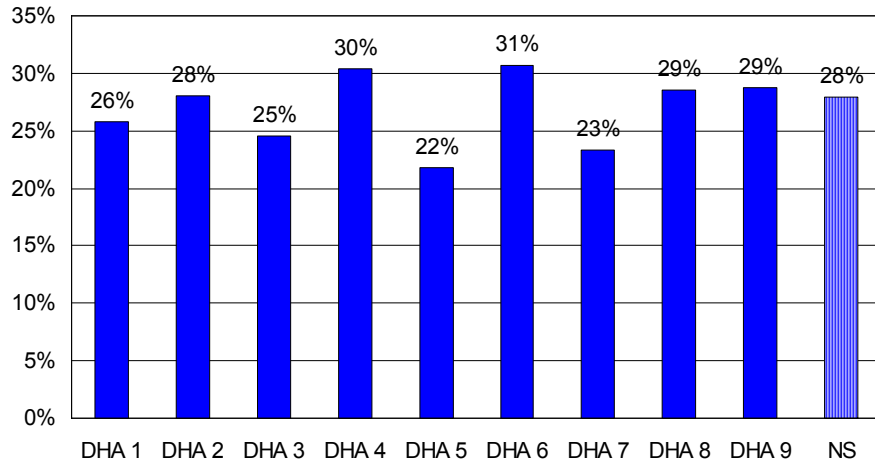
A ratio of less than one indicates that more residents left their own DHA to receive care than the number of residents that came into the DHA to receive care. A ratio greater than one indicates: that more people came into the DHA to receive care than the number of people that left the DHA to receive care. A ratio of one indicates that the volume of hospital discharges in the DHA is equivalent to that generated by its residents, suggesting that inflow and outflow activity, if it exists at all, is balanced. Inflow/outflow ratio ranges from a high of 1.42 in DHA 9, which indicates an inflow, which would be expected as the tertiary care facilities are located in DHA 9, to 0.65 for DHA 4 and 5.

Technical Specifications

Calculation: (The numbers of separations (discharges and deaths) from acute care hospitals within a given region) / (the number of hospital separations generated by residents of a given district (region is specified in the numerator))

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database

Caesarean Sections as a % of All Deliveries, by DHA of Residence, Fiscal 2005/06



Caesarean Section

Definition

Removal of the fetus through surgical incision of the uterus. The number of Caesarean sections (c-sections) performed, as a percent of all deliveries, in each DHA.

Significance – Rationale and Notes for Interpretation

An elevated number of Caesarean sections may increase the maternal risk of morbidity and mortality. The overall Caesarean section rate has been climbing for the province since a low of 19.6% in fiscal 1995/96. For 2005/06, the rate for the province is 27.9%. Small volumes of deliveries and C-sections in a given DHA result in significant variation in C-Section rates. Caution should be used when making comparisons of rates across DHAs. WHO has set a benchmark for Caesarean sections as 15% of all deliveries.¹

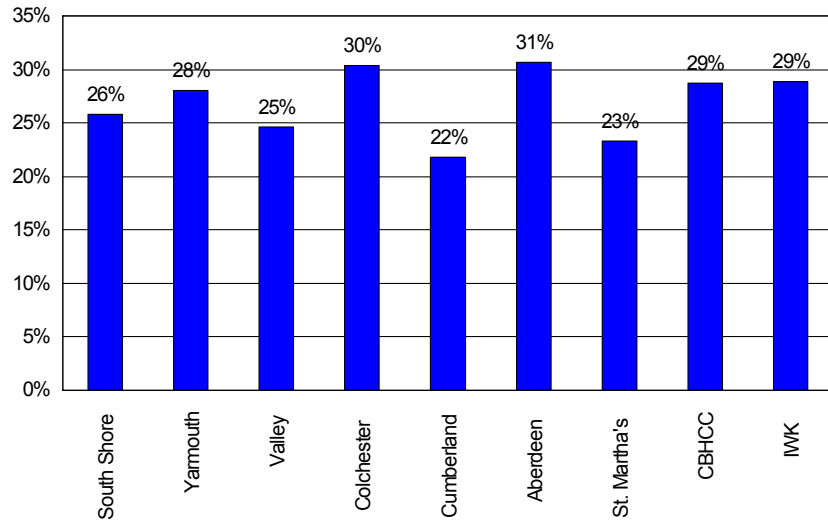
Technical Specifications

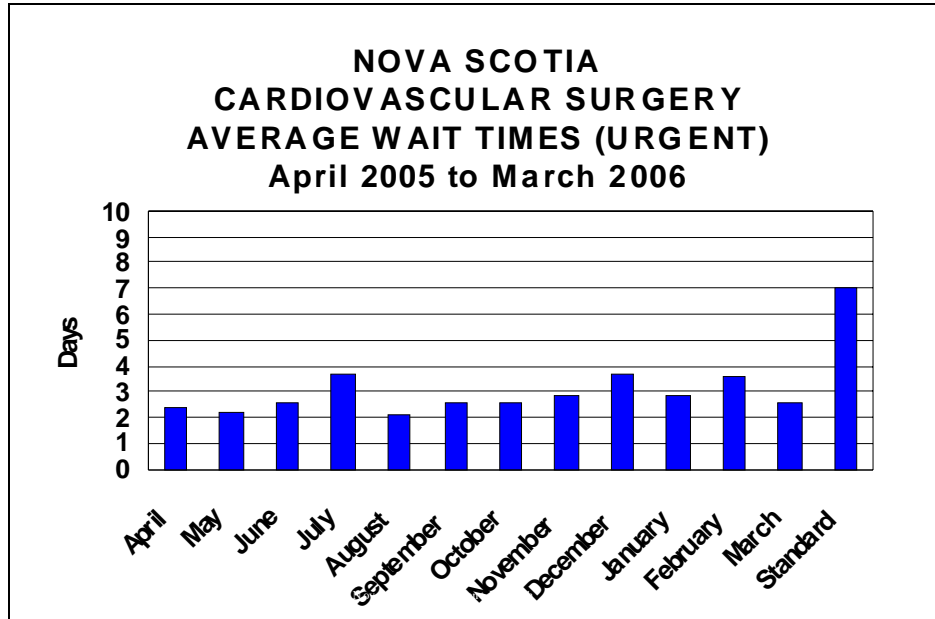
Calculation: C-sections were counted using any procedure starting with 5MD60^^. $(\text{The total number of caesarean sections per DHA of residence} / \text{the total number of deliveries}) \times 100$

Source: Nova Scotia Department of Health, Canadian Institute for Health Information Discharge Abstract Database

¹ CIHI Health Indicators 2006 Definitions, Data Sources and Rationale February 2006

Caesarean Sections as a % of All Deliveries, by Hospital, Fiscal 2005/06





Cardiovascular Surgery Wait Times

Definition

1. Maximum wait time in days for cardiovascular surgery for urgent patients by month. **Urgent** patients are critically ill and cannot be discharged from hospital prior to receiving surgery. They have failed maximal medical therapy and remain unstable. The current wait time standard is 7 days.

2. Maximum wait time in days for cardiovascular surgery for elective patients by month. **Semi-Urgent "A"** patients are unstable, have failed medical therapy and are at significant risk of heart attack or heart failure and mortality. In many instances, patients are transferred back to their District hospital while arrangements are being made to have surgery. The current wait time standard is 2-3 weeks. **Semi-Urgent "B"** patients have coronary artery disease and are doing poorly on medical therapy. They would have chest pain walking 1-2 blocks and are incapable of employment. If these patients can exercise greater than 2 mets (a met is a standardized score on a cardiac stress test) but less than 5 mets during a stress ECG test they fall into this category. The current wait time standard is 6-8 weeks. **Elective** patients are stable on medical therapy; unable to work due to cardiac limitations; and felt to further improve with bypass surgery. The current waiting time standard is 3 months.

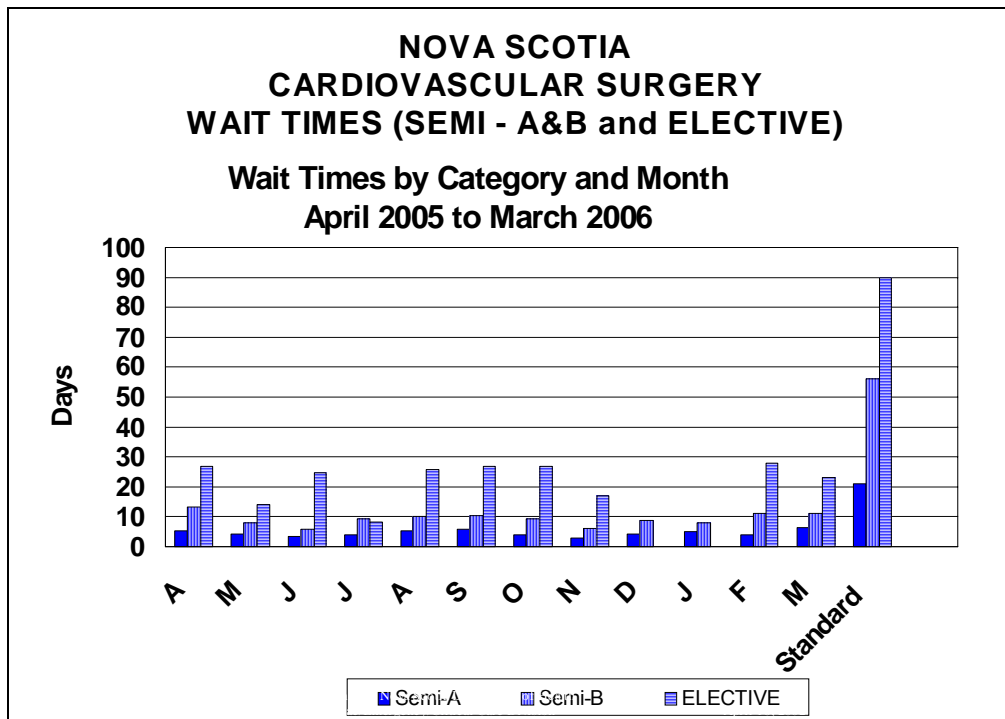
Significance – Rationale and Notes for Interpretation

Systematic collection and comparison of wait time data are complex. Historically, different groups have defined and monitored wait times in different ways. For example, some calculate wait times from when a person first visits a family doctor. Others start the clock when the patient is assessed by a specialist or when test results confirm the need for further treatment or from some other point. There are advantages and disadvantages to each approach. Nonetheless, such differences have to be reconciled if meaningful comparisons between jurisdictions are to be made.

Technical Specifications

Calculation: The total number of days waiting between the procedure booking date (by the referring physician) and the date of the procedure.

Source: Divisions of Cardiology and Cardiovascular Surgery, QEII Health Sciences Centre
 Monthly Wait Times



Section 6 Insured Programs Indicators

Insured Programs expenditures are measured by examining the cost and the number of insured services provided to Nova Scotia residents.

Expenditures for Insured Programs data are based on the date the service occurred.

Physician services expenditure data include:

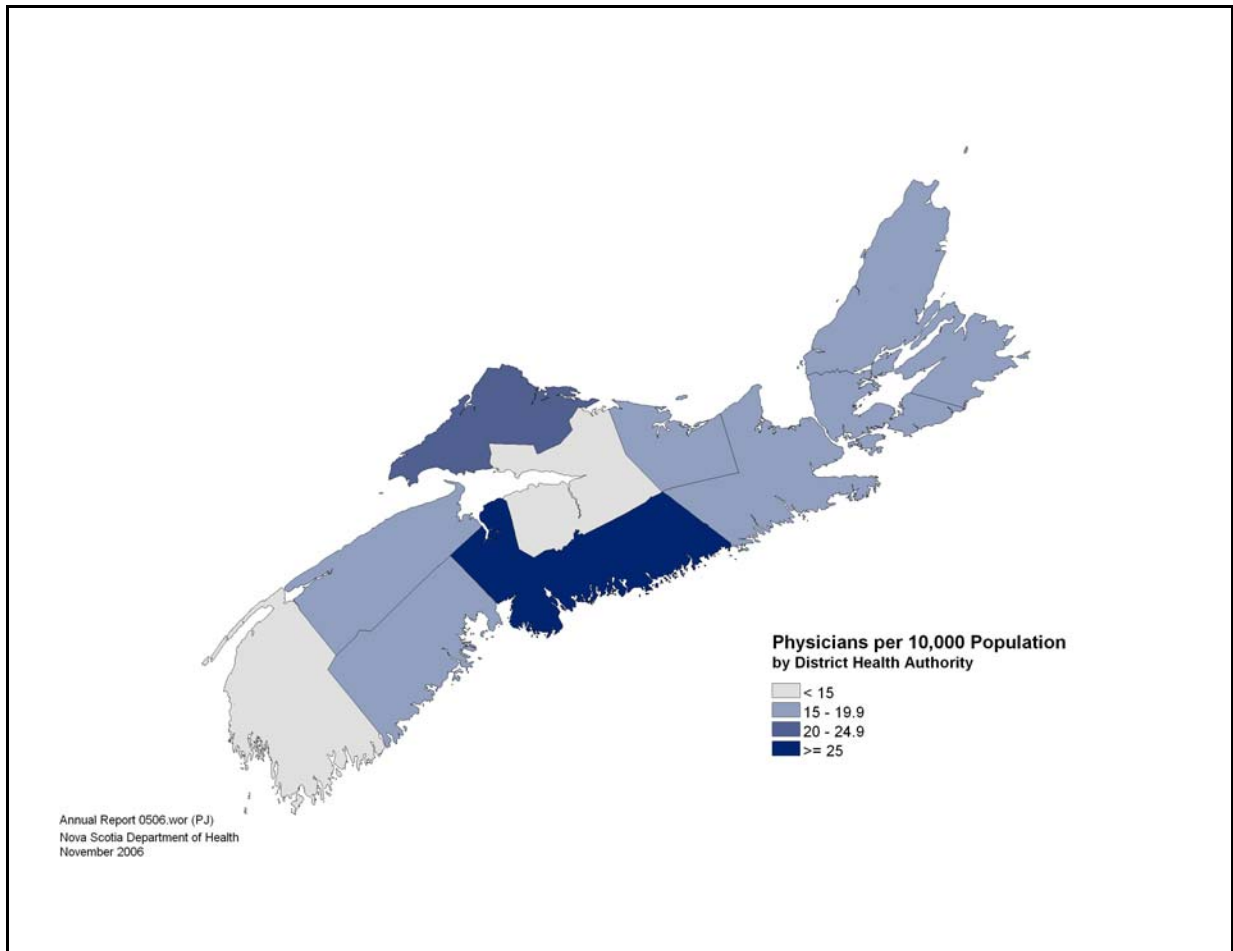
- the amount paid by the Province of Nova Scotia to physicians for insured services to Nova Scotia residents in-province, out-of-province, or out-of-country, unless otherwise stated.
- expenditures for Fee-for-Service, Alternate Funded physician groups, Canadian Medical Protective Assoc. and Benefit Funds, Rural Stabilization, Emergency Room services, and miscellaneous accounting adjustments.
- In Nova Scotia, physician services for First Nations People are paid for by the province. This is not the same in all provinces and territories.

Physician services expenditure data exclude:

- all federal payment categories as services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally.
- physician payments not the responsibility of the Department of Health. These exclusions include services for Workers Compensation Board, Community Services and services provided to residents of other provinces and territories.

Seniors' Pharmacare program includes both the Department of Health expenditures and Seniors' contributions.

Population data are from Statistics Canada's estimates as of July 1st each year.



Physicians per 10,000 Population

Definition

Map of population per physician, including specialists, by District Health Authority.

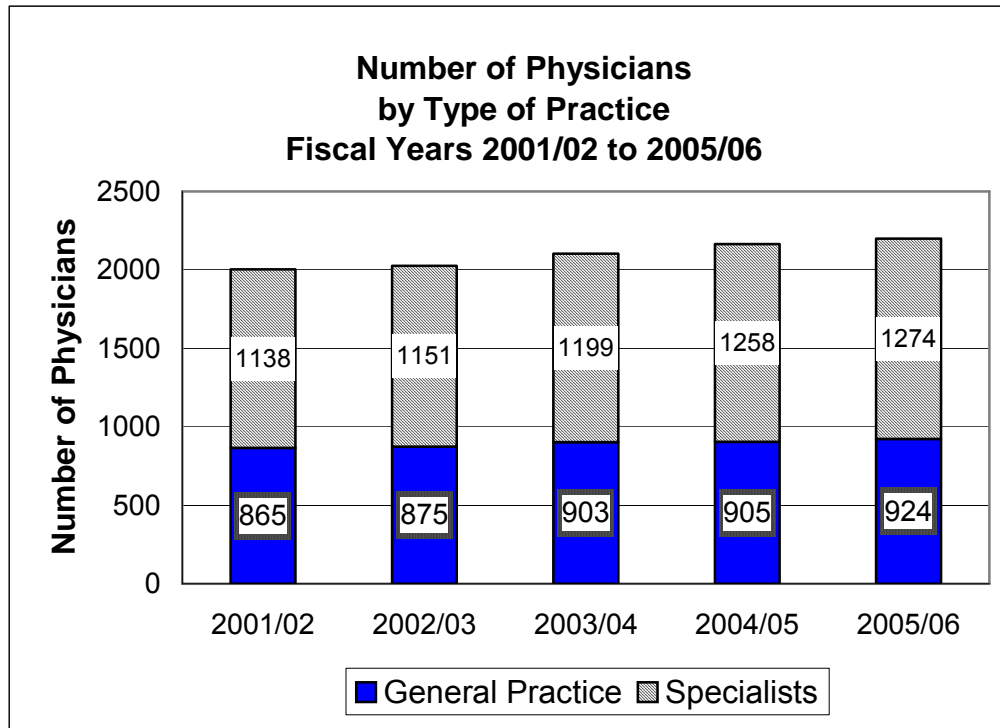
Significance – Rationale and Notes for Interpretation

Health care professions per population is used as an indicator of relative access to health care. Reflecting the location of the province's tertiary facilities and the vast majority of medical specialists, the number of physicians per 10,000 population is highest within the Capital district, indicating greater access. The lowest number of physicians per 10,000 population (least access) occurs in the southwest portion of the province (DHA 2). Note: On its own, number of professionals per population does not indicate whether or not there are sufficient numbers of health professionals in a given area.

Technical Specifications

Calculation: (Number of Physicians per DHA / Population DHA) X 10,000

Source: Statistics Canada, Nova Scotia Department of Health



Physicians' Services: Number of Physicians by type of Practice

Definition

The annual number (head count) of physicians paid by the Province of Nova Scotia for insured services delivered to Nova Scotia residents in-province.

Significance – Rationale and Notes for Interpretation

Total number includes any physician (full time, part time, locum) who was paid by the province during the fiscal year.

Type of Practice is based on Functional Specialty. Functional Specialty is intended to reflect the specialty that the physician practices for the greatest percentage of his/her time. It may not be consistent with the physician's licensed specialty. General Practitioners functioning primarily as Emergency Room physicians are included in the specialists count not in the General Practice count.

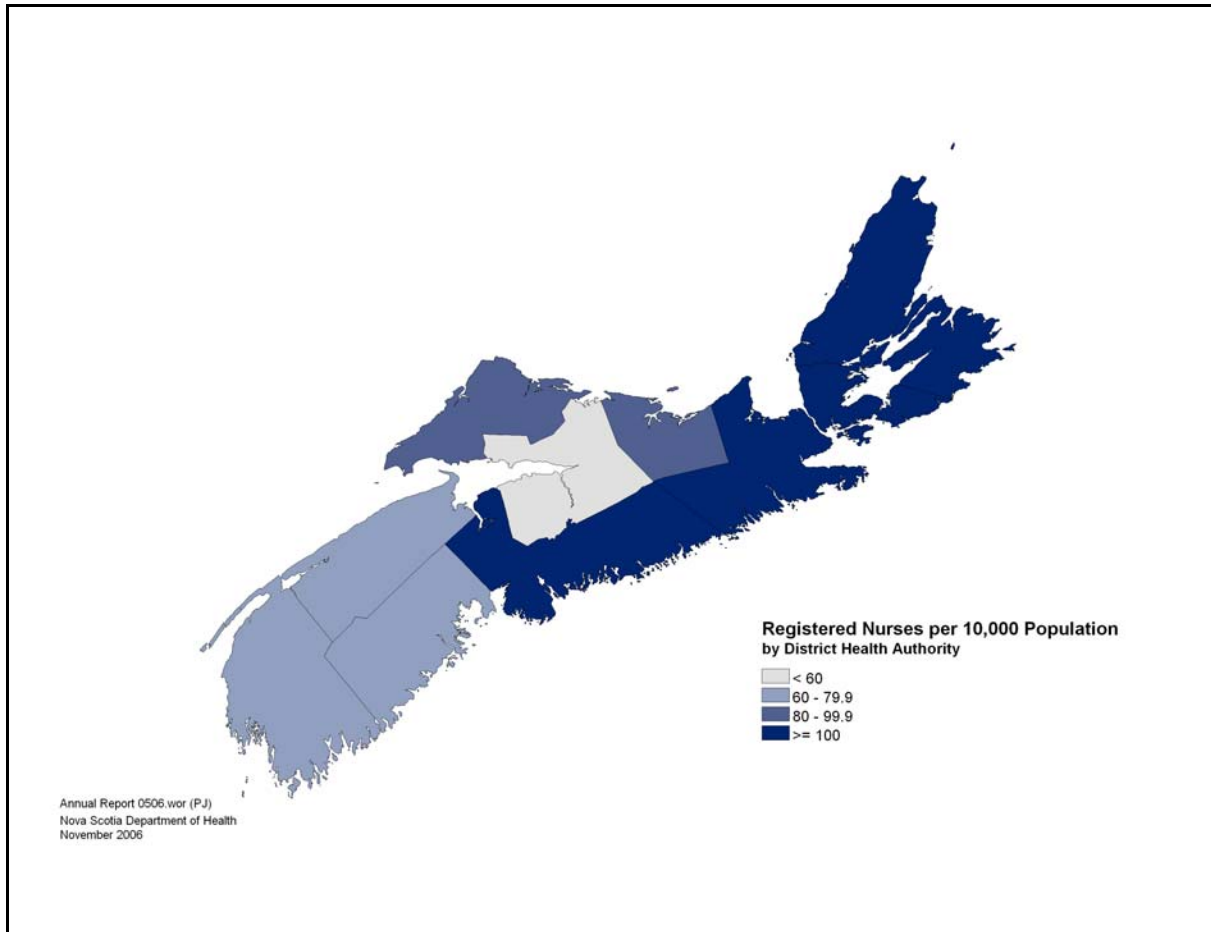
Technical Specifications

Calculation: Head count of physicians by functional specialty. (Physicians not paid by Department of Health are excluded)

Disclosures

Excludes 14 physicians in 2003/04 and 4 physicians in 2004/05 whose specialty is 'Other'. This category includes Administration, Occupational Medicine (GP), and Other.

Source: Medavie Blue Cross, Department of Health Annual Statistical Tables



Registered Nurses per 10,000 population

Definition

Map of population per registered nurse by District Health Authority.

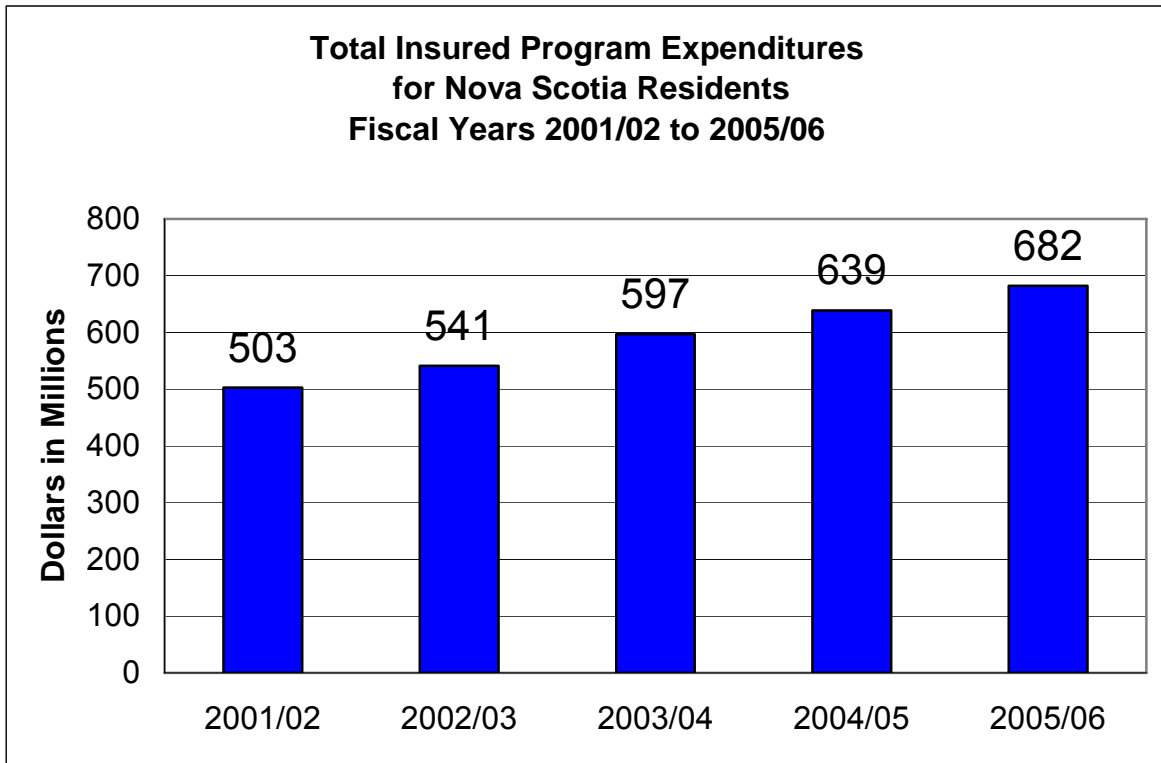
Significance – Rationale and Notes for Interpretation

Health care professional per population is used as an indicator of relative access to the health care system. Reflecting the location of the province's tertiary facilities, the highest number of registered nurses per 10,000 population is within the Capital district, indicating greater access. The lowest number of registered nurses per 10,000 population (least access) occurs in Colchester East Hants (DHA 4). Note: On its own, professionals per population does not indicate whether or not there are sufficient numbers of health professionals in a given area.

Technical Specifications

Calculation: (Number of Registered Nurses per DHA / DHA Population) X 10,000

Source: Statistics Canada, Nova Scotia Department of Health



Insured Services: Total Expenditures for Insured Services

Definition

This measure refers to the total annual expenditures for the following Insured programs: Physician Services, Dental (Children's Oral Health, Dental Surgery, and Special Dental Programs), Optometry, Pharmacare (Seniors and Special Assistance Programs), and Prosthetics.

Significance – Rationale and Notes for Interpretation

This data shows annual program expenditures for insured services in Nova Scotia. Government health care expenditures have increased by over 175 million dollars since 2001/02. Medicare data includes Fee-for-Service, Alternative Funded physician groups, Canadian Medical Protective Assoc. and Benefit Funds, Rural Stabilization, Emergency Room, and miscellaneous accounting adjustments. Pharmacare data includes Drug Cost, Dispensing Fees and Special Funding Assistance Programs. This represents both the Department of Health expenditure and Seniors' contributions for the Pharmacare programs. Dental, Optometric, and Prosthetics services include miscellaneous accounting adjustments.

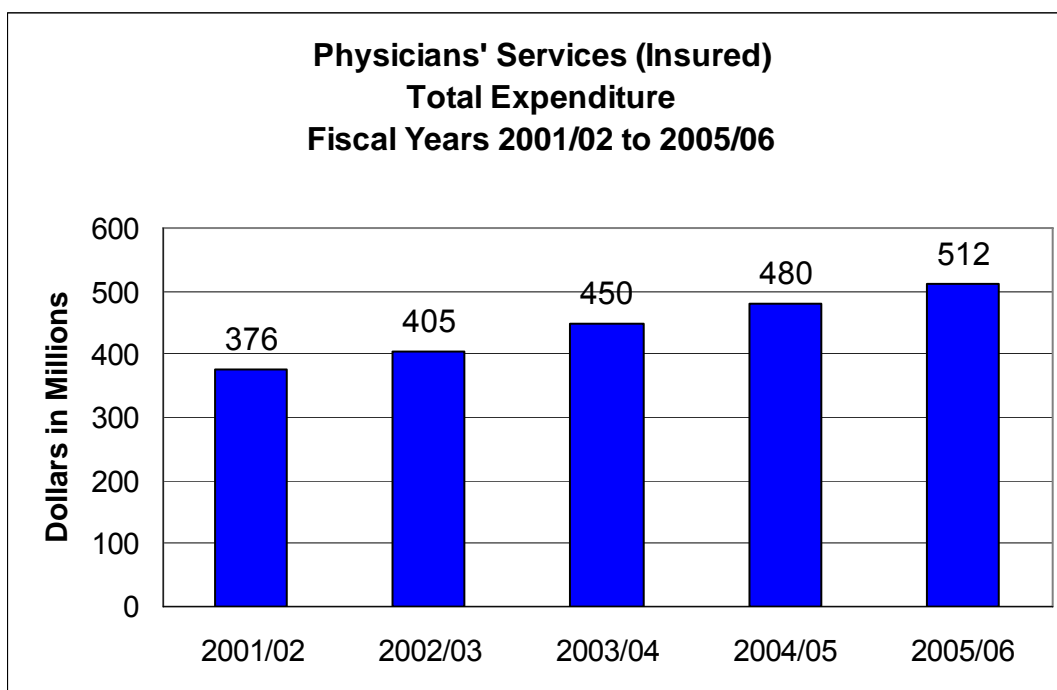
Technical Specifications

Calculation: Total program expenditures for insured services per fiscal year, expressed in millions of dollars.

Source: Medavie Blue Cross, Department of Health Annual Statistical Tables.

Disclosures

Exclusions: This measure excludes health services that are not the responsibility of the Department of Health. These exclusions include services for Workers Compensation Board, Community Services, members of the Royal Canadian Mounted Police (RCMP) and Canadian Armed Forces Personnel as their services are federally funded, and services to residents of other provinces and territories.



Physicians' Services: Total Expenditure for Insured Physicians' Services

Definition

This data represents the total annual payments to physicians for insured physician services provided by physicians to Nova Scotia residents in-province, out-of-province and out-of-country.

Significance – Rationale and Notes for Interpretation

Total expenditures for physician services provide a means of tracking expenditure trends. As noted by the above graph, physician total expenditures have increased each year.

Technical Specifications

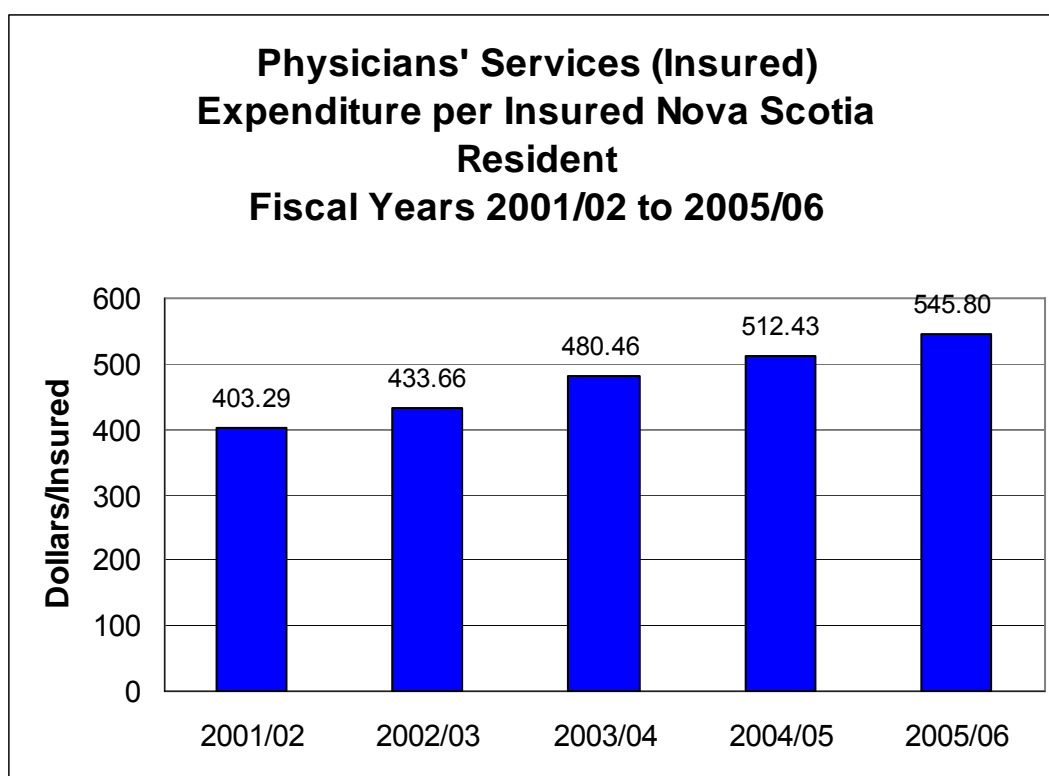
Calculation: Total amount paid to physicians expressed in millions of dollars.

Source: Medavie Blue Cross, Department of Health Annual Statistical Tables.

Disclosures

Inclusions: Physicians' payments for Fee-for-Service and Alternate Funded physician groups, Canadian Medical Protective Assoc. and Benefit Funds, Rural Stabilization, Emergency Room, and miscellaneous accounting adjustments.

Exclusions: This measure excludes physician payments not the responsibility of the Department of Health. These exclusions include services for Workers Compensation Board, Community Services, RCMP and Canadian Armed Forces personnel as their services are federally funded, and services provided to residents of other provinces and territories.



Physicians' Services: Expenditure per Insured Nova Scotia Resident

Definition:

This data represents the annual expenditure per person for insured physician services provided by physicians to Nova Scotia residents in-province, out-of-province, and out-of-country.

Significance – Rationale and Notes for Interpretation

Expenditures per insured Nova Scotia resident provide an indication of the dollars spent. As noted by the above graph, physician expenditures per insured NS resident have increased each year.

Technical Specifications

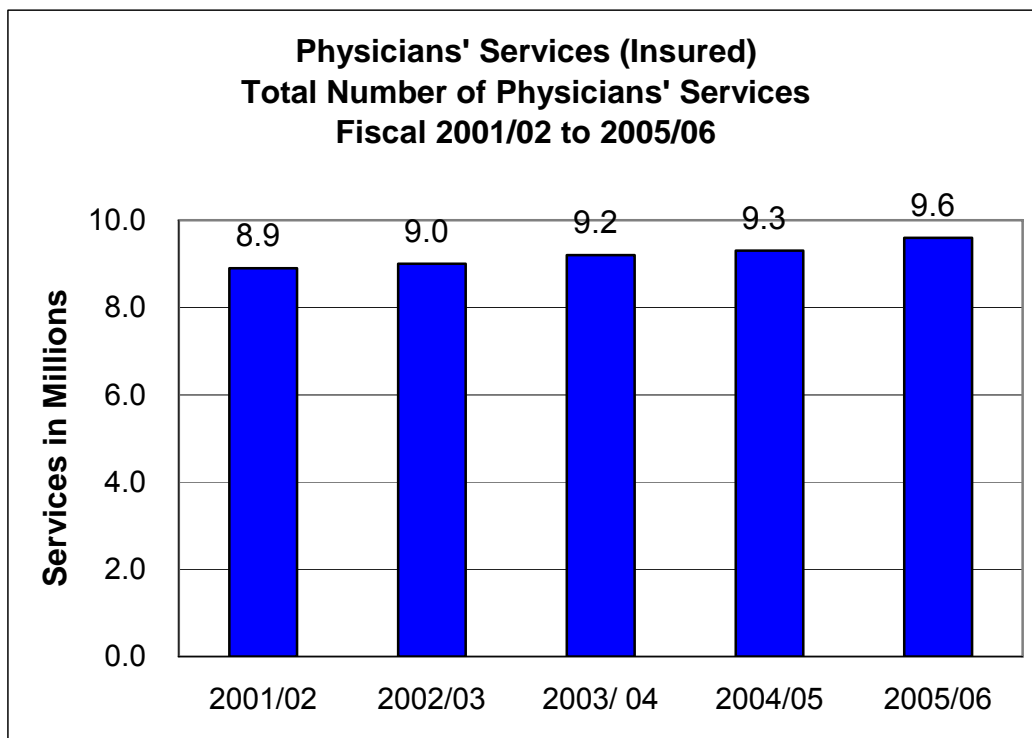
Calculation: (Total physician expenditure / number insured persons in Nova Scotia) expressed in dollars and cents.

Source: Medavie Blue Cross, Department of Health Annual Statistical Tables, Statistics Canada Census Population.

Disclosures

Inclusions: Physicians' payments for Fee-for-Service and Alternate Funded physician groups, Canadian Medical Protective Assoc. and Benefit Funds, Rural Stabilization, Emergency Room, and miscellaneous accounting adjustments.

Exclusions: This measure excludes physician payments not the responsibility of the Department of Health. These exclusions include services for Workers Compensation Board, Community Services, RCMP and Canadian Armed Forces personnel as their services are federally funded, and services provided to residents of other provinces and territories.



Physicians' Services: Total Number of Insured Services

Definition

The total annual number of insured individual services from billings submitted by Nova Scotia physicians for Nova Scotia residents in-province and for physician services refunded to residents provided while in the Province of Quebec or out-of-country.

Significance – Rationale and Notes for Interpretation

The total number of insured physician services provided to Nova Scotia residents is representative of the utilization of physician service resources. Some services may not be included as they are not available for some Alternate Funded arrangements.

Technical Specifications

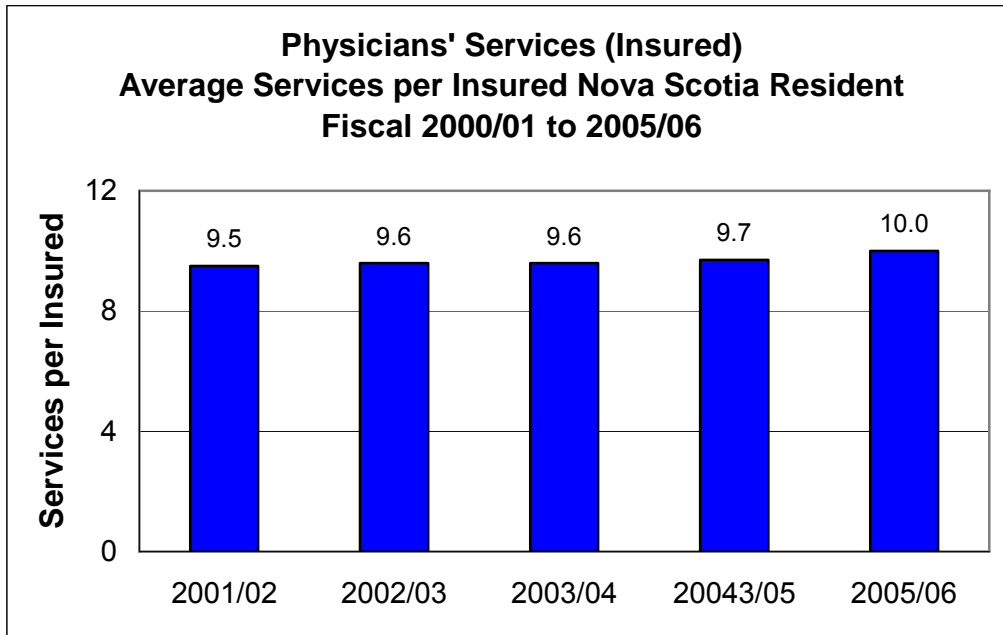
Calculation: Total number of services.

Source: Medavie Blue Cross, Department of Health Annual Statistical Tables.

Disclosures

Inclusions: Services from Fee-for-Service, Alternate Funded physician groups, NonPatient Specific in-patient and out-patient services, and physician services where a Nova Scotia resident was refunded the cost of a service provided in the Province of Quebec or out-of-country.

Exclusions: Physician services where the payment is not the responsibility of the Department of Health. These exclusions include services for Workers Compensation Board, Community Services, RCMP and Canadian Armed Forces personnel as their services are federally funded, services to residents of other provinces and territories, and services provided to Nova Scotia residents in the 8 provinces and 3 territories under the Reciprocal Billing agreement.



Physicians' Services: Average Number of Insured Services per Nova Scotia Resident

Definition

The annual number of insured services per insured Nova Scotia resident.

Significance – Rationale and Notes for Interpretation

Insured physician services per Nova Scotia resident are representative of the average utilization of physician services per person. Some services may not be included as they are not available for some Alternate Funded arrangements.

Technical Specifications

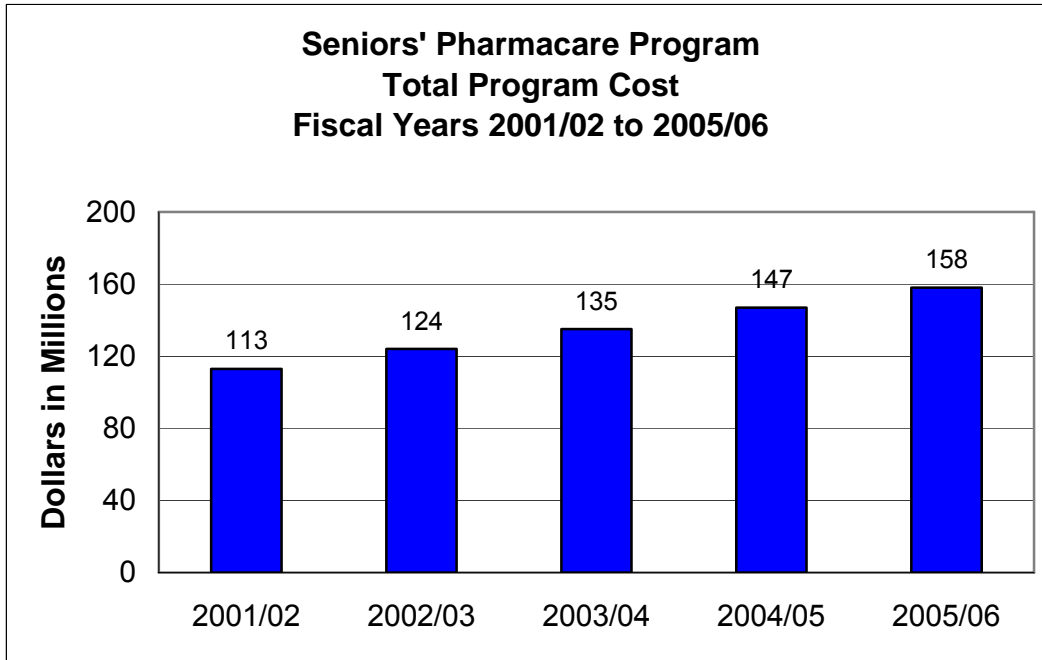
Calculation: Total number of services divided by the insured population.

Source: Medavie Blue Cross, Department of Health Annual Statistical Tables.

Disclosures

Inclusions: Services from physician payments for Fee-for-Service, Alternate Funded physician groups, NonPatient Specific in-patient and out-patient services, and physician services where the resident was refunded the cost of a service provided in the Province of Quebec or out-of-country.

Exclusions: Physician services where the payment is not the responsibility of the Department of Health. These exclusions include services for Workers Compensation Board, Community Services, RCMP and Canadian Armed Forces personnel as their services are federally funded, services to residents of other provinces and territories, and to Nova Scotia residents in the 8 provinces and 3 territories under the Reciprocal Billing agreement.



Seniors' Pharmacare Program: Total Program Cost

Definition

The Nova Scotia Seniors' Pharmacare Program is a provincial drug insurance plan that helps seniors with the cost of their prescription drugs. The Program covers drugs listed as benefits in the Nova Scotia Formulary. This measure indicates the total annual expenditure for the Program.

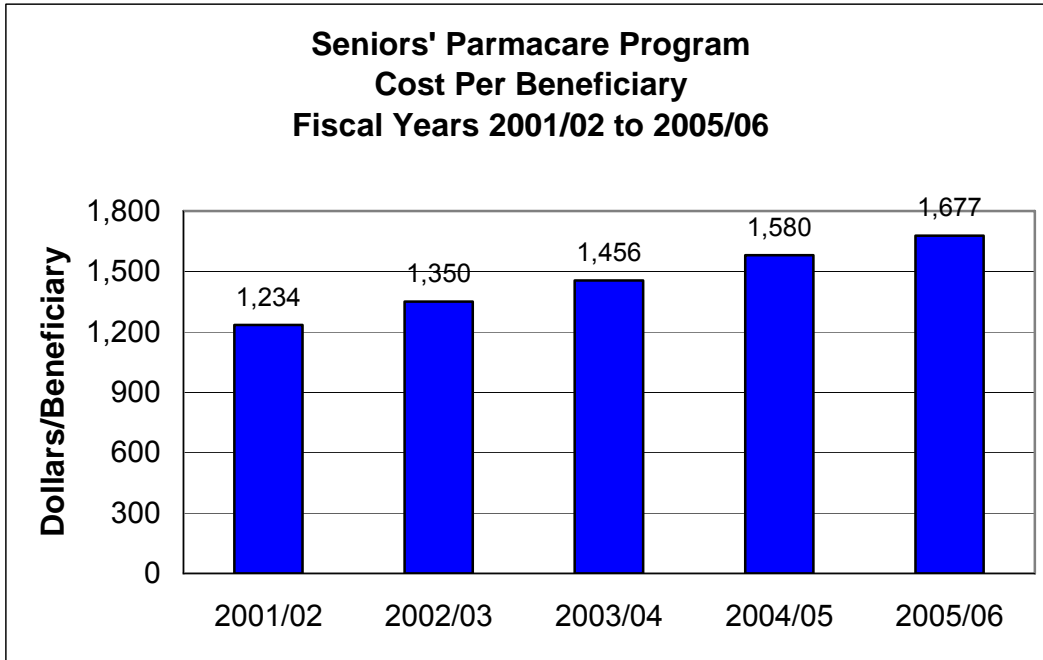
Significance – Rationale and Notes for Interpretation

This data are representative of the total expenditure for the Seniors' Pharmacare Program. As the graph notes, Program cost continues to increase. The statistical data represent the total program cost including amount paid by seniors and the Department of Health's contribution. Financial adjustments for the Audited Financial Statements are not reflected in the statistical system.

Technical Specifications

Calculation: Total Program cost per fiscal year as expressed in millions of dollars. Total Program cost is comprised of Drug Cost, Dispensing Fees, mark ups and Compounding Fees as reflected in the Decision Support System.

Source: Medavie Blue Cross, Department of Health Annual Statistical Tables, Statistics Canada Census population.



Seniors' Pharmacare Program: Program Cost per Beneficiary

Definition

The Nova Scotia Seniors' Pharmacare Program is a provincial drug insurance plan that helps seniors with the cost of their prescription drugs. The Program covers drugs listed as benefits in the Nova Scotia Formulary. This measure indicates the annual average cost per beneficiary for participants in the Program.

Significance – Rationale and Notes for Interpretation

This data are representative of the annual average cost per beneficiary for the Seniors' Pharmacare Program. As the graph notes, Average Cost per Beneficiary continues to increase. The statistical data represent the total cost per beneficiary for the Program revenues paid by seniors plus the Department of Health's contribution. Financial adjustments for the Audited Financial Statements are not reflected in the statistical system.

Technical Specifications

Calculation: Total Program cost divided by the number of unique beneficiaries expressed in dollars.

Source: Medavie Blue Cross, Department of Health Annual Statistical Tables

Section 7 Management Information Systems Indicators

The MIS Standards are national standards that provide an integrated approach to managing financial and statistical data related to the operations of Canadian health service organizations. They were developed in recognition of the need to improve the effectiveness and efficiency of health service organizations in Canada through better information and measures of productivity.

These guidelines address information at the functional centre and service recipient-specific level, but do not encompass information related to the care, treatment or clinical status of the service recipient, or attempt to quantify or assess the quality of such services.

The indicators found in this section detail how financial and statistical data may be integrated to yield information that is useful for planning, control and evaluation. All functional centre statistics and indicators are designed to provide managers with useful information that can assist them with planning, staffing, budgeting and efficiency management. Indicators link two data elements together to measure performance and to provide information that can be used to facilitate decisions or compare performance.

Here are some definitions that may help your understanding of the information presented in this section:

Functional Centre: a subdivision of an organization used in a functional accounting system to record the budget and actual direct expenses; statistics; and/or revenues, if any, which pertain to the function or activity being carried out.

Inpatient Days: the days during which services are provided to an inpatient between the census-taking hours on successive days. The day of admission is counted as an inpatient day but the day of separation is not an inpatient day. When the service recipient is admitted and separated (discharged or died) on the same day, one inpatient day is counted. Inpatient days apply to nursing inpatient functional centres (primary accounts 712*).

Compensation Expense: is the sum of gross salaries expense, benefit contribution expense, purchased compensation expense, and fees for service expense arising from the remuneration of management and operational support personnel, unit-producing personnel, and medical personnel employed by, or under contract to the health service organization.

Compensation - Medical Personnel (Medical Fees): this account is used to record the compensation expense for medical practitioners who provide medical services and who are remunerated by the health service organization on a salary or contractual basis. Excludes medical personnel who fulfill a management role.

Direct Costs: include all the expenditures for salaries, supplies, equipment, amortization, and other outlays seen in the accounts of the functional centre, including direct expense transfers. Direct costs exclude costs of absorbing cost centres that initially resided in the accounts of transient cost centres but have subsequently been allocated as indirect expense.

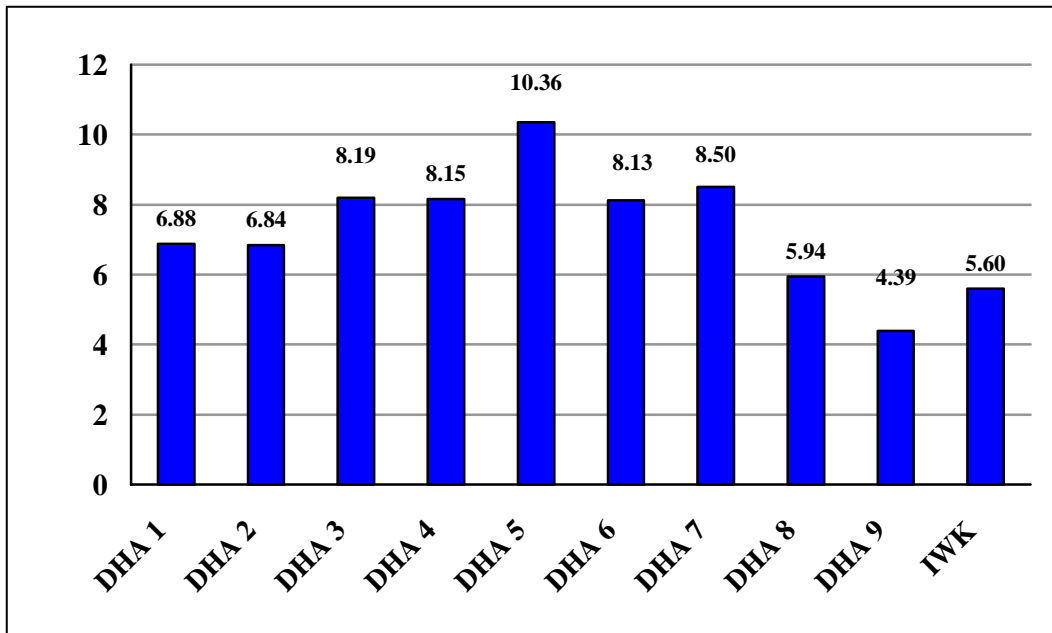
Full-Time Equivalent (FTE): the total earned hours charged to a functional centre, expressed in terms of equivalent full-time positions, according to the health service organization's normal earned hours per full-time position.

The above definition can be expressed by the following formula:

$$FTE = \frac{\textit{Total Earned Hours in Period}}{\textit{Normal Earned Hours for Period}}$$

Workload Unit: one minute of unit-producing personnel time spent performing service recipient and non-service recipient activities of the functional centre.

Administrative Services Expense as a % of Total Expense 2005 – 2006 Fiscal Year



Note: After receipt of their final submission, an error was noticed in a transaction that has over stated the result for Cumberland Health Authority. We have read only rights to data after final submission and consequently cannot change this information. The result for Cumberland Regional should be 10.11%.

Definition: The proportion of total expenses attributable to administration.

Significance – Rationale and Notes for Interpretation

An indicator of a hospital's efficiency.

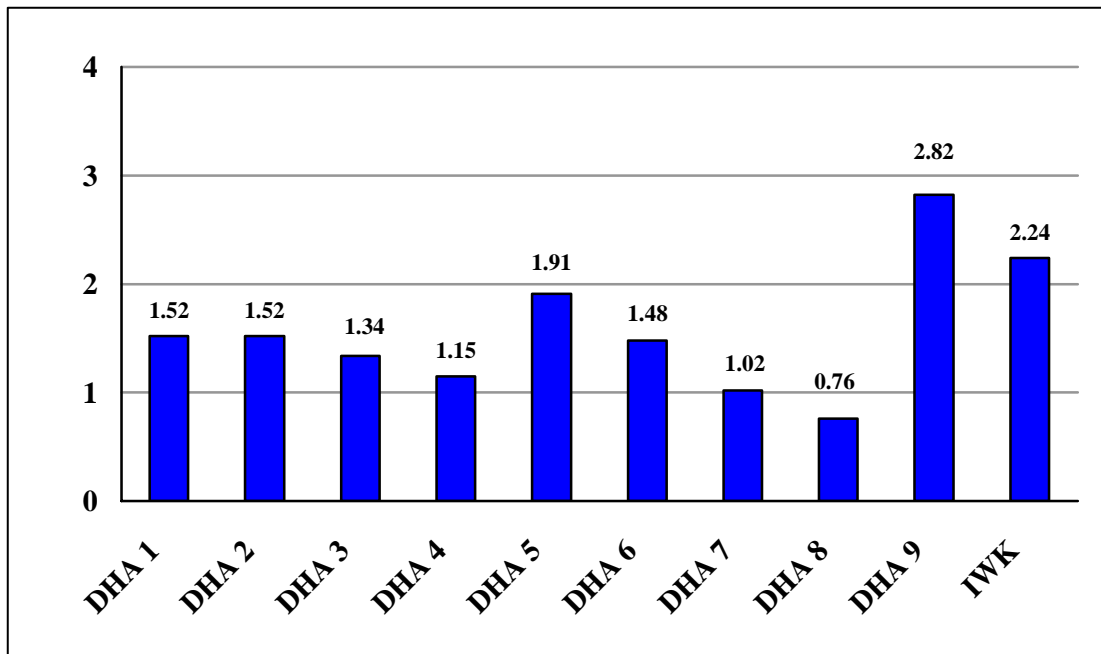
Technical Specifications

Calculation: Total expenditures, net of recoveries, (secondary financial accounts 3* - 9* and 12*) assigned to administrative cost centers (primary accounts 7*110*, 7*115*, 7*120*, 7*130*), divided by total gross expenditures, net of recoveries, for the District (secondary financial accounts 3* - 9*, and 12*) assigned to all cost centers.

$$\frac{\text{Administrative Expenses}}{\text{Total Expenses}}$$

Source: NS DoH, MIS Database

Information Services Expense as a % of Total Expense 2005 – 2006 Fiscal Year



Note: After receipt of their final submission, an error was noticed in a transaction that has over stated the result for Cumberland Health Authority. We have only read rights to data after final submission and consequently cannot change this information. The result for Cumberland Regional should be 1.8%.

Definition: The proportion of total expenses attributable to information systems.

Significance – Rationale and Notes for Interpretation

Administrative Expense as a proportion of total expense is a measure of efficiency. This is an indicator that examines the expenditures on information services.

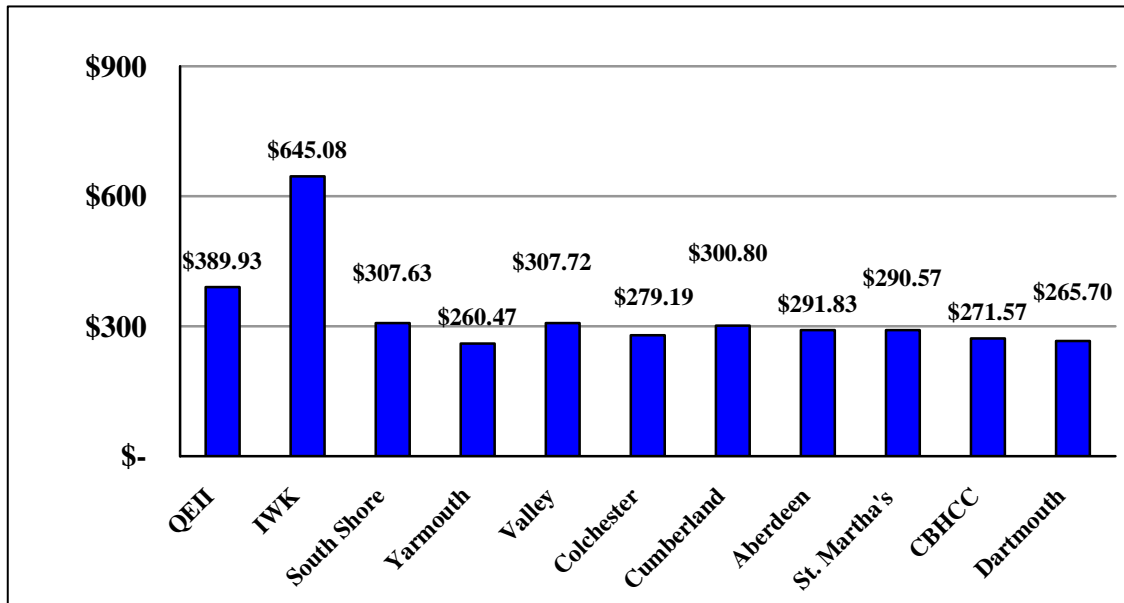
Technical Specifications

Calculation: Gross expenditures, net of recoveries, for System Support divided by total gross expenditures, net of recoveries, for the District. MIS account codes used in the numerator include primary accounts 7* 1 25* and secondary financial accounts 3* - 9* and 12*. The denominator includes secondary financial accounts 3* - 9* and 12*.

$$\frac{\text{Systems Support, gross expenditures, net of recoveries}}{\text{Total expenditures, net of recoveries}}$$

Source: NS DoH, MIS Database

Direct Cost (Exc. Med Fees) per Patient Day Medical / Surgical Nursing Inpatient Units 2005 – 2006 Fiscal Year



Definition: The average direct cost of providing services to one inpatient/resident during one inpatient/resident day. It is calculated by dividing the functional centre's direct operating expenses by the number of inpatient/resident days in a given period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

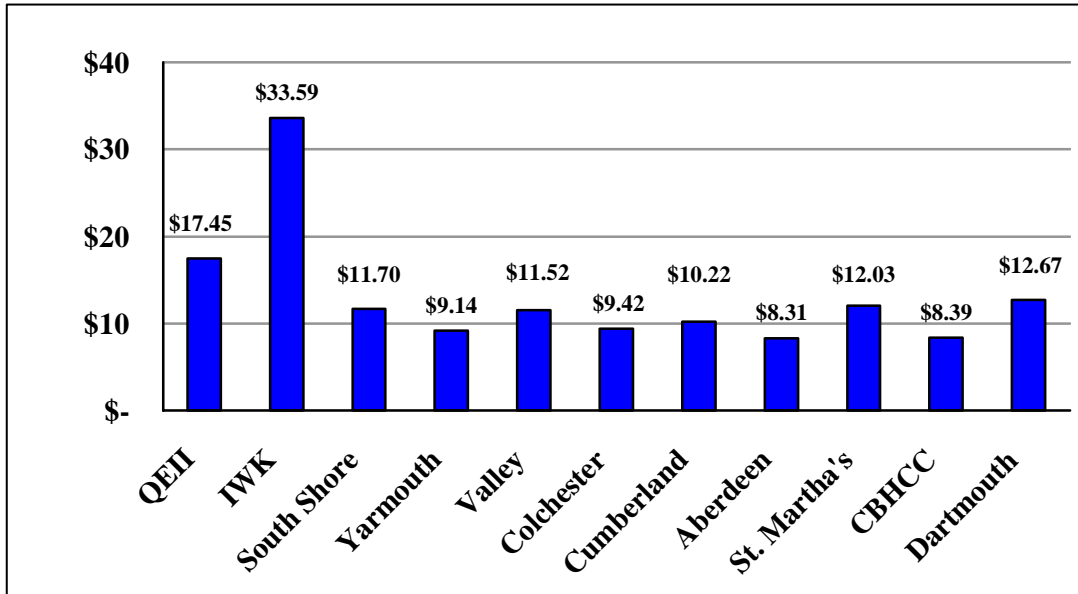
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, excluding medical fees (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 39*) attributable to either Medical, Surgical, Combined Med/Surg, Pediatric and Palliative Care Inpatient Nursing Units (primary accounts 7*210*, 7*220*, 7*230*, 7*270, or 7*290*) divided by the number of inpatient days (secondary statistical account 403*).

$$\frac{\text{Gross expenditures, net of recoveries (excluding medical fees)}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Med/Surg Expense per Patient Day Medical / Surgical Nursing Inpatient Units 2005- 2006 Fiscal Year



Definition: The average med/surg expense for an inpatient day is calculated by dividing the med/surg expense consumed by an inpatient functional centre for a given period by the number of inpatient days of that consuming functional centre for the same period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

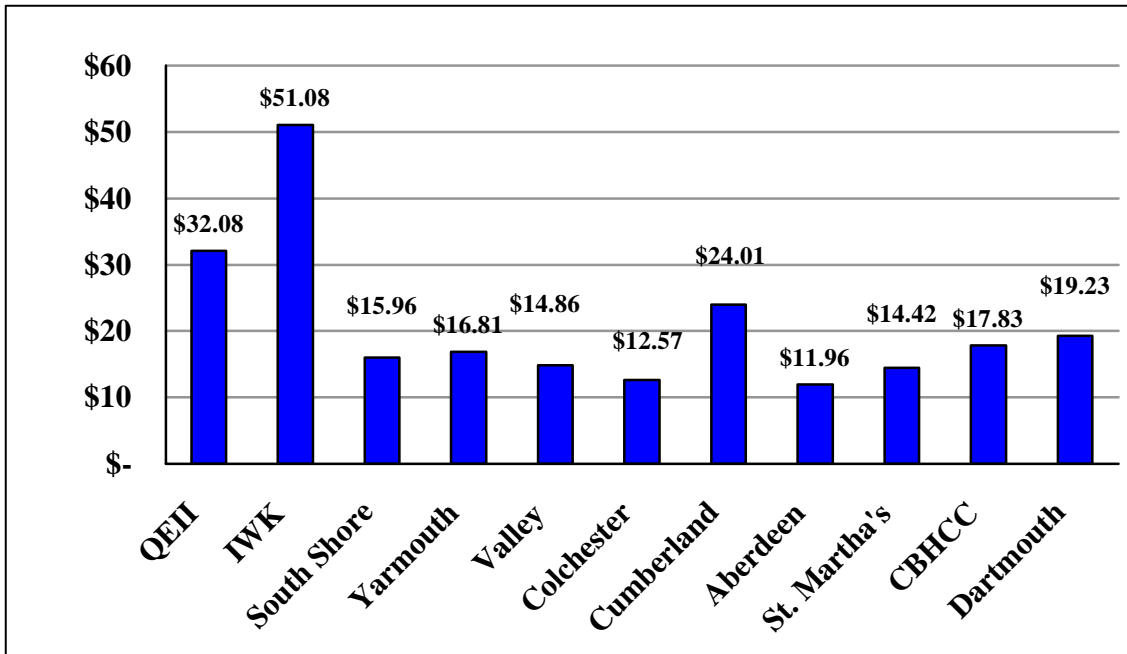
Technical Specifications

Calculation: Total medical and surgical supply expense (secondary financial accounts 460*) attributable to any Medical, Surgical, Combined Med/Surg, Pediatric or Palliative Care Nursing Inpatient Units (primary accounts 7*210*, 7*220*, 7*230*, 7*270, or 7*290*) divided by the number of inpatient days consumed by those functional centres (secondary statistical account 403*).

$$\frac{\text{Medical / Surgical Expenses}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Drug Expense per Patient Day Medical / Surgical Inpatient Units 2005 – 2006 Fiscal Year



Definition: The average drug cost for an inpatient day is calculated by dividing the drug costs consumed by an inpatient functional centre for a given period by the number of inpatient days of that consuming functional centre for the same period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

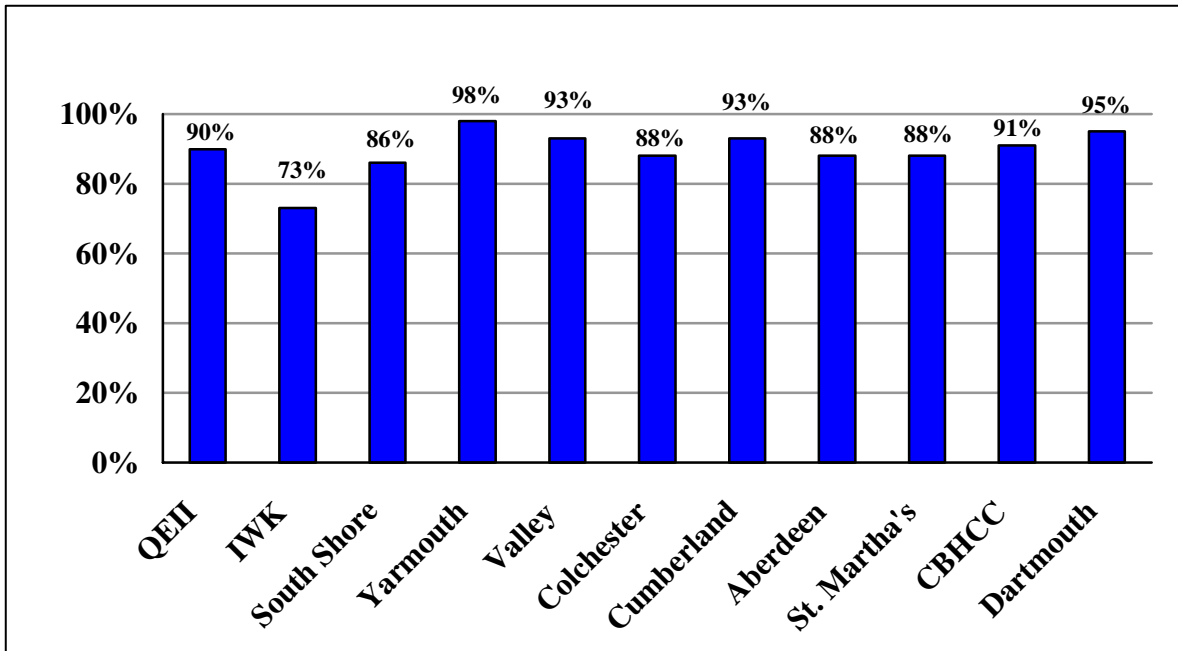
Technical Specifications

Calculation: Total Drug expense (secondary financial accounts 465*), attributable to any Medical, Surgical, Combined Med/Surg, or Pediatric Inpatient Nursing Units (primary accounts 7*210*, 7*220*, 7*230*, 7*270 or 7*290*) divided by the number of inpatient days consumed by those functional centres (secondary statistical account 403*).

$$\frac{\text{Drug Costs}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Percentage Occupancy Medical / Surgical Nursing Inpatient Units 2005 – 2006 Fiscal Year



Definition: The percentage of beds which are available and staffed for inpatient accommodation and which are occupied by a service recipient.

Significance – Rationale and Notes for Interpretation

An indicator of resource use, used for budgeting, planning, and evaluation.

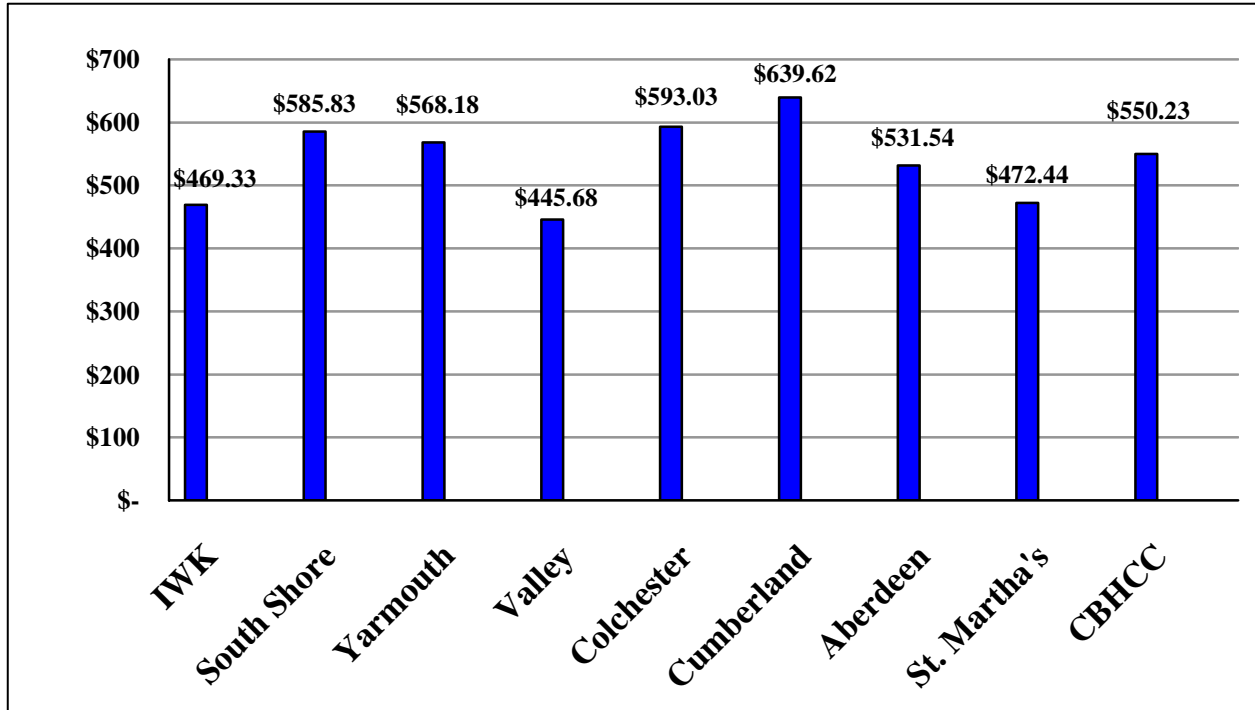
Technical Specifications

Calculation: The total number of inpatient days (secondary statistical account 403*), divided by the total number of bed days, staffed and in operation, (secondary statistical account 827*) attributable to Medical, Surgical, Combined Med/Surg, Pediatric and Palliative Care Inpatient Nursing Units (primary accounts 7*210*, 7*220*, 7*230*, 7* 270, or 7*290*) multiplied by 100 to yield a percentage.

$$\frac{\text{Inpatient Days}}{\text{Bed Days Staffed and in Operation}} \times 100$$

Source: NS DoH, MIS Database

Direct Cost (Exc. Med Fees) Per Patient Day Obstetrical Nursing Inpatient Units 2005 – 2006 Fiscal Year



Definition: The average direct cost of providing services to one inpatient/resident during one inpatient/resident day. It is calculated by dividing the functional centre's direct operating expenses by the number of inpatient/resident days in a given period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

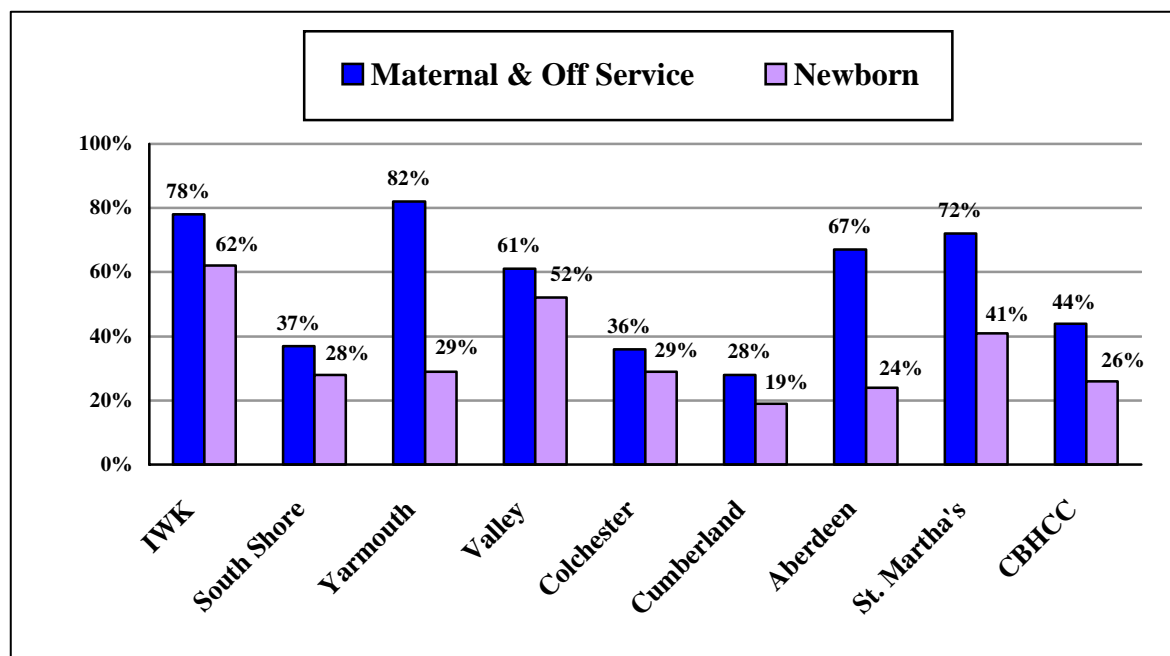
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, excluding medical fees (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 39*) attributable to Obstetrical inpatient nursing units (primary accounts 7*250*) divided by the number of inpatient days (secondary statistical account 403*).

$$\frac{\text{Gross expenditures, net of recoveries, (excluding medical fees)}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Percentage Occupancy Obstetrical Nursing Inpatient Units 2005 – 2006 Fiscal Year



Definition: The percentage of beds which are available and staffed for inpatient accommodation and which are occupied by a service recipient.

Significance – Rationale and Notes for Interpretation

An indicator of resource use, used for budgeting, planning, and evaluation.

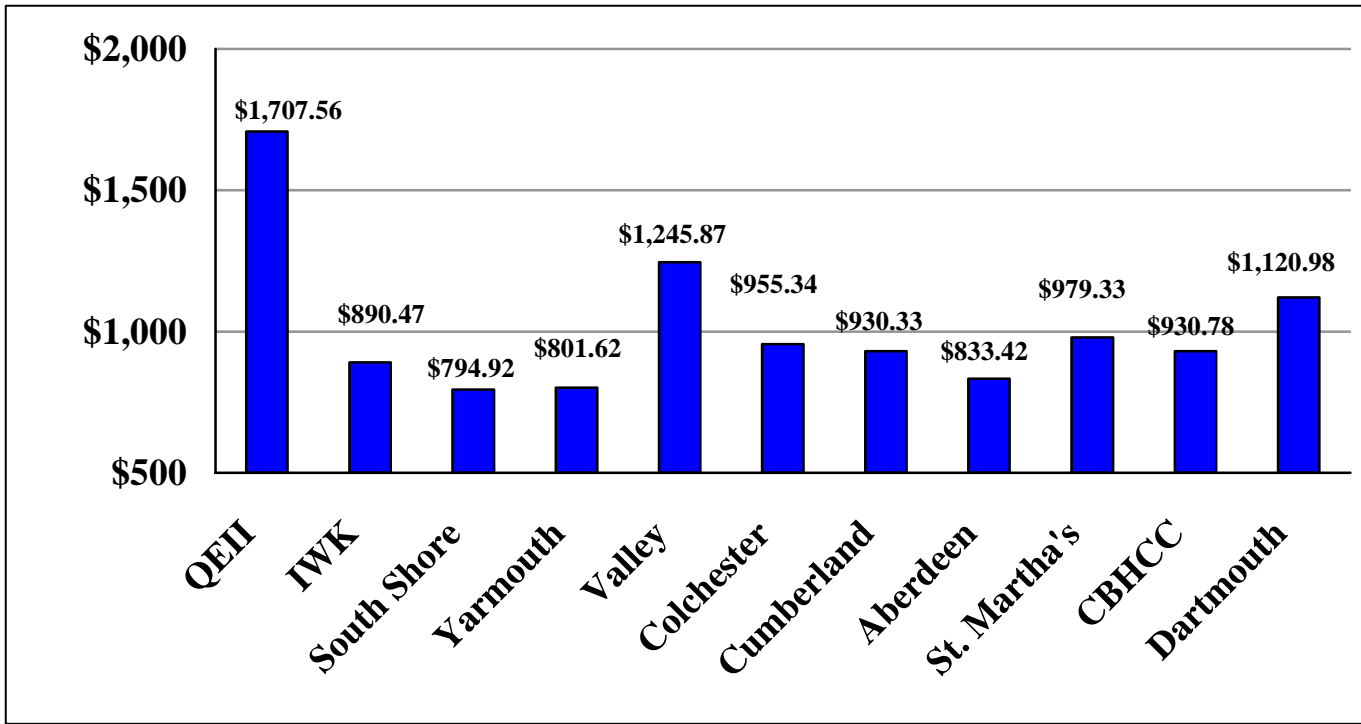
Technical Specifications

Calculation: The total number of inpatient days in the maternal / newborn functional centre (secondary statistical account 40310* and 40340* respectively) divided by the total number of bed days, staffed and in operation, (secondary statistical account 827* and 828* respectively) attributable to the Obstetrical Inpatient Nursing Unit (primary accounts 7*250*), multiplied by 100 to yield a percentage.

$$\frac{\text{Inpatient Days, either Maternal \& Off Service or Newborn}}{\text{Bed Days Staffed and in Operation, either Maternal \& Off Service or Newborn}} \times 100$$

Source: NS DoH, MIS Database

Direct Cost per Patient Day Intensive Care Units 2005 – 2006 Fiscal Year



Definition: The average direct cost of providing services to one ICU patient during one inpatient day. It is calculated by dividing the functional centre's direct operating expenses by the number of inpatient days in a given period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

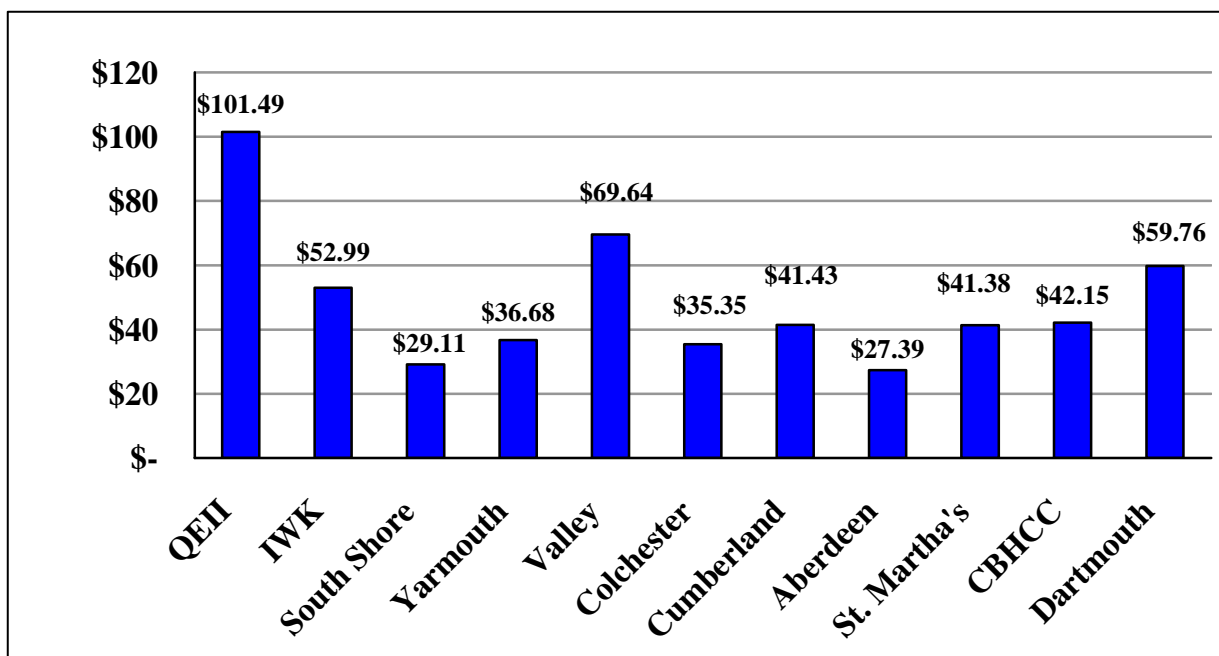
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, excluding medical fees (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 39*) attributable to Intensive Care Inpatient Nursing Units (primary accounts 7*240*) divided by the number of inpatient days (secondary statistical account 403*).

$$\frac{\text{Direct Costs, Net Recoveries (excluding medical fees)}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Med/Surg Expense per Patient Day Intensive Care Units 2005 – 2006 Fiscal Year



Definition: The average med/surg expense for an inpatient day. It is calculated by dividing the med/surg expense consumed by an inpatient functional centre for a given period by the number of inpatient days of that consuming functional centre for the same period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

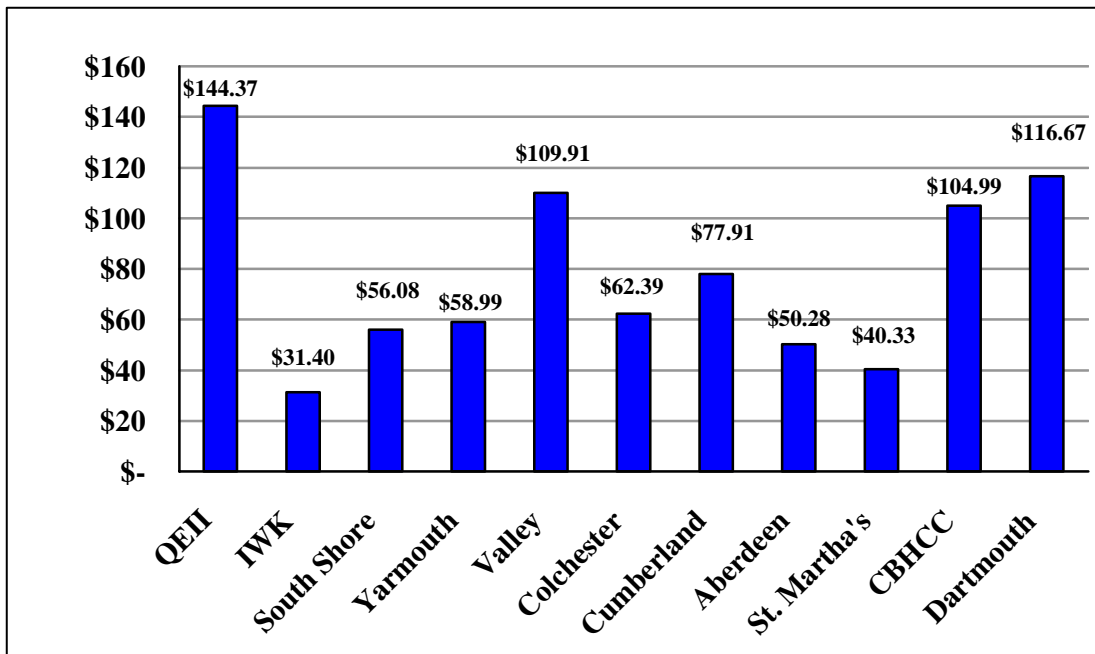
Technical Specifications

Calculation: Total Medical and Surgical supply expenses (secondary financial accounts 460*) attributable to Intensive Care Nursing Inpatient Units (primary accounts 7*240*) divided by the number of inpatient days (secondary statistical account 403*).

$$\frac{\text{Medical / Surgical Expenses}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Drug Expense per Patient Day Intensive Care Units 2005 – 2006 Fiscal Year



Definition: The average drug cost for an inpatient day. It is calculated by dividing the drug costs consumed by an inpatient functional centre for a given period by the number of inpatient days of that consuming functional centre for the same period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

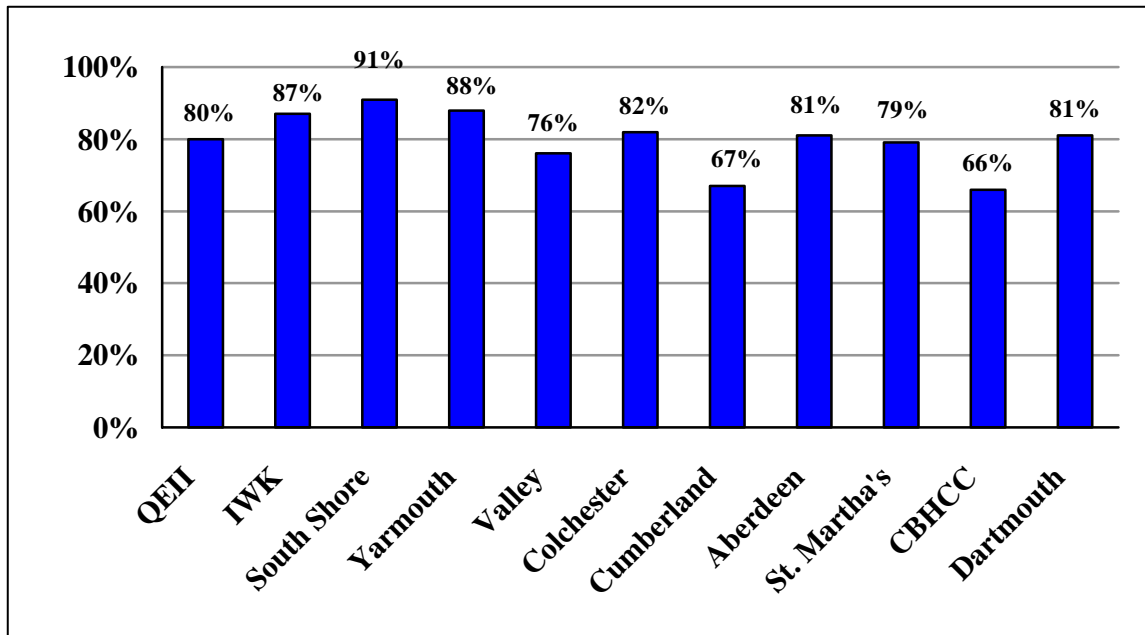
Technical Specifications

Calculation: Total drug expenses (secondary financial accounts 465*), attributable to Intensive Care Inpatient Nursing Units (primary accounts 7*240*) divided by the number of inpatient days (secondary statistical account 403*).

$$\frac{\text{Drug Costs}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Percentage Occupancy Intensive Care Units 2005 – 2006 Fiscal Year



Definition: The percentage of beds which are available and staffed for inpatient accommodation and which are occupied by a service recipient.

Significance – Rationale and Notes for Interpretation

An indicator of resource use, used for budgeting, planning, and evaluation.

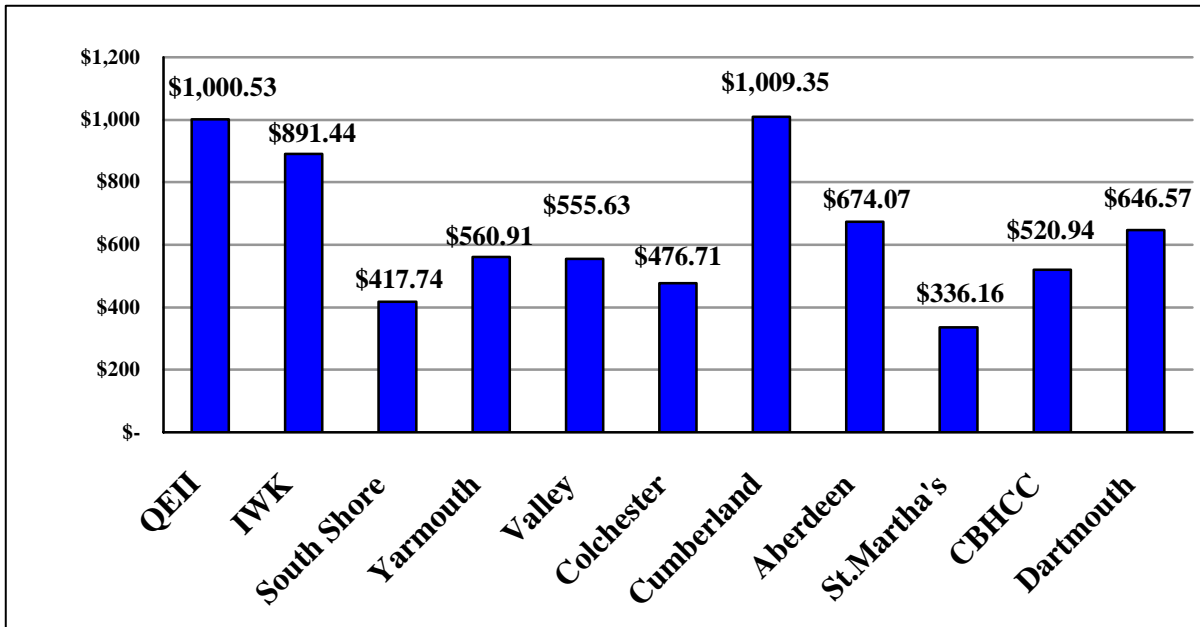
Technical Specifications

Calculation: The total number of inpatient days (secondary statistical account 403*), divided by the total number of bed days, staffed and in operation (secondary statistical account 827*) attributable to the Intensive Care Inpatient Nursing Units (primary accounts 7*240*), multiplied by 100 to yield a percentage.

$$\frac{\text{Inpatient Days}}{\text{Bed Days Staffed and in Operation}} \times 100$$

Source: NS DoH, MIS Database

Direct Cost (Exc. Med Fees) per OR Case (Excludes Prosthesis Expense) 2005 – 2006 Fiscal Year



Definition: The average direct cost for a surgical visit. It is calculated by dividing their functional centre's direct operating expense by the total number of surgical visits to the Operating Room in a given period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

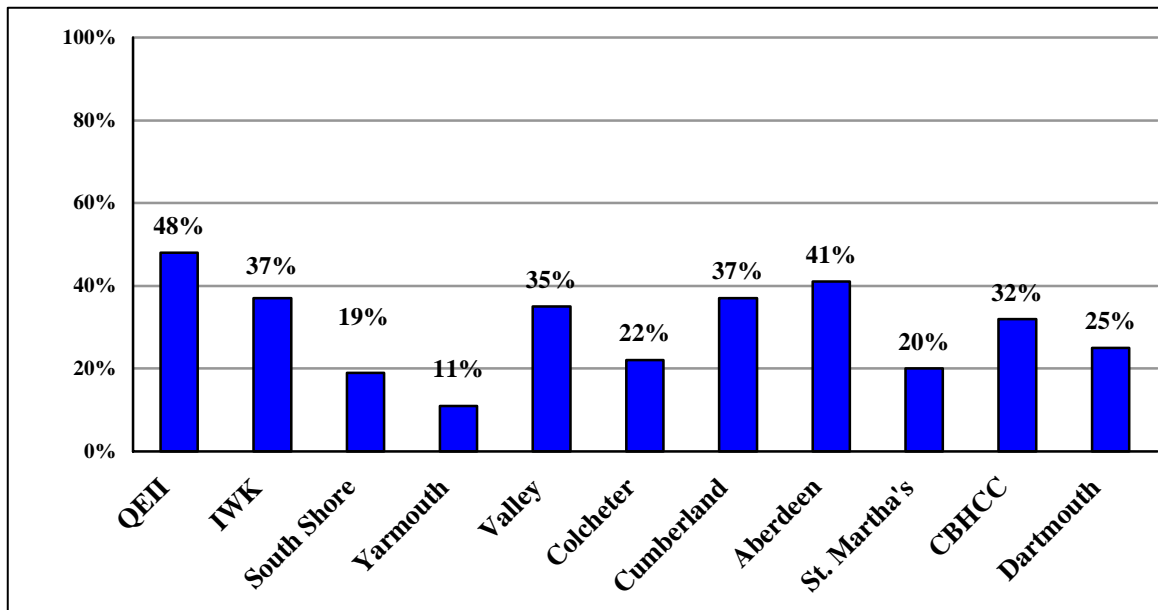
Technical Specifications

Calculation: Total direct costs, net of recoveries, excluding medical fees (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390) attributable to the Operating Room (primary accounts 7*260*) divided by the number of surgical visits (secondary statistical account 437*).

$$\frac{\text{Direct Costs, net of recoveries (excluding medical fees)}}{\text{Surgical Visits}}$$

Source: NS DoH, MIS Database

Percentage of Inpatient OR Cases to Total OR Cases 2005 – 2006 Fiscal Year



Definition: The percentage of inpatient Operating Room surgical cases to total Operating Room surgical cases.

Significance – Rationale and Notes for Interpretation

An indicator of resource and utilization use, used for budgeting, planning, and evaluation.

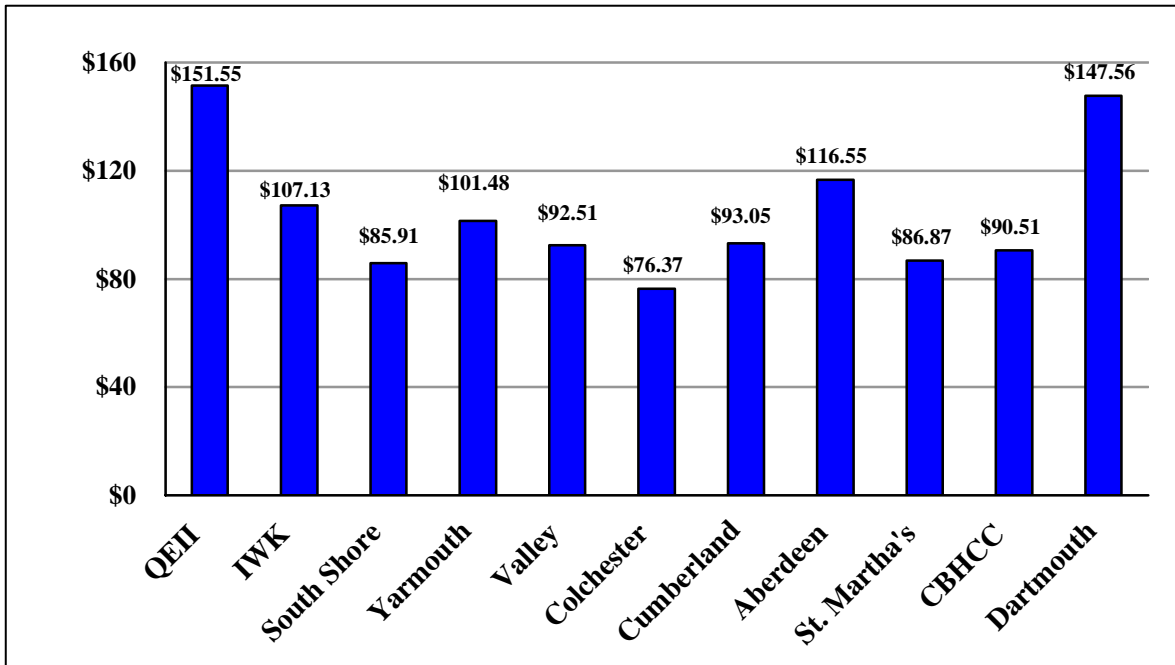
Technical Specifications

Calculation: The total number of inpatient surgical visits (secondary statistical account 437 1*), divided by the total number of operating room surgical visits (secondary statistical account 437*) attributable to the Operating Rooms (primary accounts 7*260*), multiplied by 100 to yield a percentage.

$$\frac{\text{Inpatient Surgical Visits}}{\text{Total Surgical Visits}} \times 100$$

Source: NS DoH, MIS Database

Average Direct Cost (Exc. Med Fees) per ER Visit 2005 – 2006 Fiscal Year



Definition: The average direct cost for a visit to the Emergency Department. It is calculated by dividing their functional centre's direct operating expense by the total number of ER visits to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

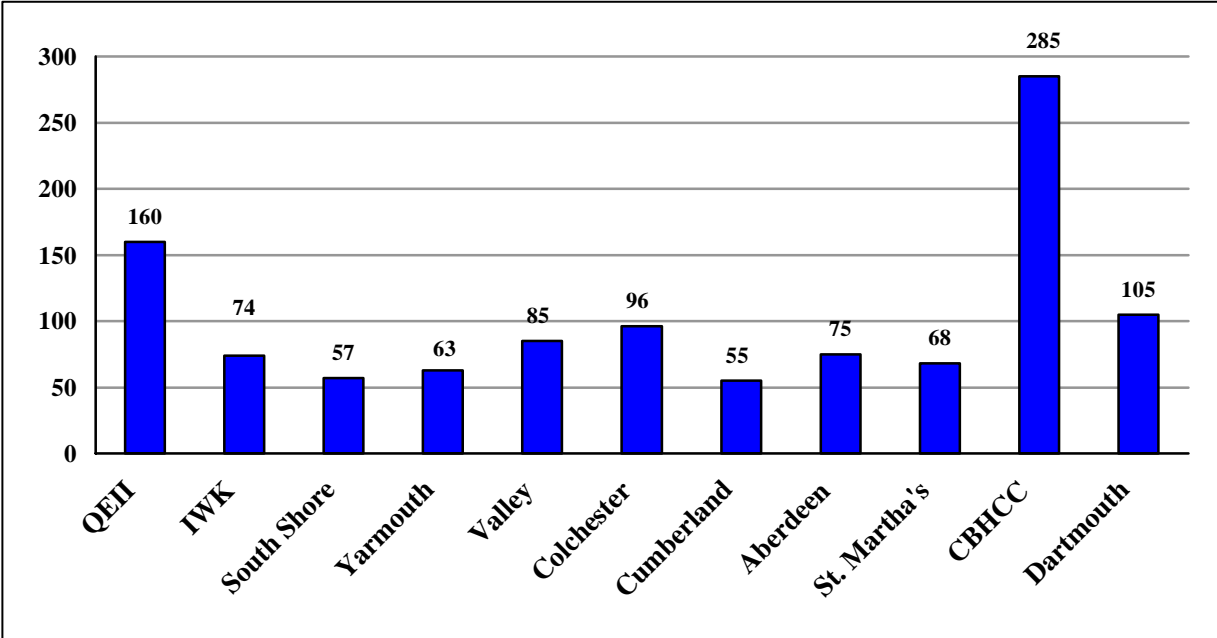
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to Emergency Services (primary accounts 71310*), divided by the total number of emergency visits (secondary statistical accounts 450*).

$$\frac{\text{Gross expenditures, net of recoveries, (excluding Medical Fees)}}{\text{Total Emergency Visits}}$$

Source: NS DoH, MIS Database

Average ER Visits per Calendar Day 2005 – 2006 Fiscal Year



Definition: The average number of visits per day to the Emergency Department. It is calculated by dividing the total number of visits by the number of calendar days in a given period.

Significance – Rationale and Notes for Interpretation

An indicator of resource uses; used in budgeting, planning, and evaluation.

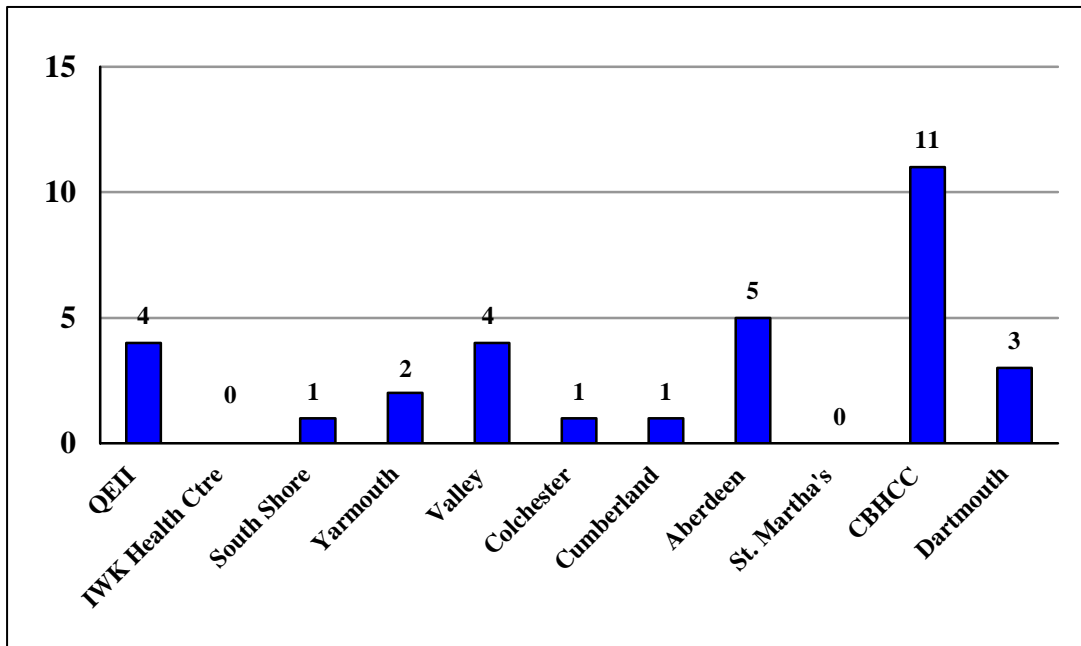
Technical Specifications

Calculation: The total number of emergency room visits (secondary statistical accounts 450* attributable to primary accounts 71310*) divided by the number of days in a year (365).

$$\frac{\text{Total Emergency Visits}}{\text{Calendar Days}}$$

Source: NS DoH, MIS Database

Average Daily Census – In patients in ER Hold Beds 2005 – 2006 Fiscal Year



Definition: The average number of patients, per calendar day, who are admitted to the health care organization but because there is no inpatient bed available must stay in an inpatient bed in the facility's Emergency Department.

Significance – Rationale and Notes for Interpretation

An indicator of resource uses; used in budgeting, planning, and evaluation.

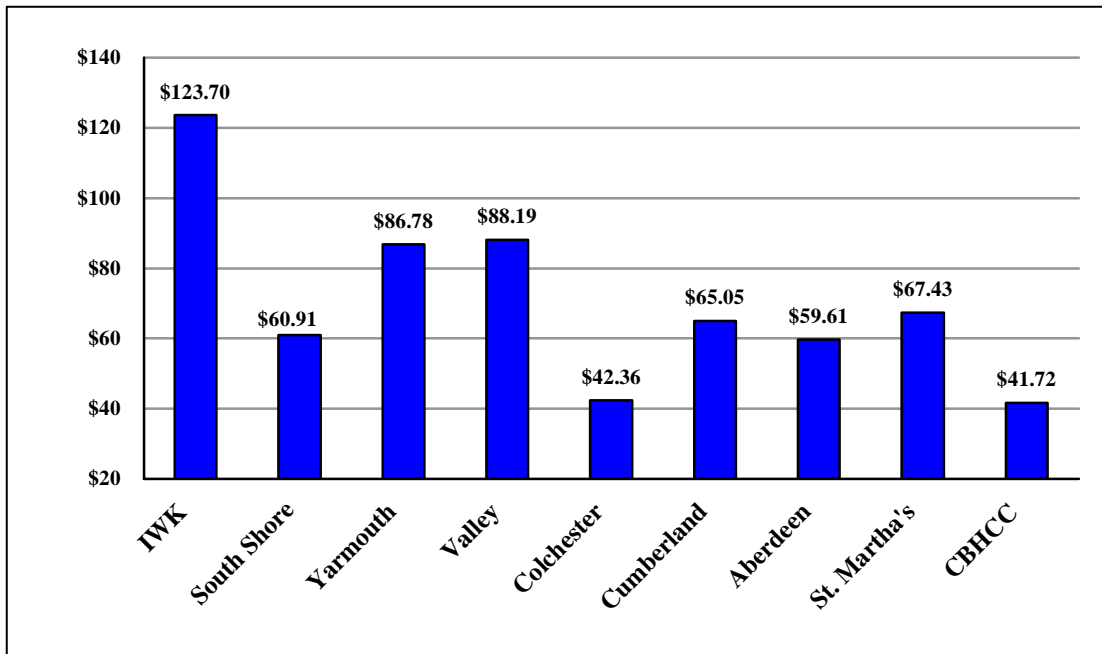
Technical Specifications

Calculation: The total number of inpatient days in the Emergency Room (secondary statistical accounts 403* attributable to primary accounts 71310*) divided by the number of days in a year (365).

$$\frac{\text{Total inpatient days in the Emergency Department}}{\text{Calendar Days}}$$

Source: NS DoH, MIS Database

Direct Cost per Pre & Post Operative Services 2005 – 2006 Fiscal Year



Definition: The average direct cost for a visit to Pre & Post Operative Services. It is calculated by dividing their functional centre's direct operating expense by the total number of visits to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

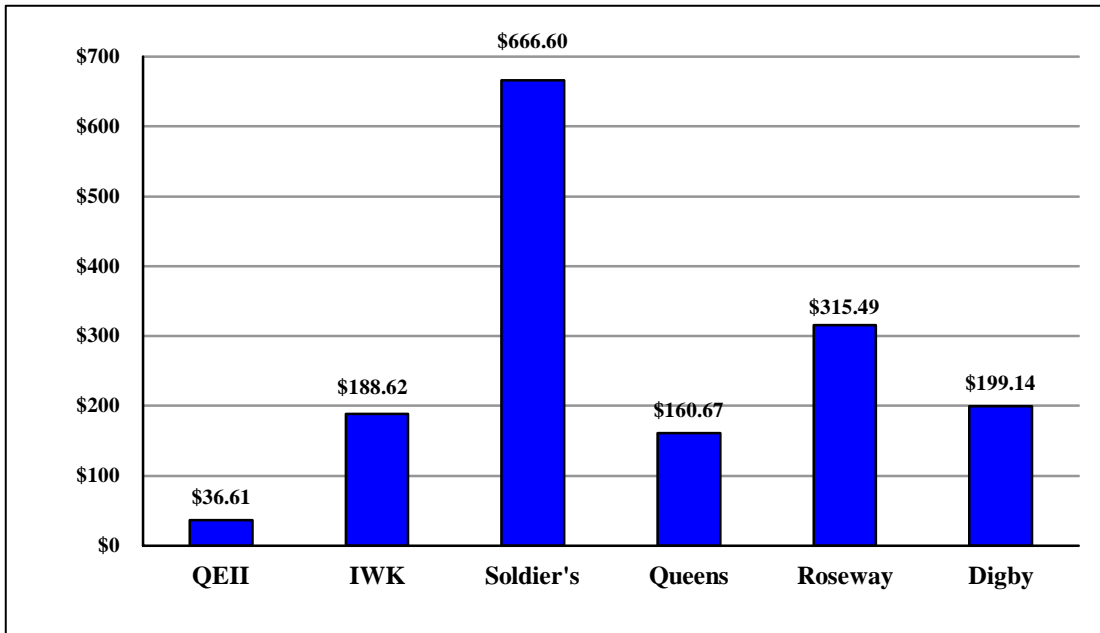
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to Day Surgery (primary account 7*34020), divided by the total number of Day Surgery visits (secondary statistical accounts 450*).

$$\frac{\text{Gross expenditures, net of recoveries, (Exc. Medical Fees)}}{\text{Total Day Surgery Visits}}$$

Source: NS DoH, MIS Database

Direct Cost per Day Surgery Services Minor Procedure Room 2005 – 2006 Fiscal Year



Definition: The average direct cost for a visit to Day Surgery Services (Procedure Room including OR & PR). It is calculated by dividing their functional centre's direct operating expense by the total number of visits to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

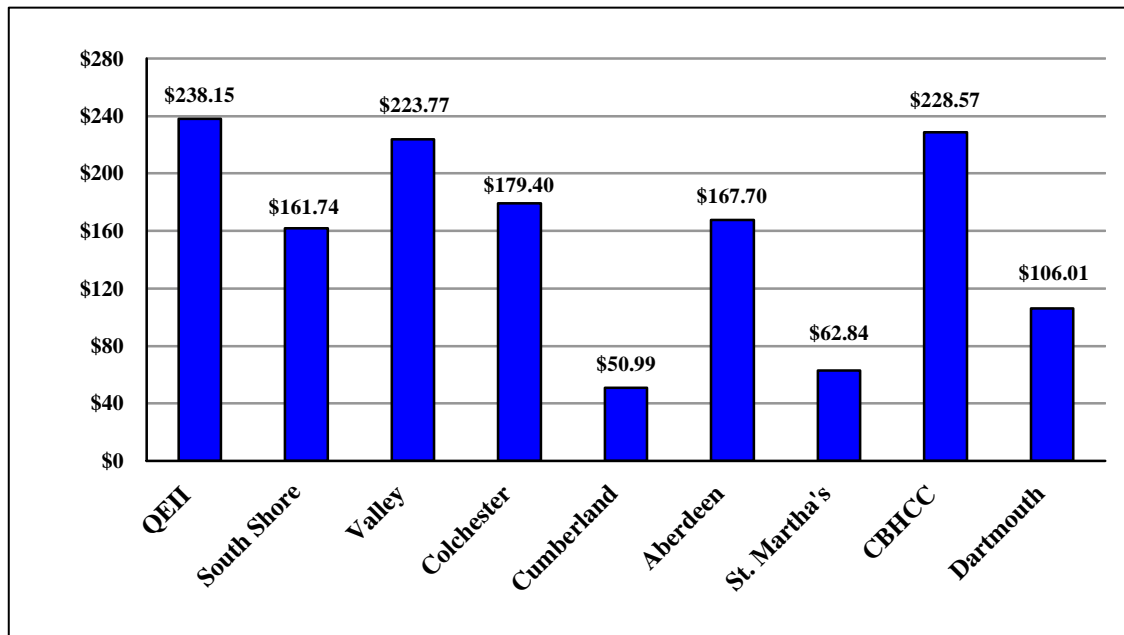
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to Day Surgery Services (primary account 7*34025), divided by the total number of Day Surgery visits (secondary statistical accounts 450*).

$$\frac{\text{Gross expenditures, net of recoveries, (Exc. Medical Fees)}}{\text{Total Day Surgery Visits}}$$

Source: NS DoH, MIS Database

Direct Cost per Endoscopy Visit 2005 – 2006 Fiscal Year



Definition: The average direct cost for a visit to an Endoscopy Unit. It is calculated by dividing their functional centre's direct operating expense by the total number of visits to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

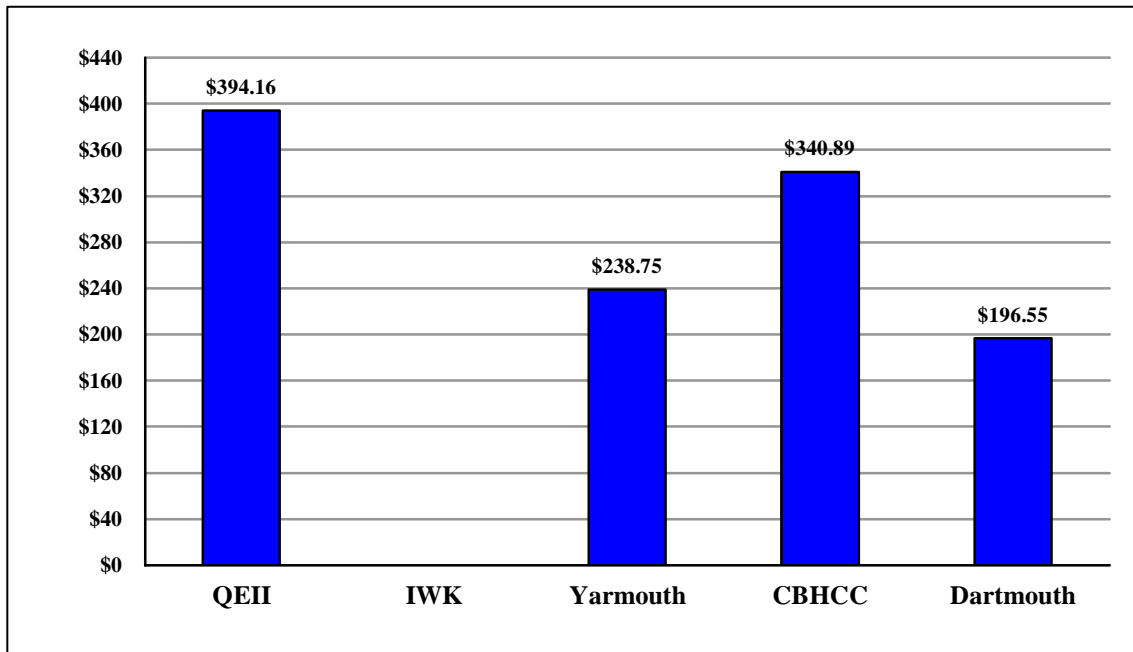
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to Endoscopy (primary account 7*34055), divided by the total number of Endoscopy visits (secondary statistical accounts 450*).

$$\frac{\text{Gross expenditures, net of recoveries, (excluding Medical Fees)}}{\text{Total Endoscopy Visits}}$$

Source: NS DoH, MIS Database

Direct Cost per Renal Dialysis Visit 2005 – 2006 Fiscal Year



Note: The IWK has only reported 25 visits for the fiscal year resulting in a Direct Cost per Renal Dialysis Visit of over \$19,000.00.

Definition: The average direct cost for a visit to Renal Dialysis. It is calculated by dividing their functional centre's direct operating expense by the total number of visits (face-to-face and telephone) to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

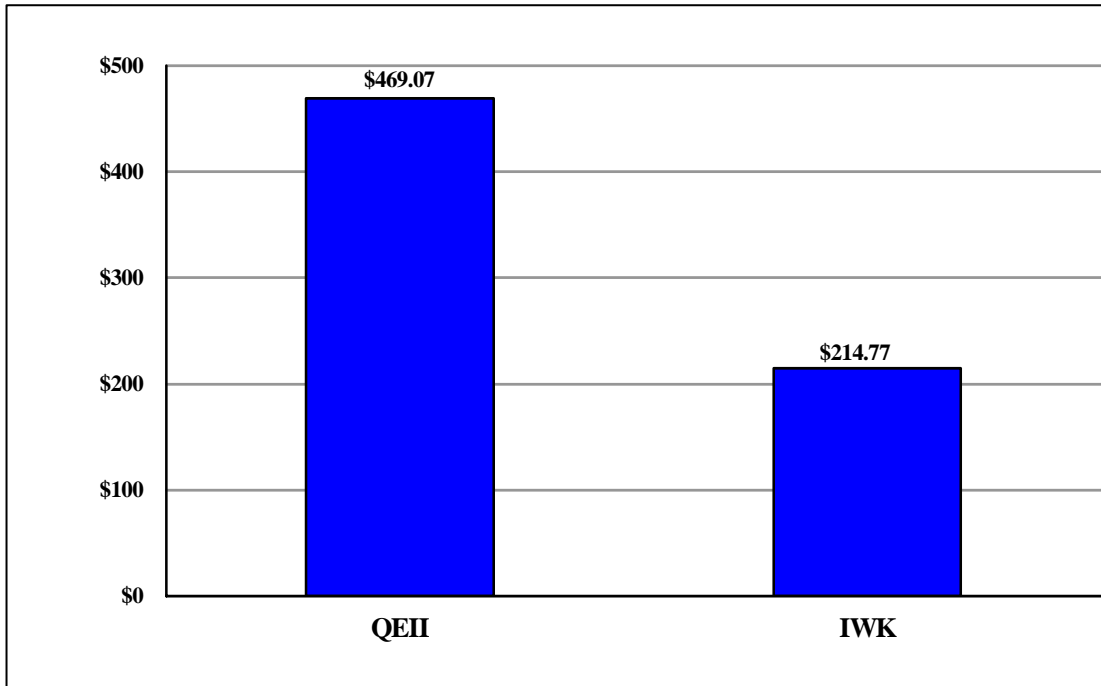
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to Renal Dialysis (primary account 7*34085), divided by the total number of renal dialysis visits (secondary statistical accounts 450* and 451*).

$$\frac{\text{Gross expenditures, net of recoveries, (excluding Medical Fees)}}{\text{Total Renal Dialysis Visits}}$$

Source: NS DoH, MIS Database

Direct Cost per Medical Day Treatment Visit 2005 – 2006 Fiscal Year



Note: This is a medical day treatment service for a variety of clients that stay longer than 3 hours such as cancer and bone marrow clients.

Definition: The average direct cost for a visit to a Medical Day Treatment Service. It is calculated by dividing their functional centre's direct operating expense by the total number of visits (face-to-face and telephone) to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

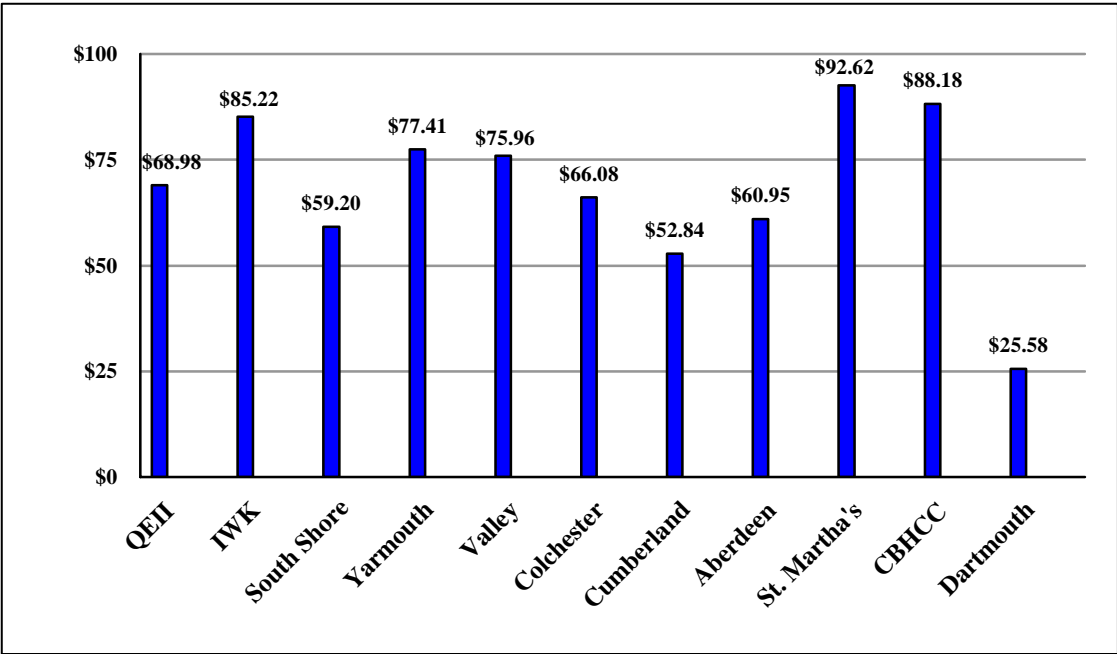
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to Medical Day Services (primary account 7*34010*), divided by the total number of visits (secondary statistical accounts 450* and 451*).

$$\frac{\text{Gross expenditures, net of recoveries, (exc. Medical Fees)}}{\text{Total Visits}}$$

Source: NS DoH, MIS Database

Direct Cost per Visit Acute Ambulatory Care Specialty Clinics 2005 – 2006 Fiscal Year



Definition: The average direct cost for a visit to an acute care ambulatory care specialty clinic. It is calculated by dividing their functional centre's direct operating expense by the total number of visits (face-to-face and telephone) to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

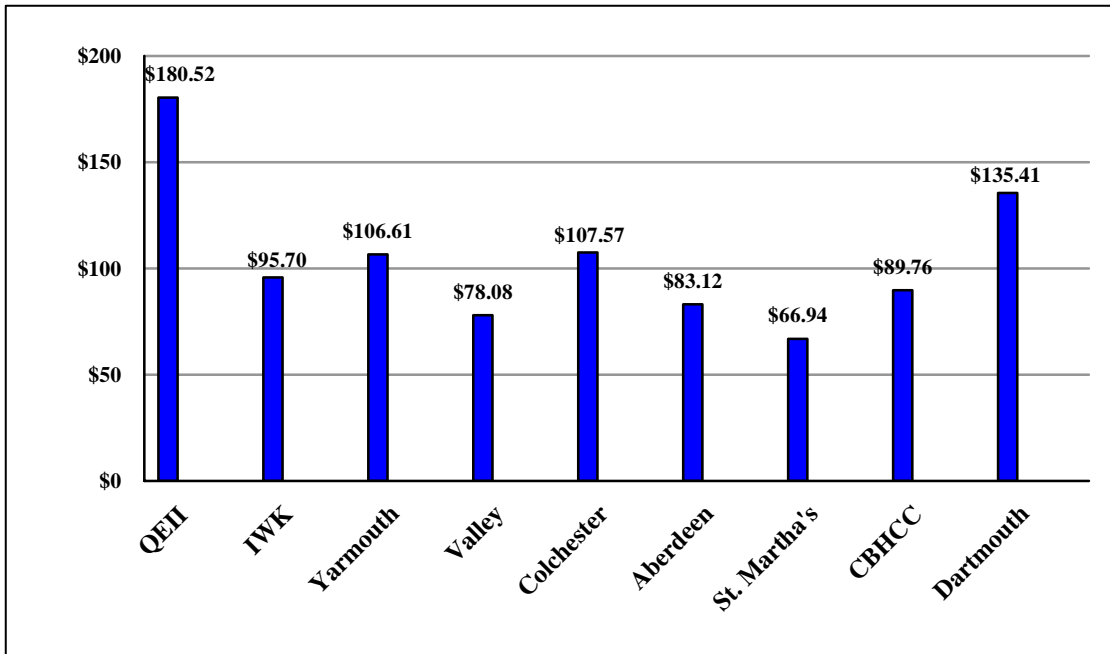
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to ambulatory care specialty clinics (primary accounts 7*350*), divided by the total number of visits (secondary statistical accounts 450* and 451*). Note: Excluded from this indicator is Diabetes Specialty Clinics (7*3 50 40*).

$$\frac{\text{Gross expenditures, net of recoveries (excluding Medical Fees)}}{\text{Total Visits}}$$

Source: NS DoH, MIS Database

Direct Cost per Diabetes Specialty Clinics 2005 – 2006 Fiscal Year



Definition: The average direct cost for a visit to an acute care ambulatory care specialty clinic. It is calculated by dividing their functional centre's direct operating expense by the total number of visits (face-to-face and telephone) to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

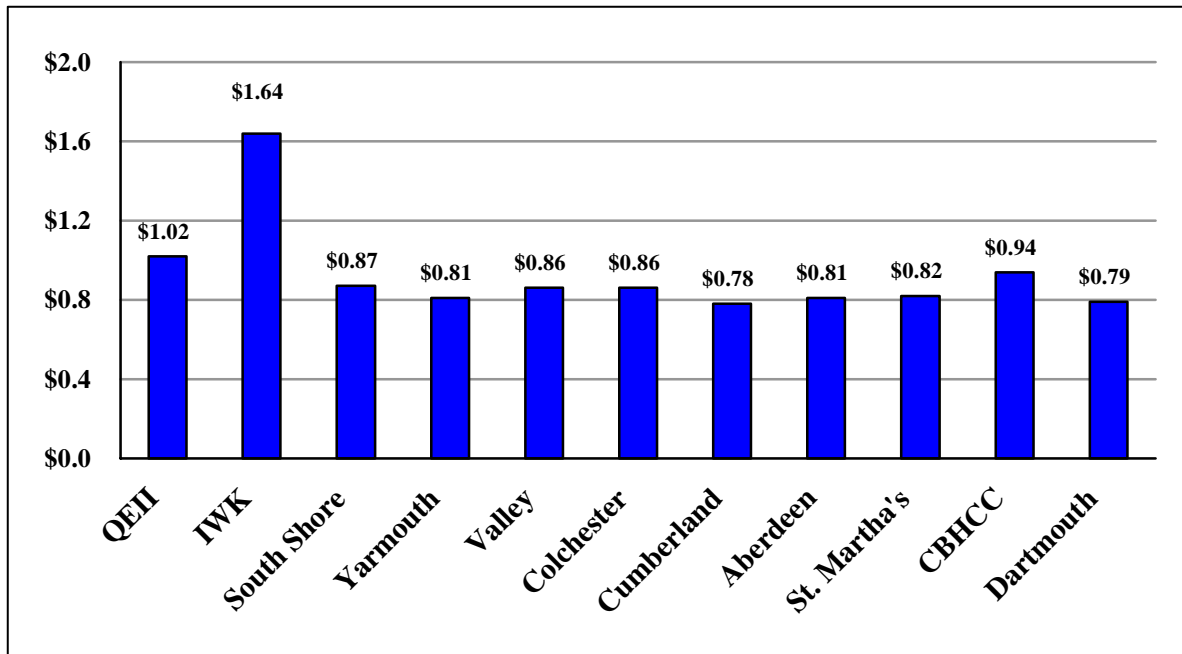
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to ambulatory care specialty clinics (primary accounts 7*350 40*), divided by the total number of visits (secondary statistical accounts 450* and 451*).

$$\frac{\text{Gross expenditures, net of recoveries (excluding Medical Fees)}}{\text{Total Visits}}$$

Source: NS DoH, MIS Database

Average Direct Cost (Exc. Med Fees) per Workload Unit Laboratory Services 2005 2006 Fiscal Year



Definition: The average direct cost per in-house service recipient workload unit for Laboratory Services. It is calculated by dividing the functional centre's direct operating expenses (exc. Referred-out expense) by the total in-house service recipient workload units generated by the functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

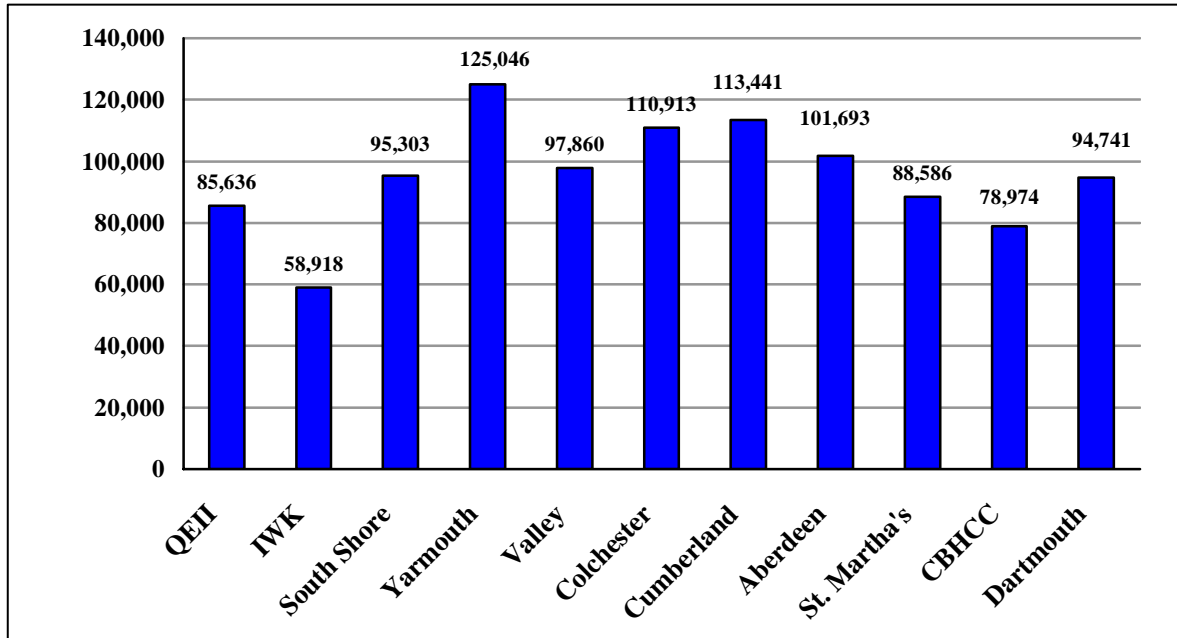
Technical Specifications

Calculation: The total gross expenditures, net recoveries, and excluding referred-out expense and medical fees (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390* and 8*) for Laboratory Services (primary accounts 71410*), divided by total Laboratory in-house workload units (secondary statistical accounts 115*).

$$\frac{\text{Total Gross Expenditures, Net of Recoveries (Excluding Med Fees \& RO Expense)}}{\text{In - House Workload Units}}$$

Source: NS DoH, MIS Database

Ave. Workload Units per Unit-Producing Staff Laboratory Services 2005 2006 Fiscal Year



Definition: The average number of service recipient workload units generated by each unit-producing personnel full-time equivalent. It is calculated by dividing the service recipient workload units by the number of unit-producing personnel full-time FTEs.

Significance – Rationale and Notes for Interpretation

Indicates the average number of patient care units that can be provided by one FTE in a specific location. It is useful for budgeting and program planning.

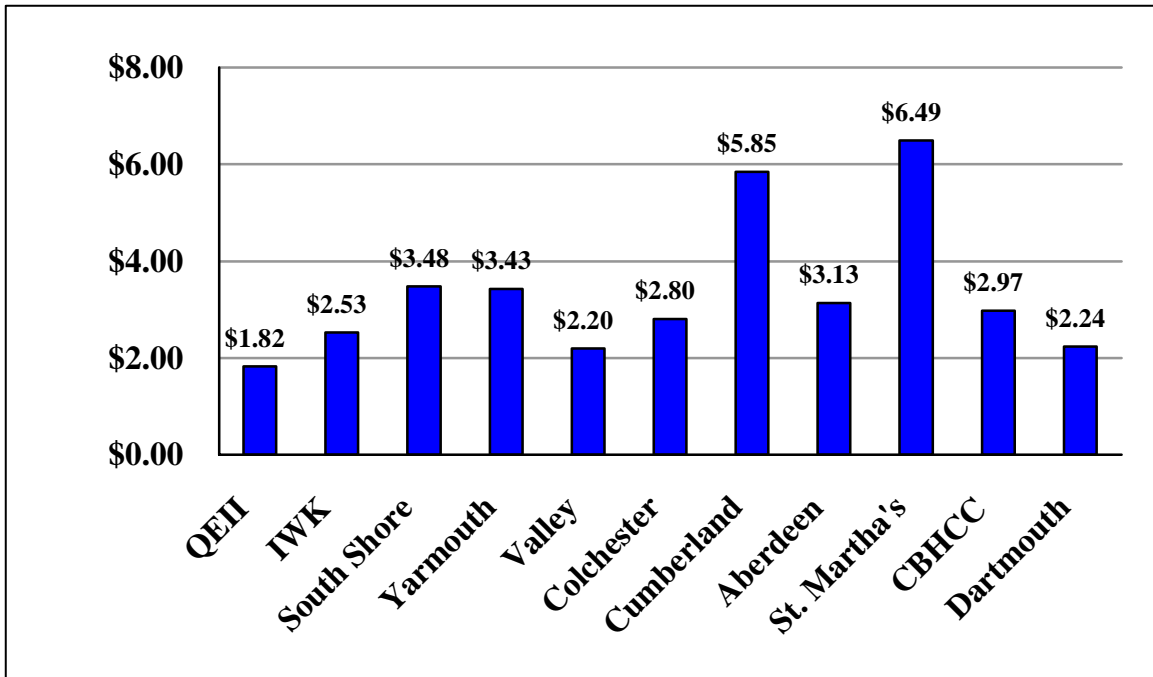
Technical Specifications

Calculation: Total Lab in-house workload units (secondary statistical accounts 115*), divided by the number of estimated UPP FTEs in laboratory services. The total number of estimated UPP FTEs can be calculated by dividing the total number of UPP earned hours (secondary financial accounts 35*) in laboratory services by the “normal” number of UPP earned hours for lab services (the “normal” number of UPP earned hours for 2005/2006 was considered to be 1957.5 hours, based on the assumption that a normal UPP workday is 7.5 hours)

$$\frac{\text{In-House Workload Units}}{\text{UPP Earned Hours} / \text{Normal UPP Earned Hours}}$$

Source: NS DoH, MIS Database

Direct Cost per Workload Unit Radiography Services Excludes Amortization Expense 2005 – 2006 Fiscal Year



Definition: The average direct cost per service recipient workload unit for Radiography Services. It is calculated by dividing the functional centre's direct operating expenses by the total service recipient workload units generated by the functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

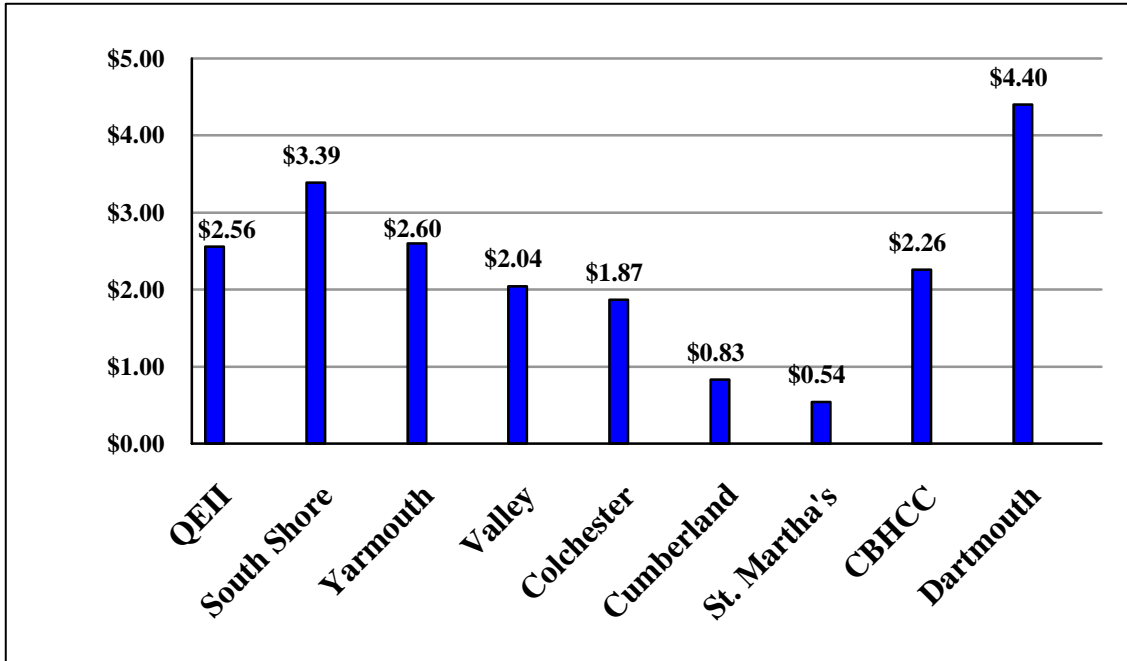
Technical Specifications

Calculation: Gross expenditures, net of recoveries, exc. Med Fees (secondary financial accounts 3* - 9*; 12*; excluding secondary financial accounts 390*) for Radiography Services (primary accounts 7*415 18) divided by the total number of Radiography workload units (secondary statistical accounts 107*).

$$\frac{\text{Gross Expenditures, Net of Recoveries, Exc. Medical Fees}}{\text{Total Radiography Workload Units}}$$

Source: NS DoH, MIS Database

Direct Cost per Workload Unit Mammography Services Excludes Amortization Expense 2005 – 2006 Fiscal Year



This includes Screening, Mobile and Diagnostic Mammography Services.

Definition: The average direct cost per service recipient workload unit for Mammography Services. It is calculated by dividing the functional centre's direct operating expenses by the total service recipient workload units generated by the functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

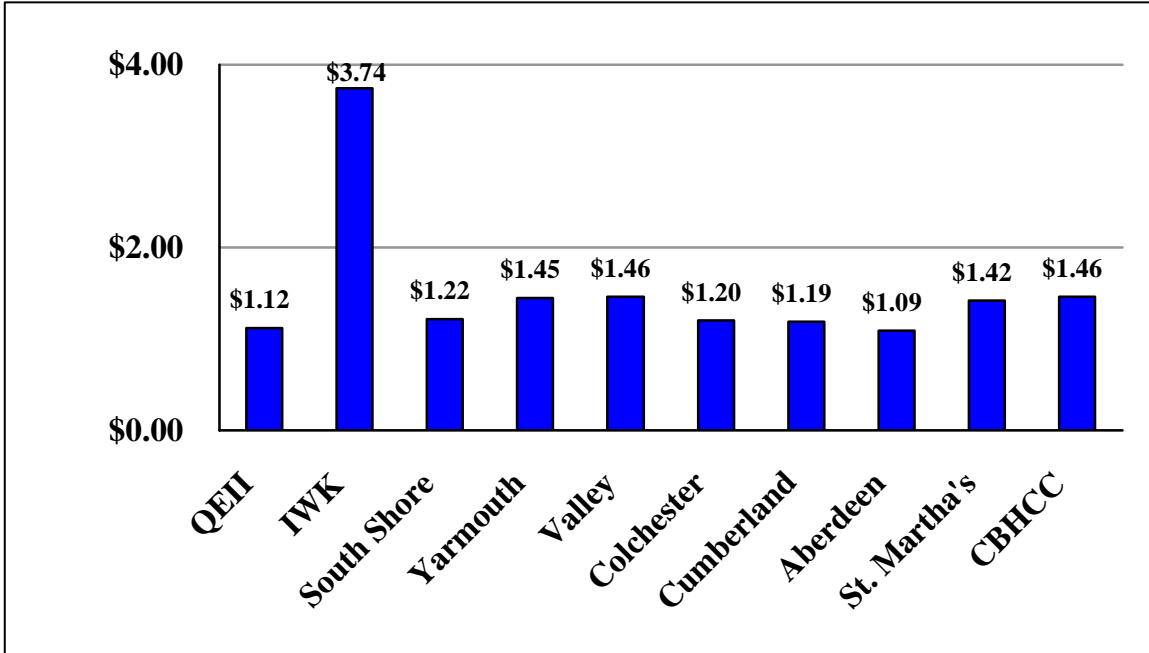
Technical Specifications

Calculation: Gross expenditures, net of recoveries, exc. Med Fees (secondary financial accounts 3* - 9*; 12*; excluding secondary financial accounts 390*) for Mammography Services (primary accounts 7*41520*) divided by the total number of Mammography workload units (secondary statistical accounts 107*).

$$\frac{\text{Gross Expenditures, Net of Recoveries, Exc. Med Fees}}{\text{Total Mammography Service Workload Units}}$$

Source: NS DoH, MIS Database

Direct Cost per Workload Unit Computed Tomography Services Excludes Amortization Expense 2005 – 2006 Fiscal Year



Note: Facilities, which have multi-slicers quite often, report a UPP Worked Productivity Index in excess of 100%.

Definition: The average direct cost per service recipient workload unit for Computed Tomography Services. It is calculated by dividing the functional centre's direct operating expenses by the total service recipient workload units generated by the functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

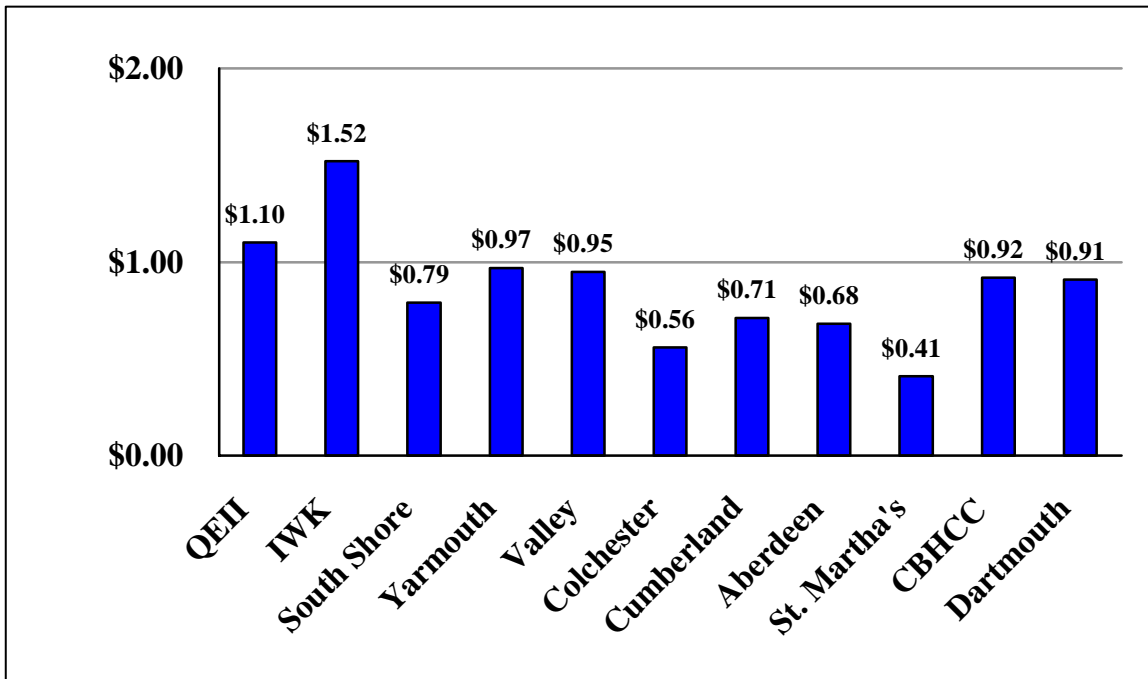
Technical Specifications

Calculation: Gross expenditures, net of recoveries, exc. Med Fees (secondary financial accounts 3* - 9*; 12*; excluding secondary financial accounts 390*) for Computed Tomography (primary accounts 7*41525*) divided by the total number of CT workload units (secondary statistical accounts 107*).

$$\frac{\text{Gross Expenditures, Net of Recoveries, Exc. Med Fees}}{\text{Total CT Workload Units}}$$

Source: NS DoH, MIS Database

Direct Cost per Workload Unit Ultrasound Services Excludes Amortization Expense 2005 – 2006 Fiscal Year



Definition: The average direct cost per service recipient workload unit for Ultrasound Services. It is calculated by dividing the functional centre's direct operating expenses by the total service recipient workload units generated by the functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

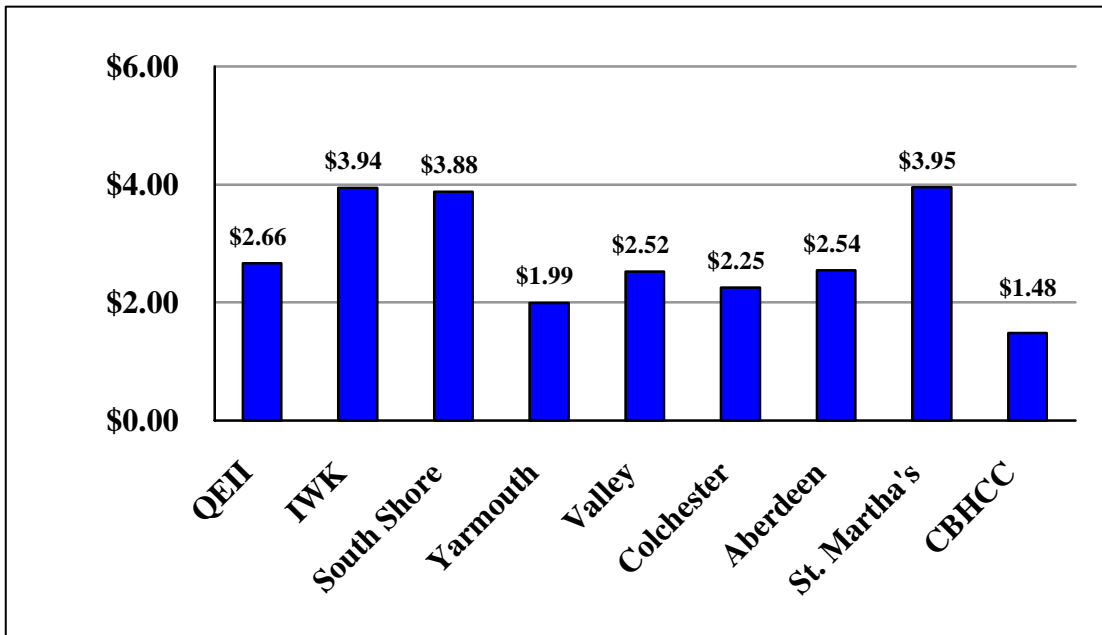
Technical Specifications

Calculation: Gross expenditures, net of recoveries, exc. Med Fees (secondary financial accounts 3* - 9*; 12*; excluding secondary financial accounts 390*) for Ultrasound (primary accounts 7*41530*) divided by the total number of Ultrasound workload units (secondary statistical accounts 107*).

$$\frac{\text{Gross Expenditures, Net of Recoveries, Exc. Med Fees}}{\text{Total Ultrasound Workload Units}}$$

Source: NS DoH, MIS Database

Direct Cost per Workload Unit Nuclear Medicine Services. Excludes Amortization Expense 2005 – 2006 Fiscal Year



Definition: The average direct cost per service recipient workload unit for Nuclear Medicine Services. It is calculated by dividing the functional centre's direct operating expenses by the total service recipient workload units generated by the functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

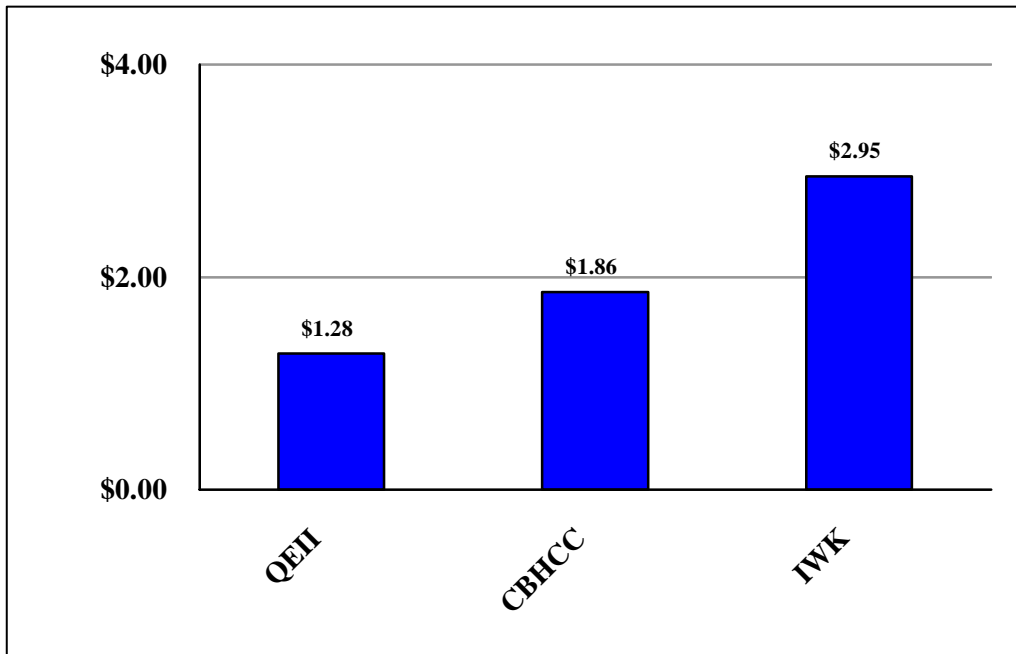
Technical Specifications

Calculation: Gross expenditures, net of recoveries, exc. Med Fees (secondary financial accounts 3* - 9*; 12*; excluding secondary financial accounts 390*) for Nuclear Medicine (primary accounts 7*41540*) divided by the total number of Nuclear Medicine workload units (secondary statistical accounts 107*).

$$\frac{\text{Gross Expenditures, Net of Recoveries, Exc. Med Fees}}{\text{Total Nuclear Medicine Workload Units}}$$

Source: NS DoH, MIS Database

Direct Cost per Workload Unit MRI Services Excludes Amortization Expense 2005 – 2006 Fiscal Year



Definition: The average direct cost per service recipient workload unit for MRI Services. It is calculated by dividing the functional centre's direct operating expenses by the total service recipient workload units generated by the functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

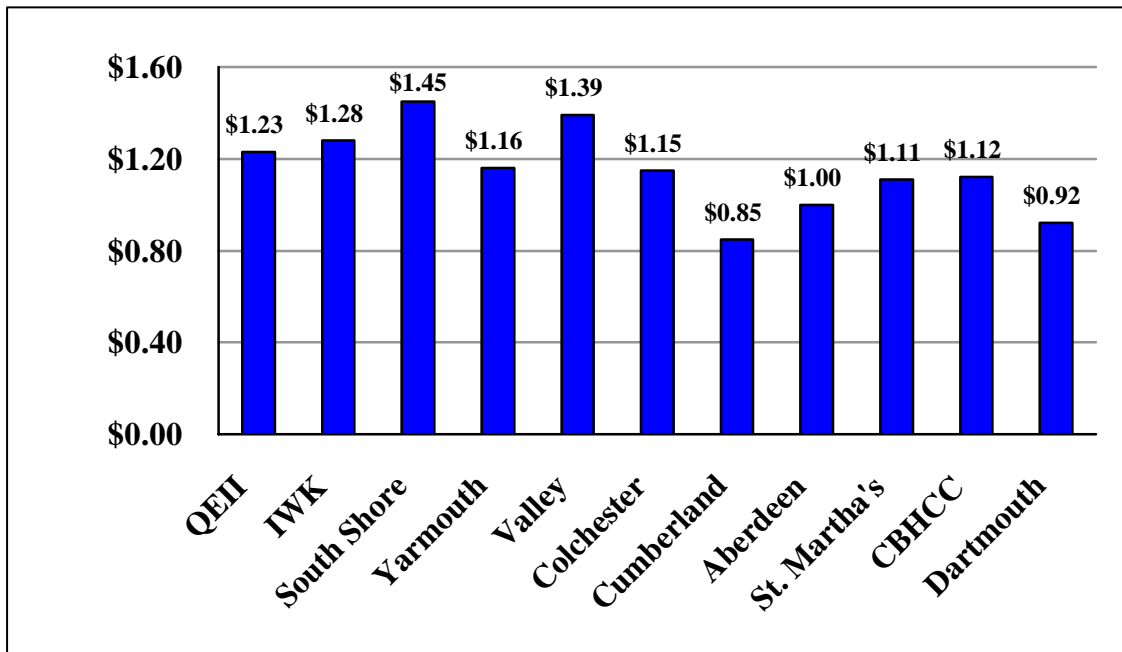
Technical Specifications

Calculation: Gross expenditures, net of recoveries, exc. Med Fees (secondary financial accounts 3* - 9*; 12*; excluding secondary financial accounts 390*) for MRI Services (primary accounts 7*41570*) divided by the total number of MRI workload units (secondary statistical accounts 107*).

$$\frac{\text{Gross Expenditures, Net of Recoveries, Exc. Med Fees}}{\text{Total MRI Workload Units}}$$

Source: NS DoH, MIS Database

Direct Cost per Workload Unit Physiotherapy Services 2005 – 2006 Fiscal Year



Definition: The average direct cost per service recipient workload unit for Physiotherapy Services. It is calculated by dividing the functional centre's direct operating expenses by the total service recipient workload units generated by the functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

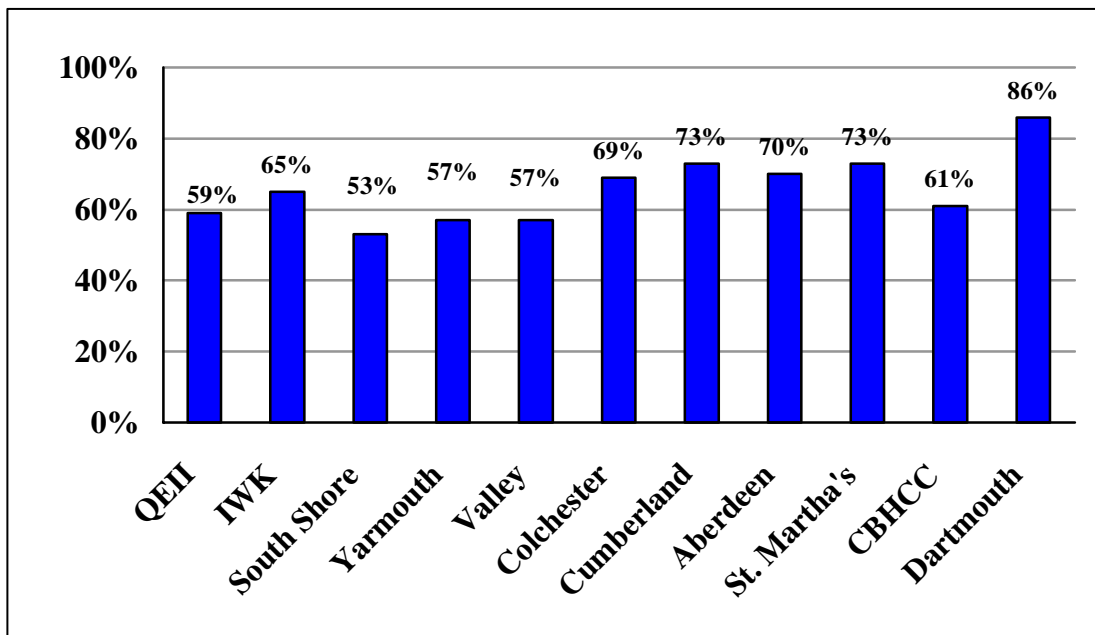
Technical Specifications

Calculation: Gross expenditures, net of recoveries, exc. Med Fees (secondary financial accounts 3* - 9*; 12*; excluding secondary financial accounts 390*) for Physiotherapy Services (primary accounts 7*450*) divided by the total number of Physiotherapy workload units (secondary statistical accounts 102*).

$$\frac{\text{Gross Expenditures, Net of Recoveries, Exc. Med Fees}}{\text{Total Physio Workload Units}}$$

Source: NS DoH, MIS Database

Unit-Producing Staff Worked Productivity Physiotherapy Services 2005 – 2006 Fiscal Year



Definition: The average number of service recipient workload units produced per unit-producing personnel worked hour or purchased hour. It is calculated by dividing the service recipient workload units by the worked and purchased hours of the unit-producing personnel in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

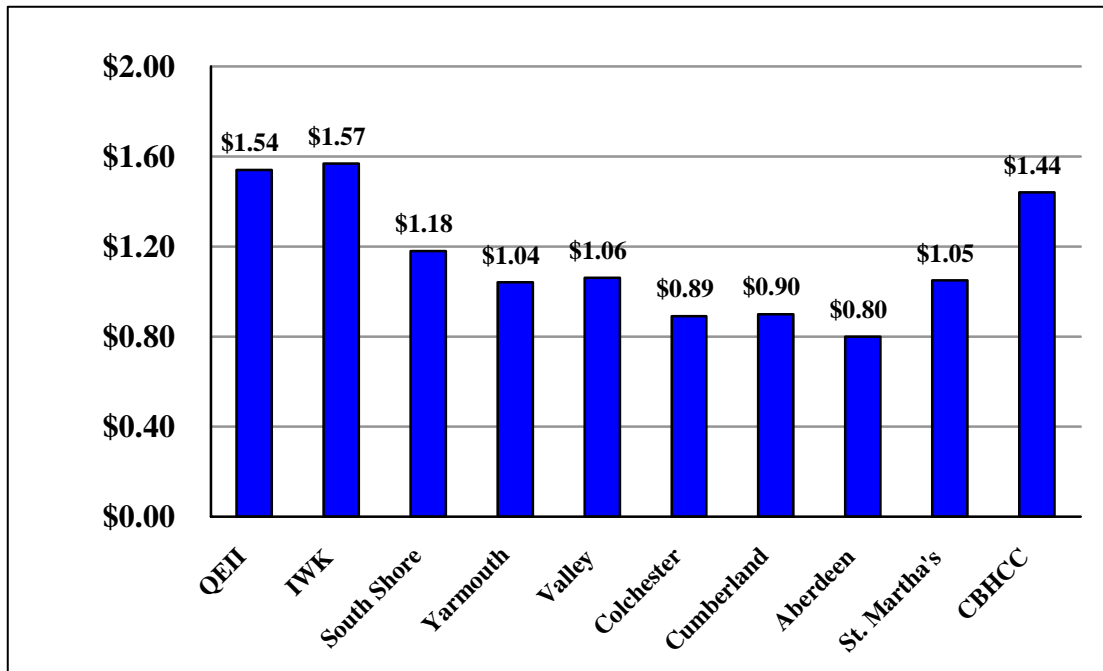
Technical Specifications

Calculation: The total Physiotherapy service recipient workload units (secondary statistical accounts 102*) divided by 60 (to convert minutes to hours) divided by UPP worked & purchased hours (secondary statistical accounts 35*10 and 35*90)

$$\frac{\text{Total Service Recipient Workload Units} / 60}{\text{Total Worked and Purchased Service Hours}}$$

Source: NS DoH, MIS Database

Direct Cost per Workload Unit Occupational Therapy 2005 –2006 Fiscal Year



Definition: The average direct cost per in-house service recipient workload unit for Occupational Therapy. It is calculated by dividing the functional centre's direct operating expense (less the contracted-out service expense, if applicable) by the in-house service recipient workload units generated by that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

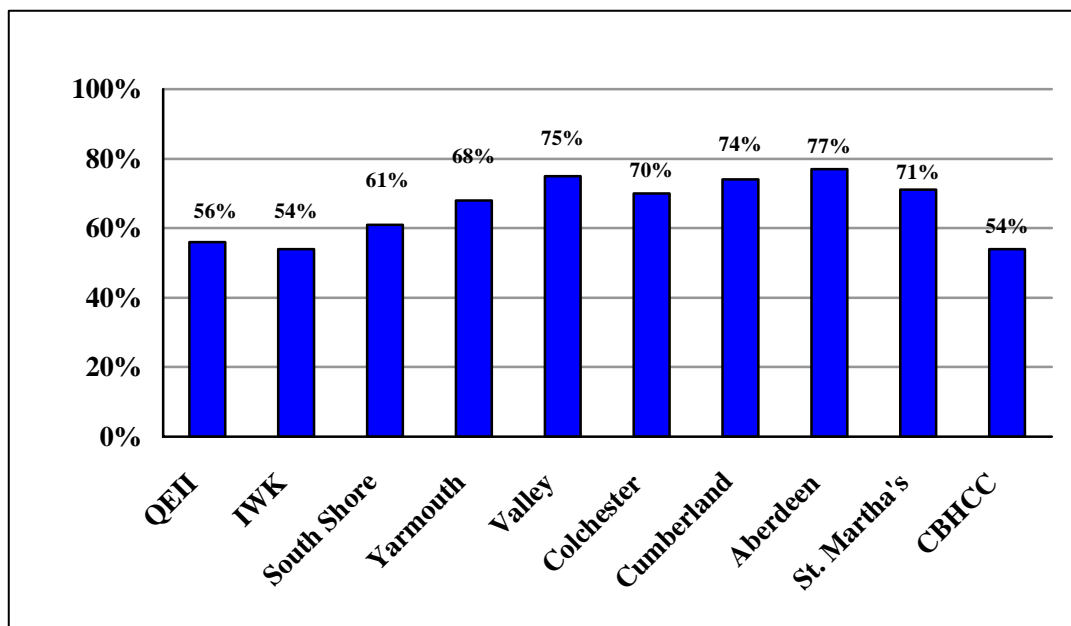
Technical Specifications

Calculation: Gross expenditures, net of recoveries, exc. Med Fees (secondary financial accounts 3* - 9*; 12*; excluding secondary financial accounts 390*) for Physiotherapy Services (primary accounts 7*455*) divided by the total number of OT workload units (secondary statistical accounts 102*).

$$\frac{\text{Gross Expenditures, Net of Recoveries, Exc. Med Fees}}{\text{Total OT Workload Units}}$$

Source: NS DoH, MIS Database

Unit-Producing Staff Worked Productivity Occupational Therapy Services 2005 – 2006 Fiscal Year



Definition: The average number of service recipient workload units produced per unit-producing personnel worked hour or purchased hour. It is calculated by dividing the service recipient workload units by the worked and purchased hours of the unit-producing personnel in a given period.

Significance – Rationale and Notes for Interpretation

Used for budgeting, program planning, and the evaluation of services.

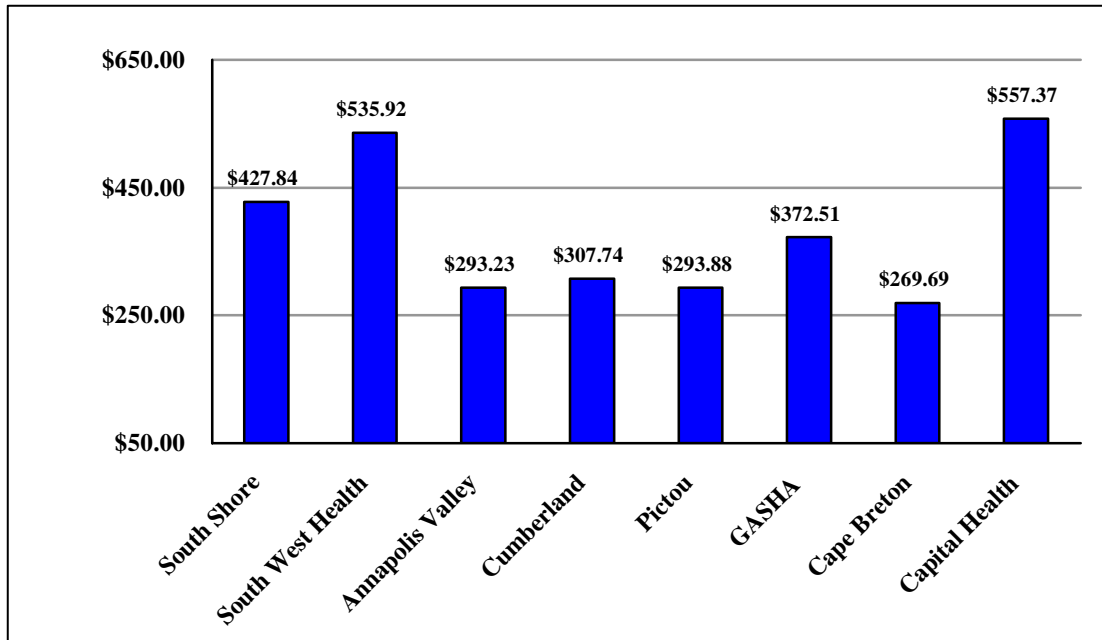
Technical Specifications

Calculation: The total OT service recipient workload units (secondary statistical accounts 102*) divided by 60 (to convert minutes to hours) divided by UPP worked & purchased hours (secondary statistical accounts 35*10 and 35*90)

$$\frac{\text{Total Service Recipient Workload Units} / 60}{\text{Total Worked and Purchased Service Hours}}$$

Source: NS DoH, MIS Database

Direct Cost per Patient Day Addiction Inpatient Services 2005 – 2006 Fiscal Year



Definition: The average direct cost of providing services to one inpatient/resident during one inpatient/resident day. It is calculated by dividing the functional centre's direct operating expenses by the number of inpatient/resident days in a given period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

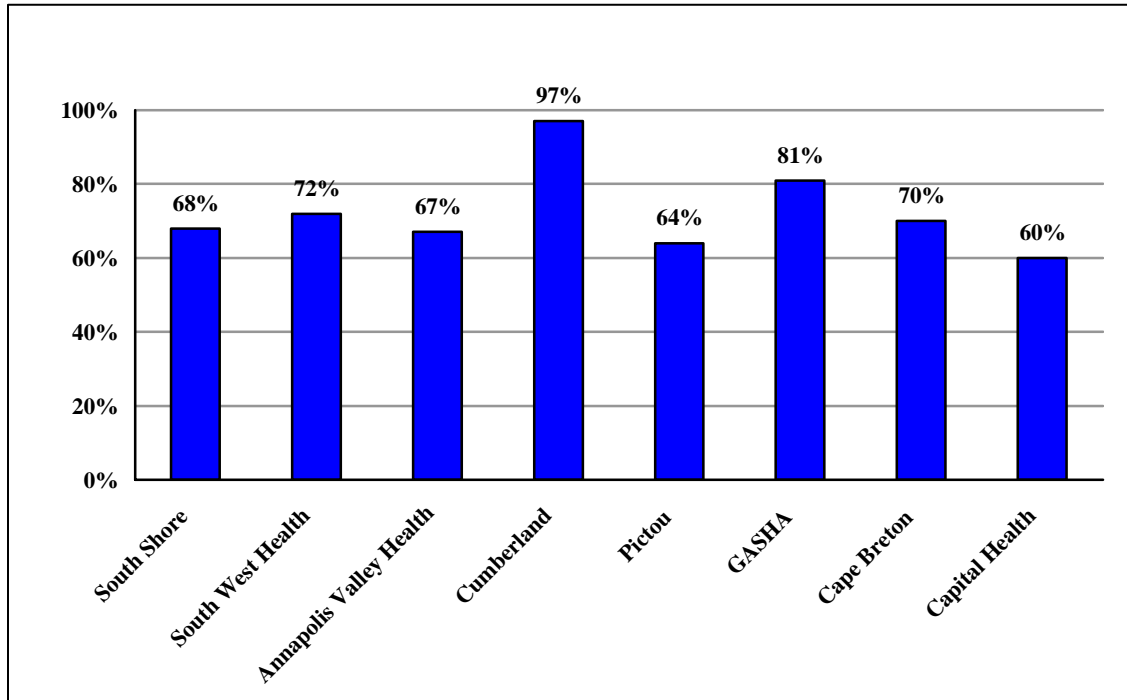
Technical Specifications

Calculation: Total gross expenditures, net of recoveries (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to Addiction Services Inpatient Nursing Units (primary accounts 7*275 40) divided by the number of inpatient days (secondary statistical account 403*).

$$\frac{\text{Gross Expenditures, Net of Recoveries (excluding medical fees)}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Percentage Occupancy Additions Services Inpatient Units 2005 – 2006 Fiscal Year



Definition: The percentage of beds which are available and staffed for inpatient accommodation and which are occupied by a service recipient.

Significance – Rationale and Notes for Interpretation

An indicator of resource use, used for budgeting, planning, and evaluation.

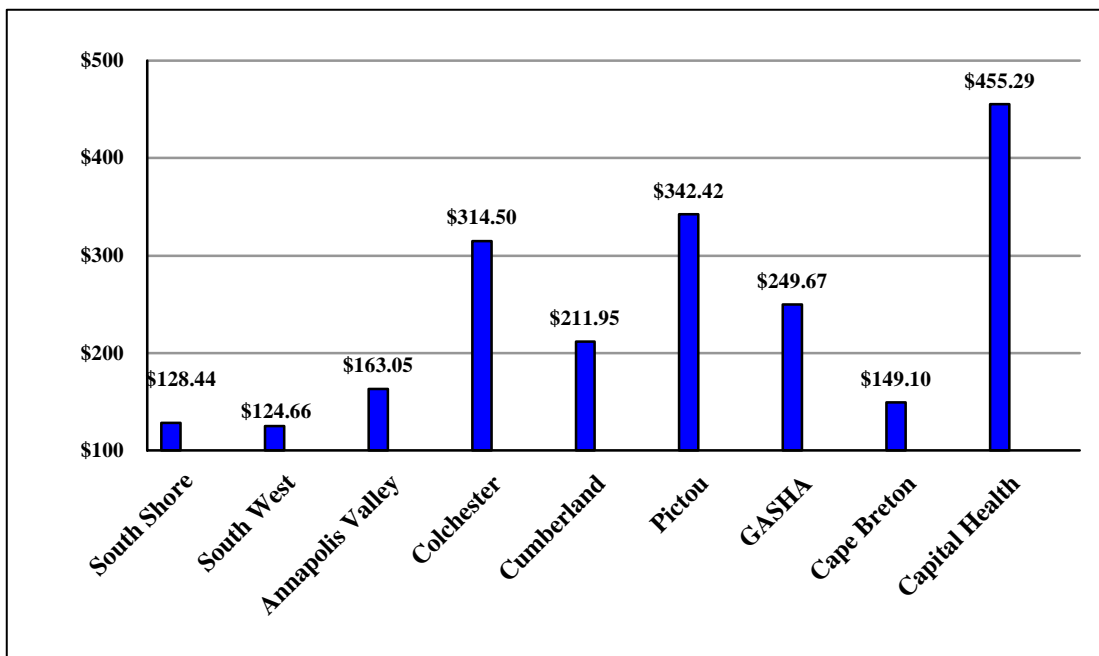
Technical Specifications

Calculation: The total number of inpatient days (secondary statistical account 403*), divided by the total number of bed days, staffed and in operation (secondary statistical account 827*) attributable to Addictions Services Inpatient Nursing units (primary accounts 7*27540*), multiplied by 100 to yield a percentage.

$$\frac{\text{Inpatient Days}}{\text{Bed Days Staffed and in Opeation}} \times 100$$

Source: NS DoH, MIS Database

Direct Cost per Visit Addiction Community Based Services 2005 – 2006 Fiscal Year



Definition: The average direct cost for a visit to a functional centre. It is calculated by dividing their functional centre's direct operating expense by the total number of visits (face-to-face and telephone) to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

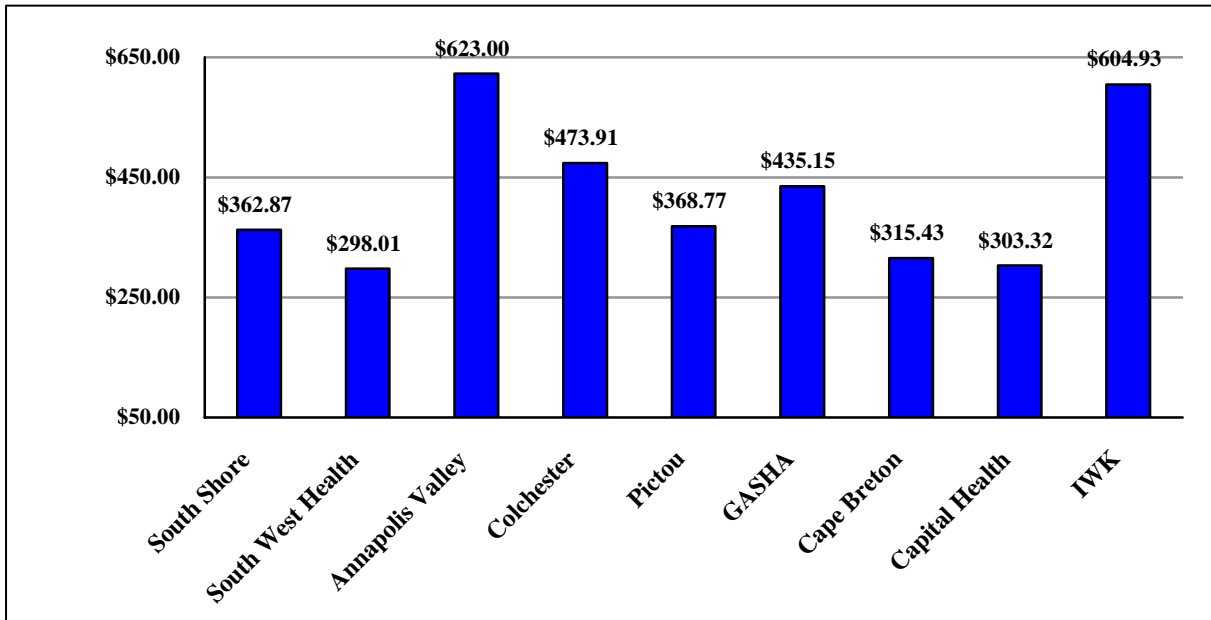
Technical Specifications

Calculation: Total gross expenditures, net of recoveries (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to Addiction Community Based Outpatient Services (primary account 7*550 80), divided by the total number of visits (secondary statistical accounts 450* and 451*).

$$\frac{\text{Direct Cost, Net of Recovery (excluding Medical Fees)}}{\text{Total Visits}}$$

Source: NS DoH, MIS Database

Direct Cost per Patient Day Mental Health Psychiatric Inpatient Units 2005 – 2006 Fiscal Year



Definition: The average direct cost of providing services to one inpatient/resident during one inpatient/resident day. It is calculated by dividing the functional centre's direct operating expenses by the number of inpatient/resident days in a given period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

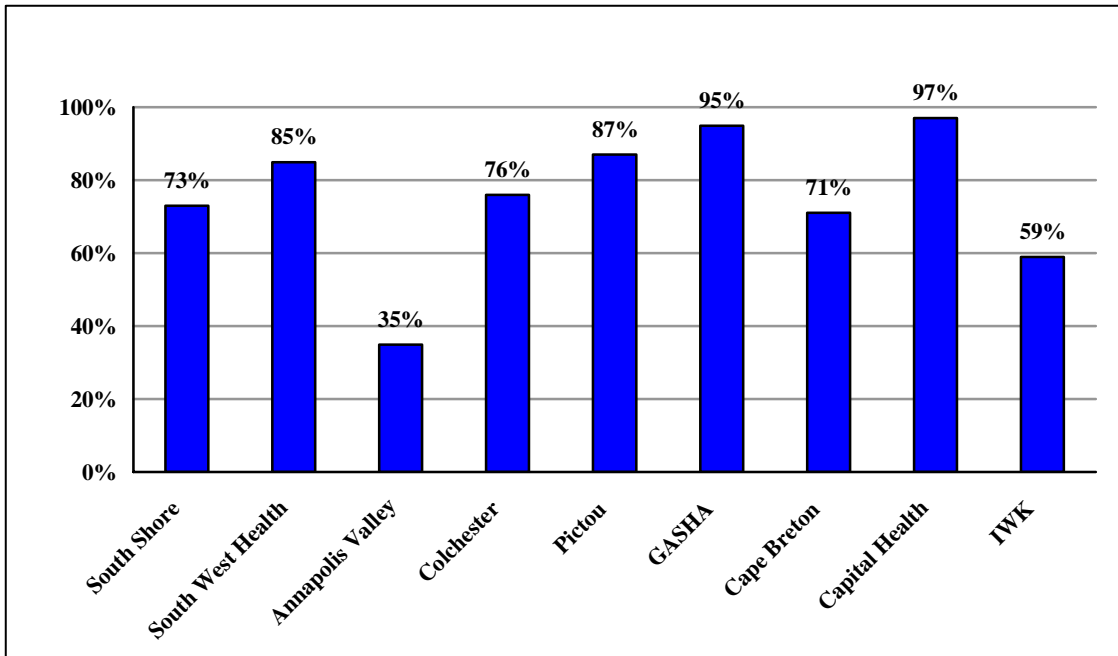
Technical Specifications

Calculation: Total gross expenditures, net of recoveries (excluding medical fees) (secondary financial accounts 3* - 9*; and 12*; excluding secondary financial accounts 390*) attributable to Psychiatric Inpatient Nursing Units (primary accounts 7*275 20* and 7*275 80*) divided by the number of inpatient days (secondary statistical account 403*).

$$\frac{\text{Gross Expenditures, Net of Recoveries (excluding medical fees)}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Percentage Occupancy Mental Health Psychiatric Inpatients Units 2005 – 2006 Fiscal Year



Definition: The percentage of beds which are available and staffed for inpatient accommodation and which are occupied by a service recipient.

Significance – Rationale and Notes for Interpretation

An indicator of resource use, used for budgeting, planning, and evaluation.

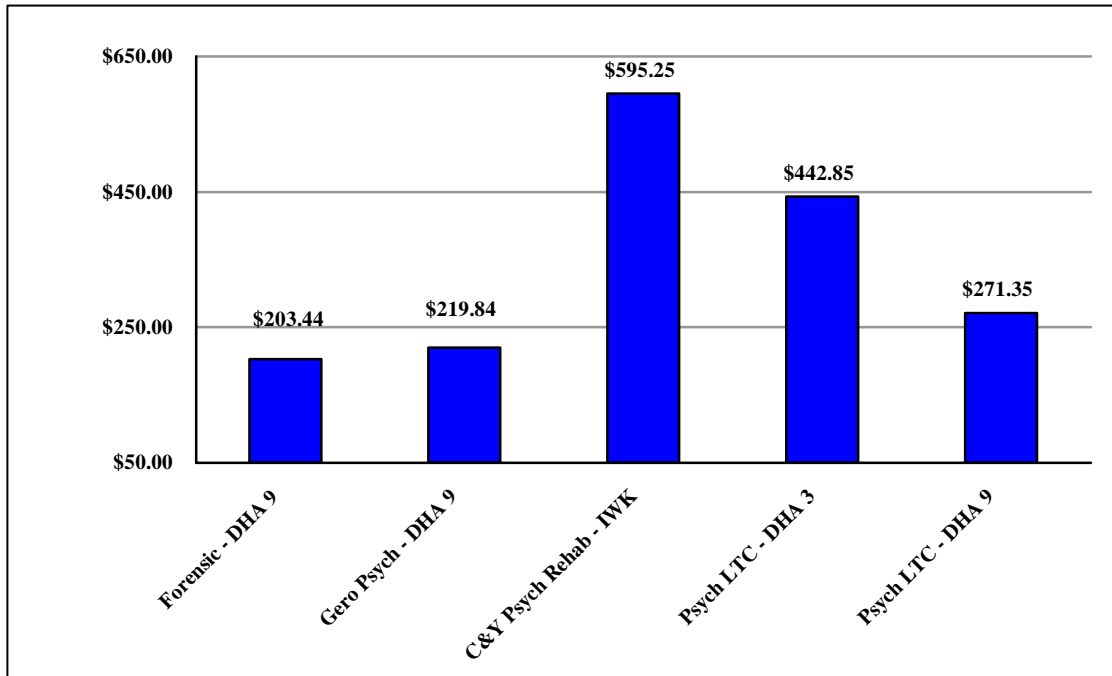
Technical Specifications

Calculation: The total number of inpatient days (secondary statistical account 403*), divided by the total number of bed days, staffed and in operation (secondary statistical account 827*) attributable to the Psychiatric Inpatient Nursing Units (primary accounts 7*275 20* and 7*275 80*), multiplied by 100 to yield a percentage.

$$\frac{\text{Inpatient Days}}{\text{Bed Days Staffed and in Opeation}} \times 100$$

Source: NS DoH, MIS Database

Direct Cost per Patient Day Other Mental Health Inpatient Units 2005 – 2006 Fiscal Year



Definition: The average direct cost of providing services to one inpatient/resident during one inpatient/resident day. It is calculated by dividing the functional centre's direct operating expenses by the number of inpatient/resident days in a given period.

Significance – Rationale and Notes for Interpretation

An indicator of complexity, used for budgeting, planning, and evaluation.

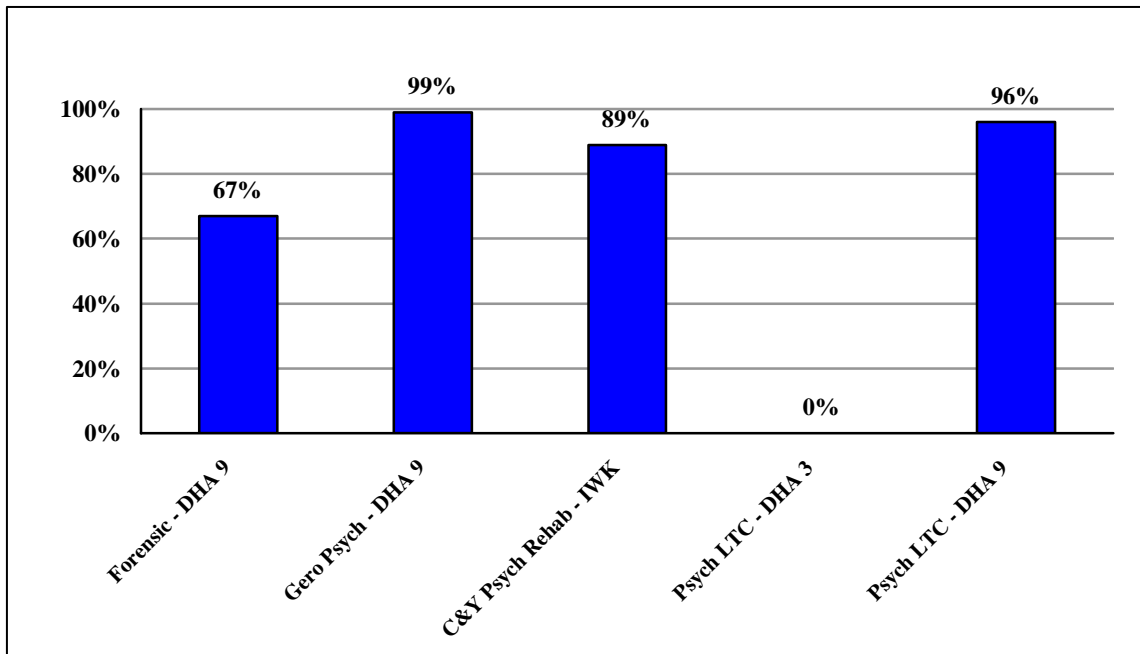
Technical Specifications

Calculation: Total gross expenditures, net of recoveries, (excluding medical fees) (secondary accounts 3* - 9*; 12*; and excluding secondary financial accounts 390*) attributable to Psychiatry cost centre (primary accounts 7*275 60, 7*275 70, 7*275 90*) divided by the number of inpatient days (secondary statistical account 403*).

$$\frac{\text{Gross Expenditures, Net of Recoveries (excluding medical fees)}}{\text{Inpatient Days}}$$

Source: NS DoH, MIS Database

Percentage Occupancy Other Mental Health Inpatient Units 2005 – 2006 Fiscal Year



Definition: The percentage of beds which are available and staffed for inpatient accommodation and which are occupied by a service recipient.

Significance – Rationale and Notes for Interpretation

An indicator of resource use, used for budgeting, planning, and evaluation.

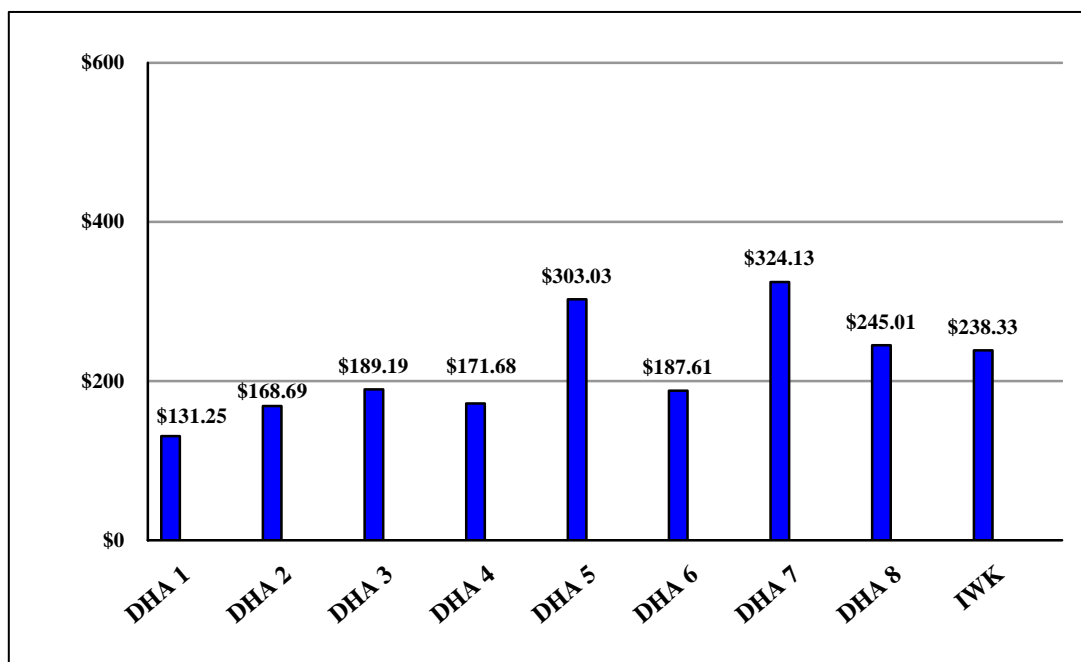
Technical Specifications

Calculation: The total number of inpatient days (secondary statistical account 403*), divided by the total number of bed days, staffed and in operation (secondary statistical account 827*) attributable to the Psychiatry Inpatient Nursing Units (primary accounts 7*275 60*, 7*275 70* and 7*275 90*), multiplied by 100 to yield a percentage.

$$\frac{\text{Inpatient Days}}{\text{Bed Days Staffed and in Opeation}} \times 100$$

Source: NS DoH, MIS Database

Direct Cost per Visit MHS Child & Youth Outpatient Services 2005 – 2006 Fiscal Year



Definition: The average direct cost for a visit to a functional centre. It is calculated by dividing their functional centre's direct operating expense by the total number of visits (face-to-face and telephone) to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

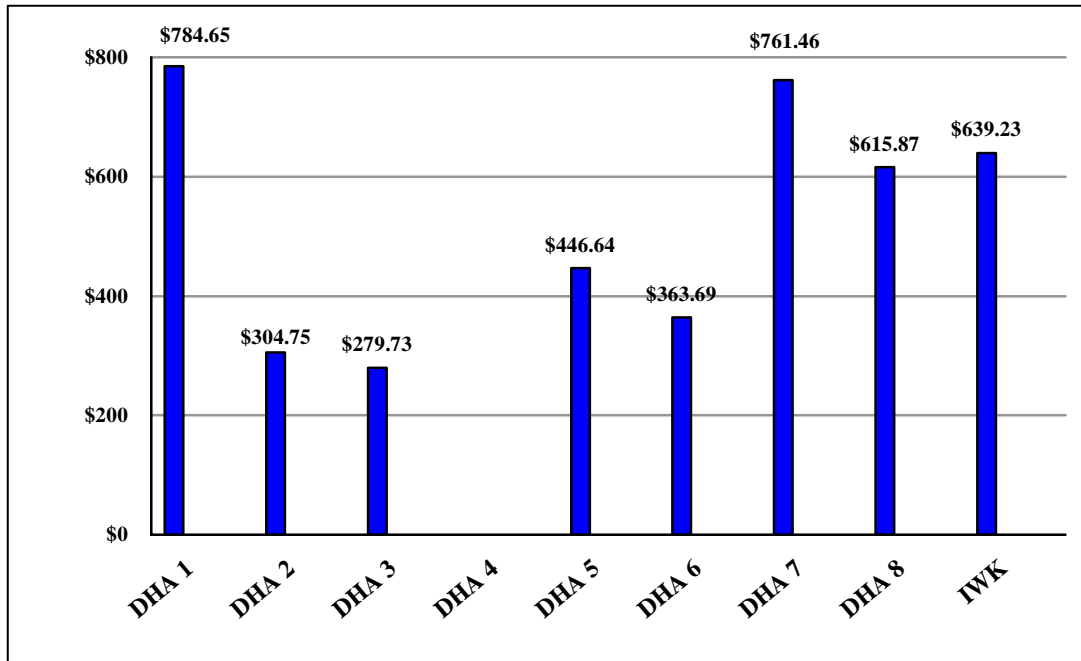
Technical Specifications

Calculation: Total gross expenditures, net of recoveries (excluding medical fees) (secondary financial accounts 3* - 9*; 12*; and excluding secondary financial accounts 390*) attributable to the MHS Child & Youth Outpatient Services (primary account 7*3 50 70 25), divided by the total number of visits, both face-to-face and telephone (secondary statistical accounts 450* and 451*).

$$\frac{\text{Direct Cost, Net of Recovery (excluding Medical Fees)}}{\text{Total Visits}}$$

Source: NS DoH, MIS Database

Direct Cost per Visit MHS Child & Youth Autism Programs 2005 – 2006 Fiscal Year



Note: Colchester East Hants District reported 30 visits for the fiscal year resulting in a Direct Cost per Visit of over \$5,000.

Definition: The average direct cost for a visit to a functional centre. It is calculated by dividing their functional centre's direct operating expense by the total number of visits (face-to-face and telephone) to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

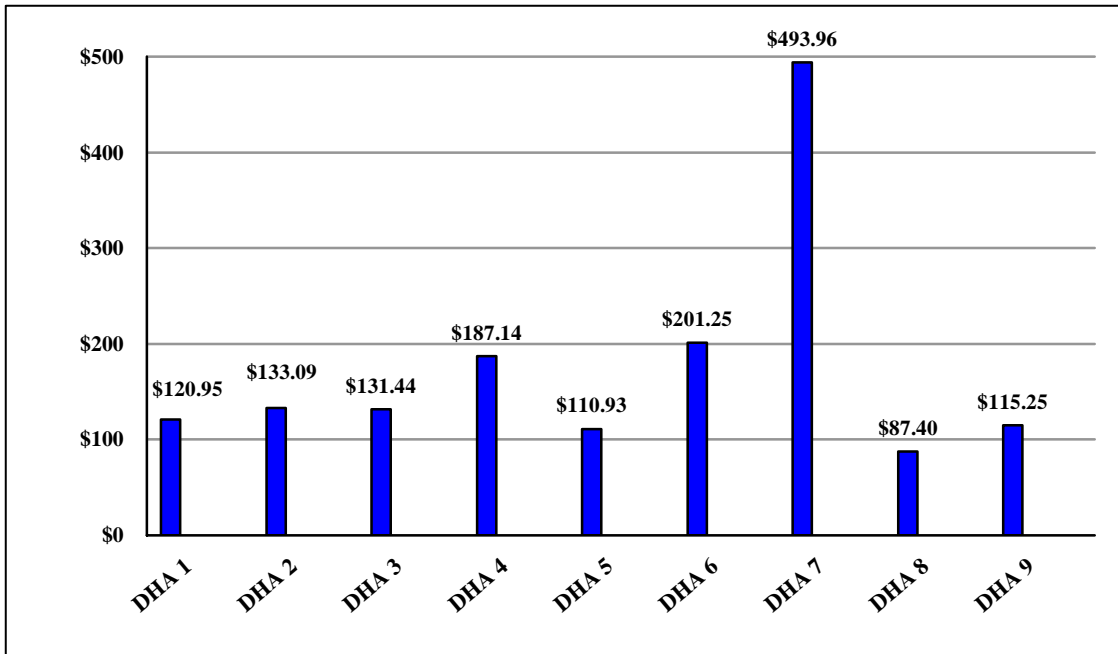
Technical Specifications

Calculation: Total gross expenditures, net of recoveries (excluding medical fees) (secondary financial accounts 3* - 9*; 12*; and excluding secondary financial accounts 390*) attributable to the MHS Child & Youth Outpatient Services (primary account 7*3 50 70 26), divided by the total number of visits, both face-to-face and telephone (secondary statistical accounts 450* and 451*).

$$\frac{\text{Direct Cost, Net of Recovery (excluding Medical Fees)}}{\text{Total Visits}}$$

Source: NS DoH, MIS Database

Direct Cost per MHS Visit Adult Outpatient Services 2005 – 2006 Fiscal Year



Definition: The average direct cost for a visit to a functional centre. It is calculated by dividing their functional centre's direct operating expense by the total number of visits (face-to-face and telephone) to that functional centre in a given period.

Significance – Rationale and Notes for Interpretation

Used for program planning, evaluating differences in acuity, and monitoring activity based budget projections.

Technical Specifications

Calculation: Total gross expenditures, net of recoveries (excluding medical fees) (secondary financial accounts 3*- 9*; 12*; and excluding secondary financial accounts 390*) attributable to the MHS Adult Outpatient Services (primary account 7*3 50 80*), divided by the total number of visits, both face-to-face and telephone (secondary statistical accounts 450* and 451*).

$$\frac{\text{Gross Expenditures, Net of Recoveries (excluding Medical Fees)}}{\text{Total Visits}}$$

Source: NS DoH, MIS Database

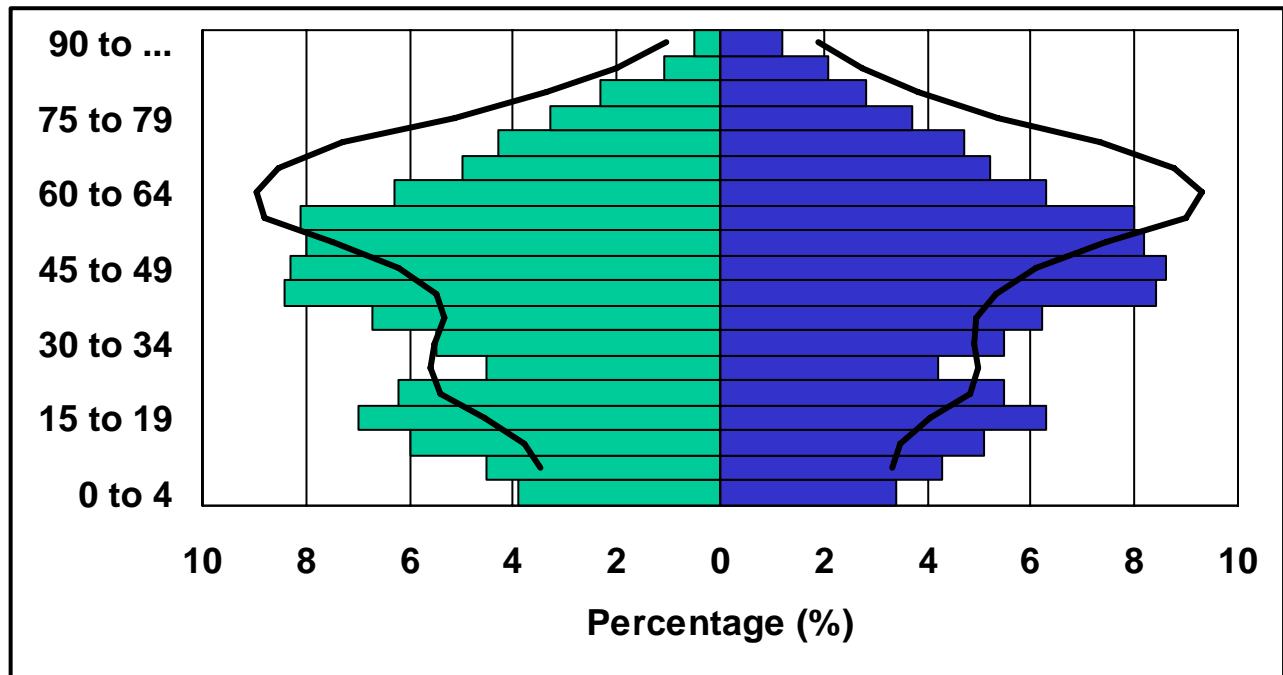
Section 8 Population Pyramids, Nova Scotia and DHAs 2005 and 2016: A Comparison

Highlights

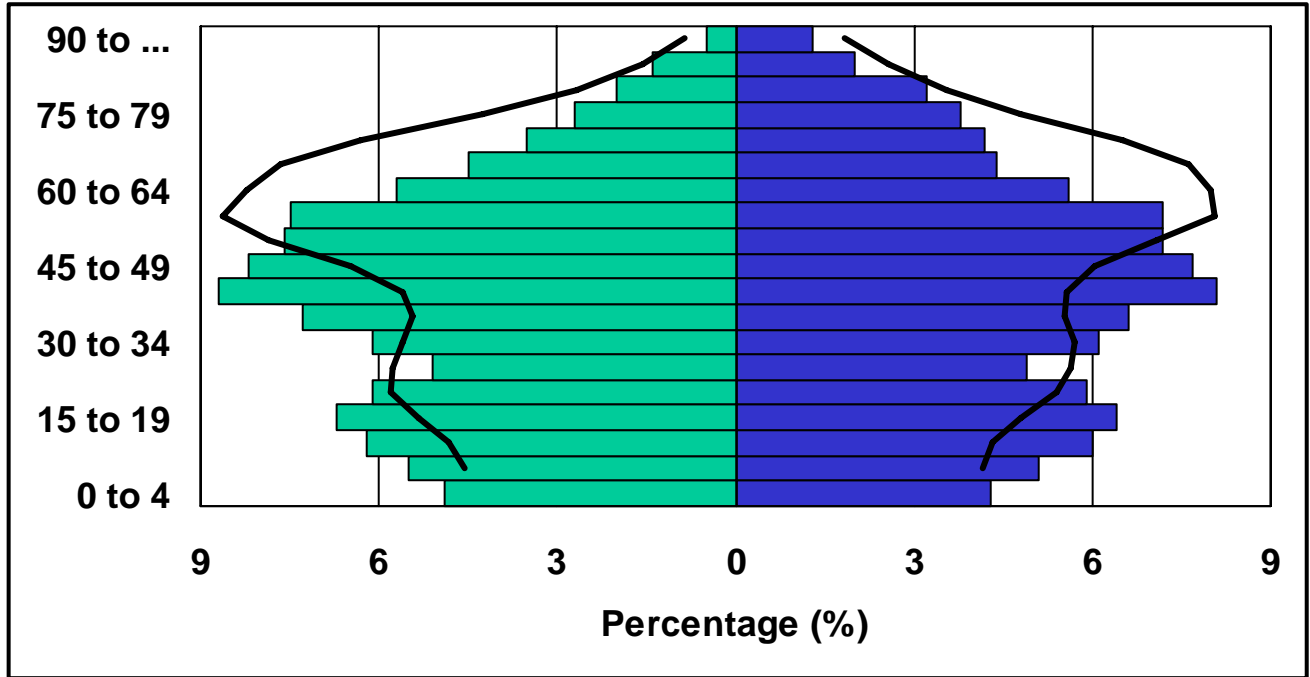
- All DHAs show increased proportions of their populations moving into 'retirement' ages and thus, potentially, increase Health Care use
- The size of this 'retirement age cohort' varies between DHAs

**Green = Male, Blue = Female,
Black Lines = 2016 population projection**

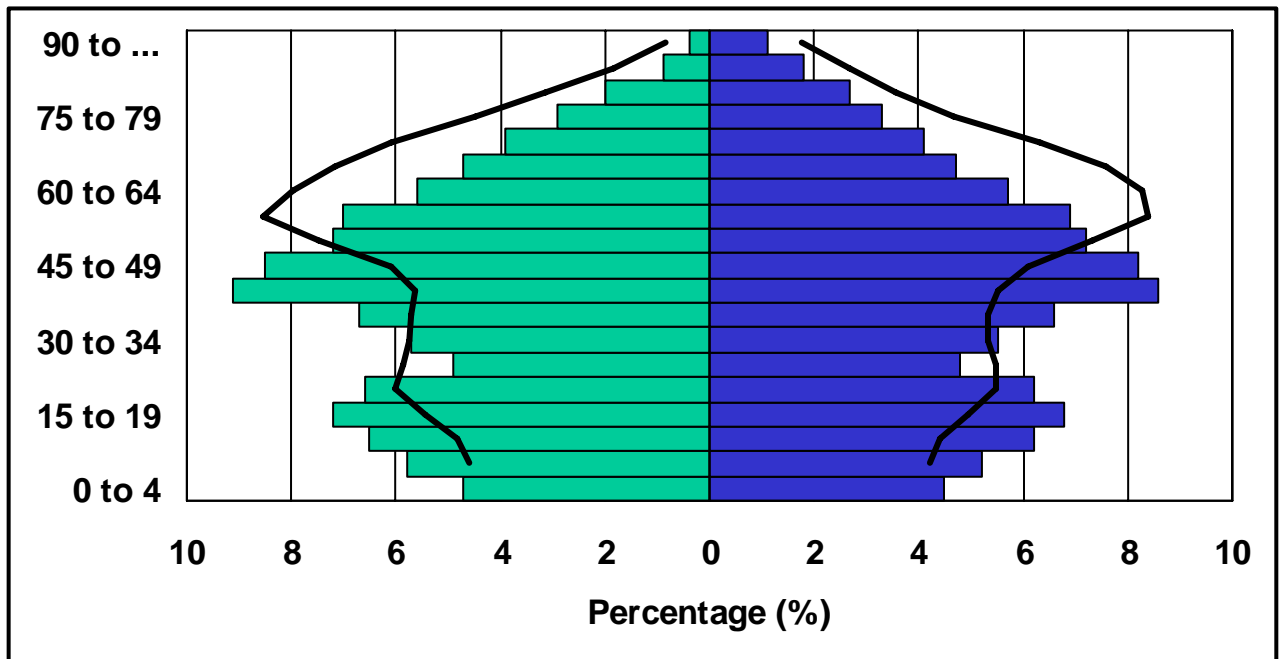
1. Population Pyramid for SSDHA (DHA 1) for 2005 and 2016



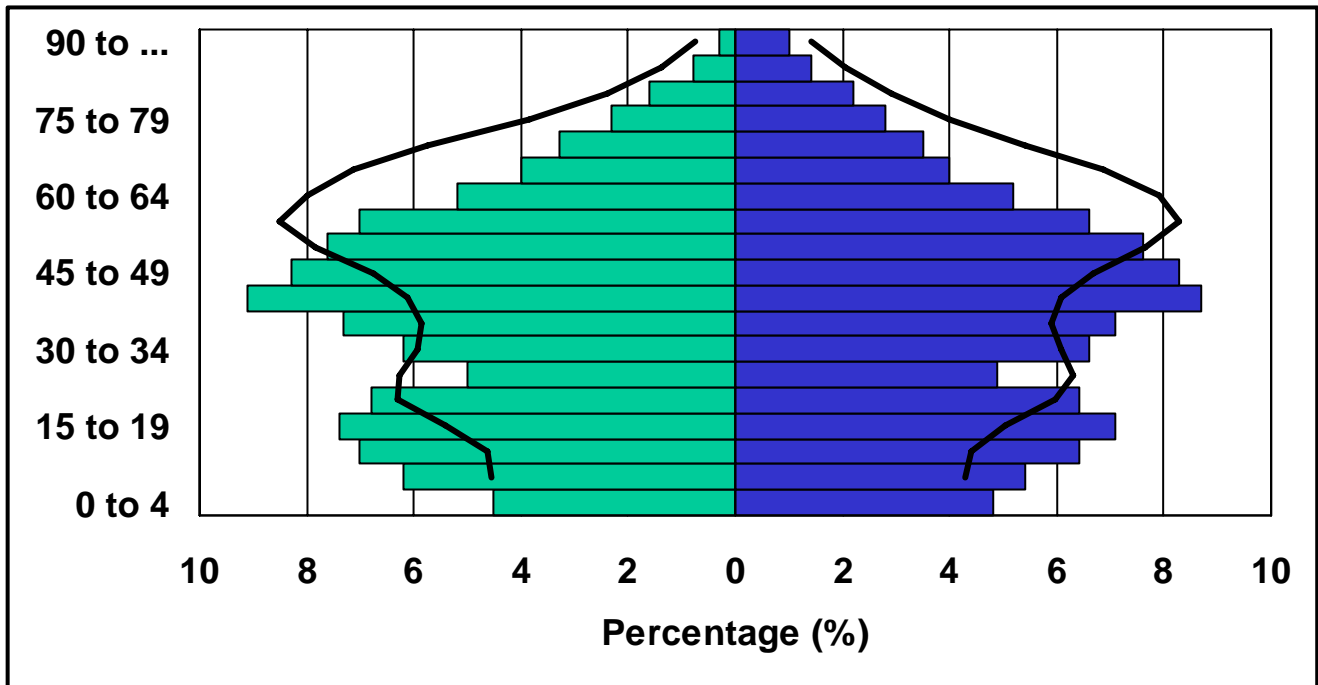
2. Population Pyramid for SWNHA (DHA 2) for 2005 and 2016



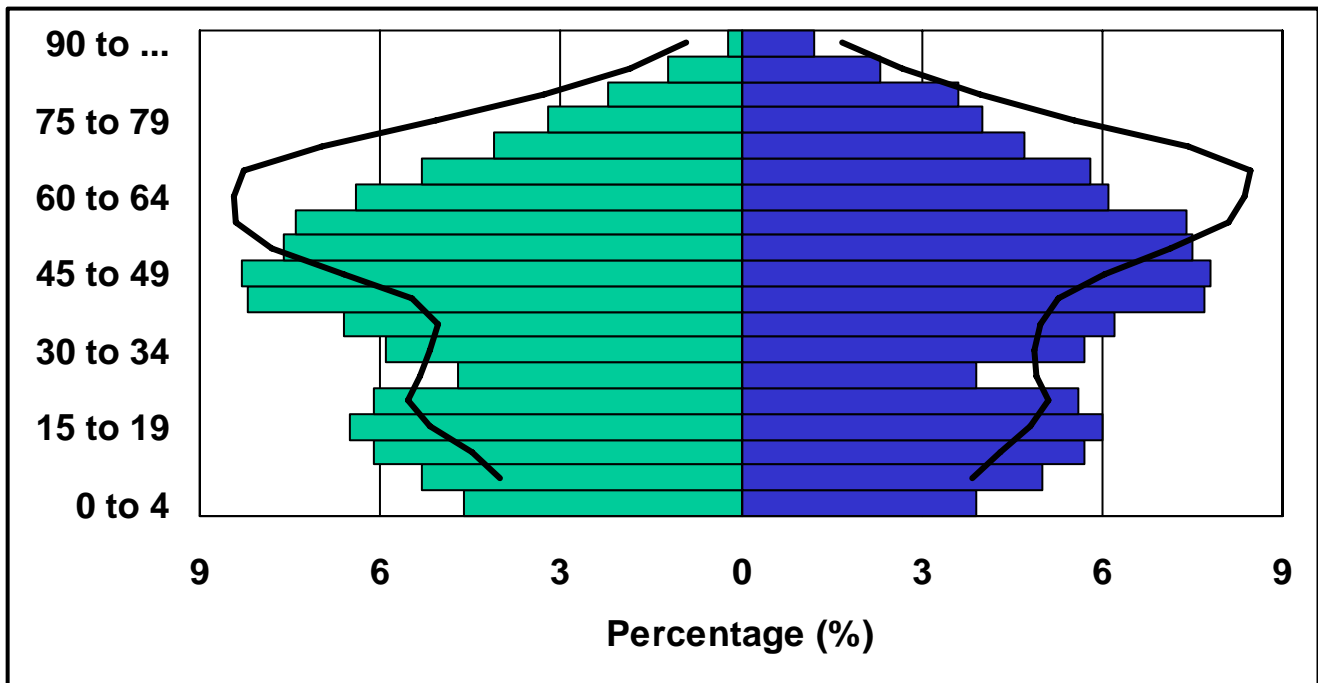
3. Population Pyramid for AVDHA (DHA 3) for 2005 and 2016



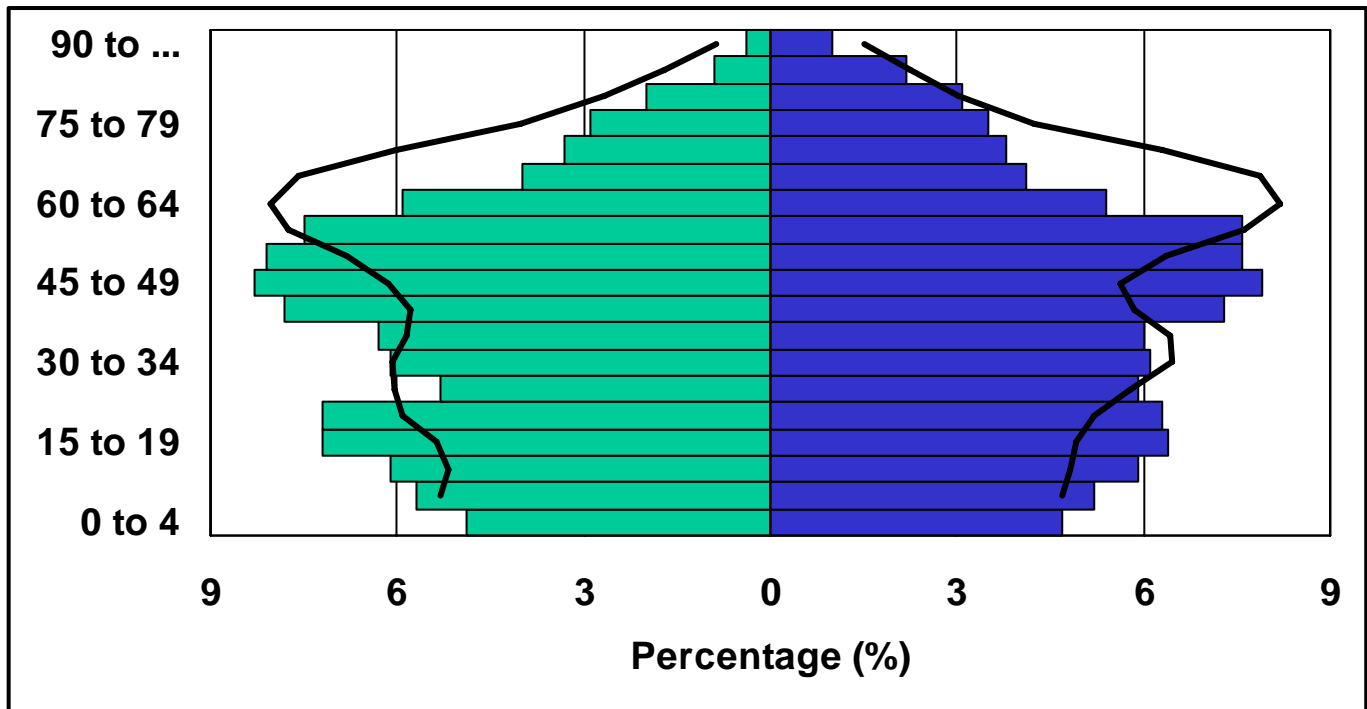
4. Population Pyramid for CEHHA (DHA 4) for 2005 and 2016



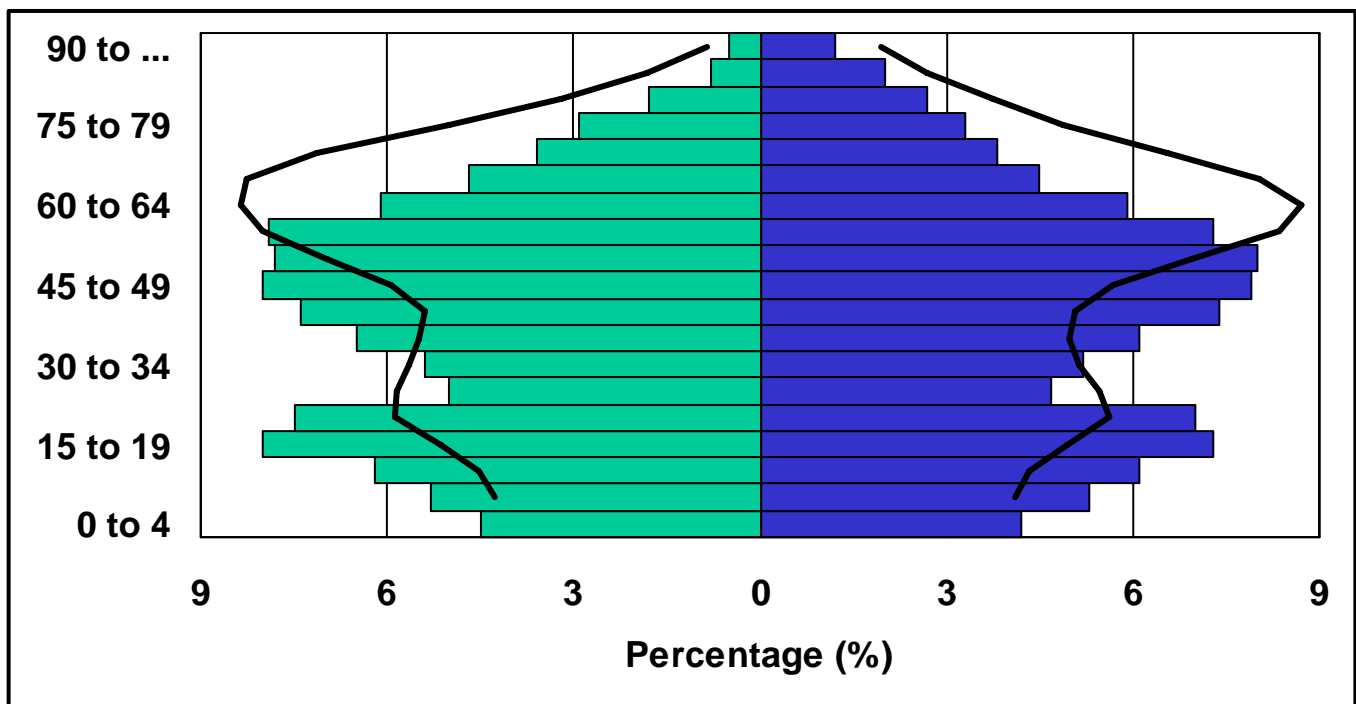
5. Population Pyramid for CHA (DHA 5) for 2005 and 2016



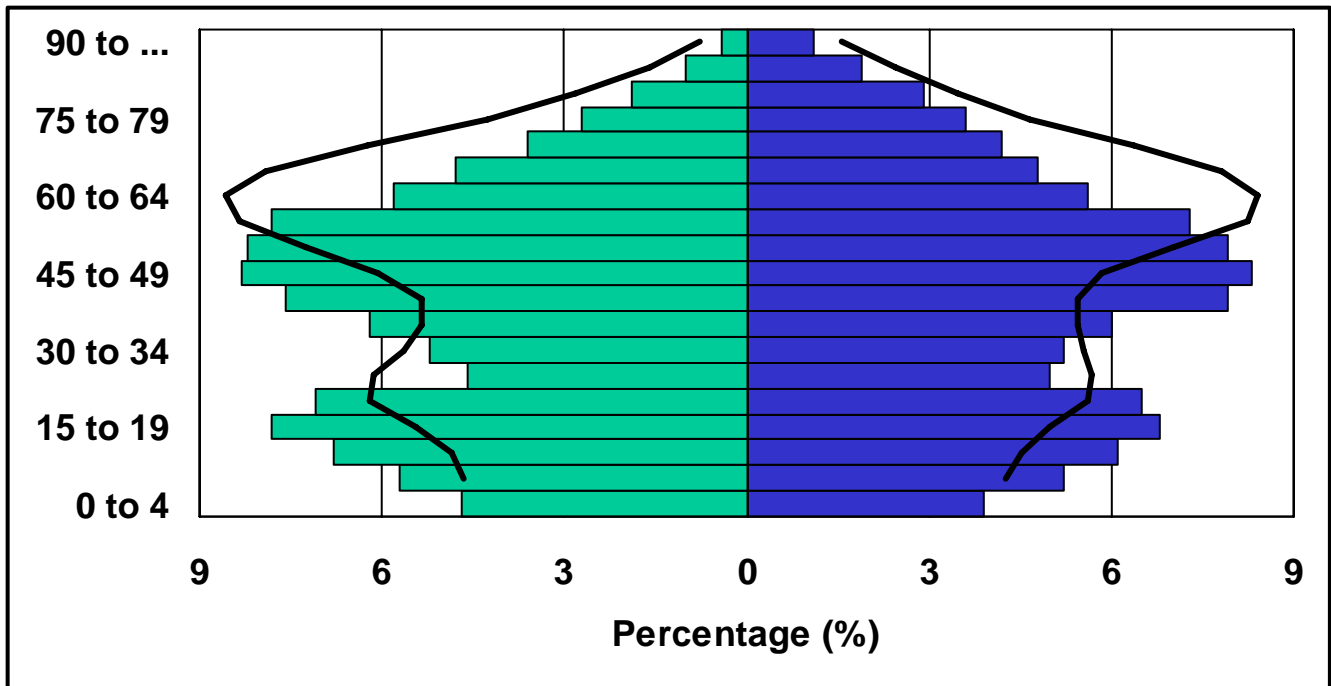
6. Population Pyramid for PCHA (DHA 6) for 2005 and 2016



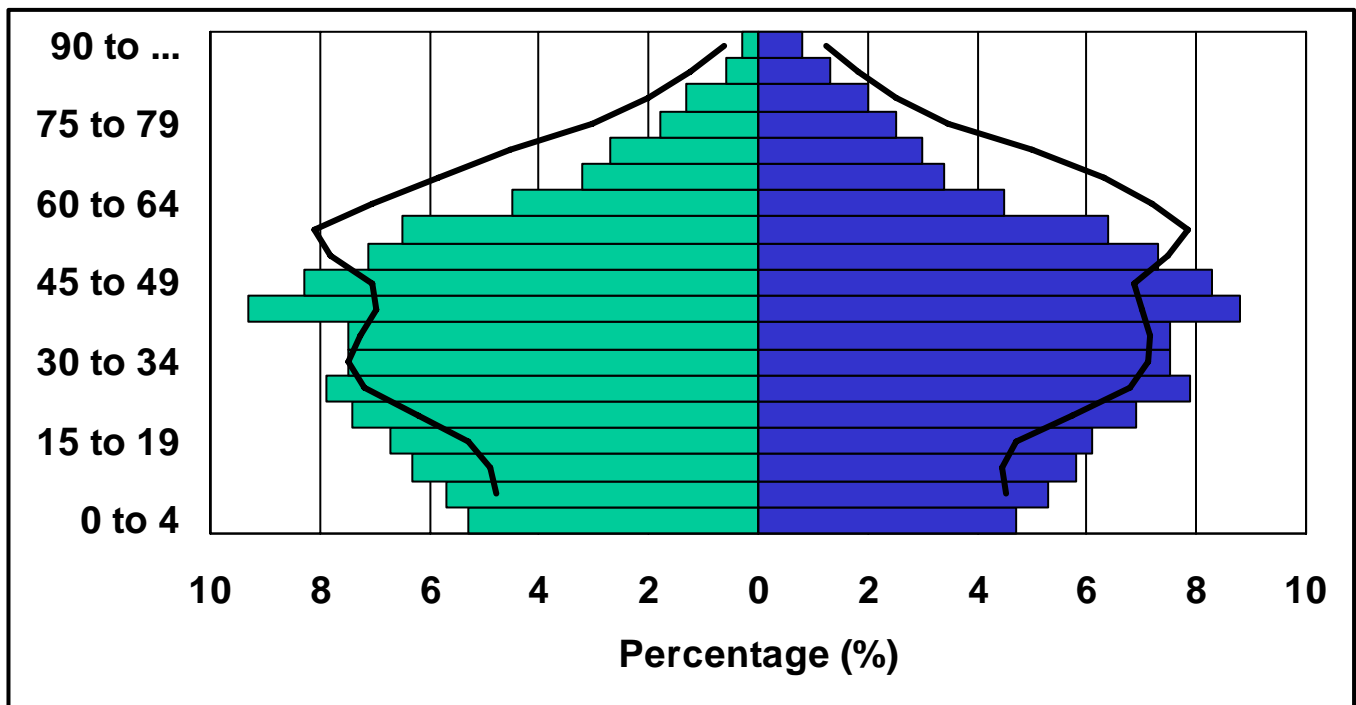
7. Population Pyramid for GASHA (DHA 7) for 2005 and 2016



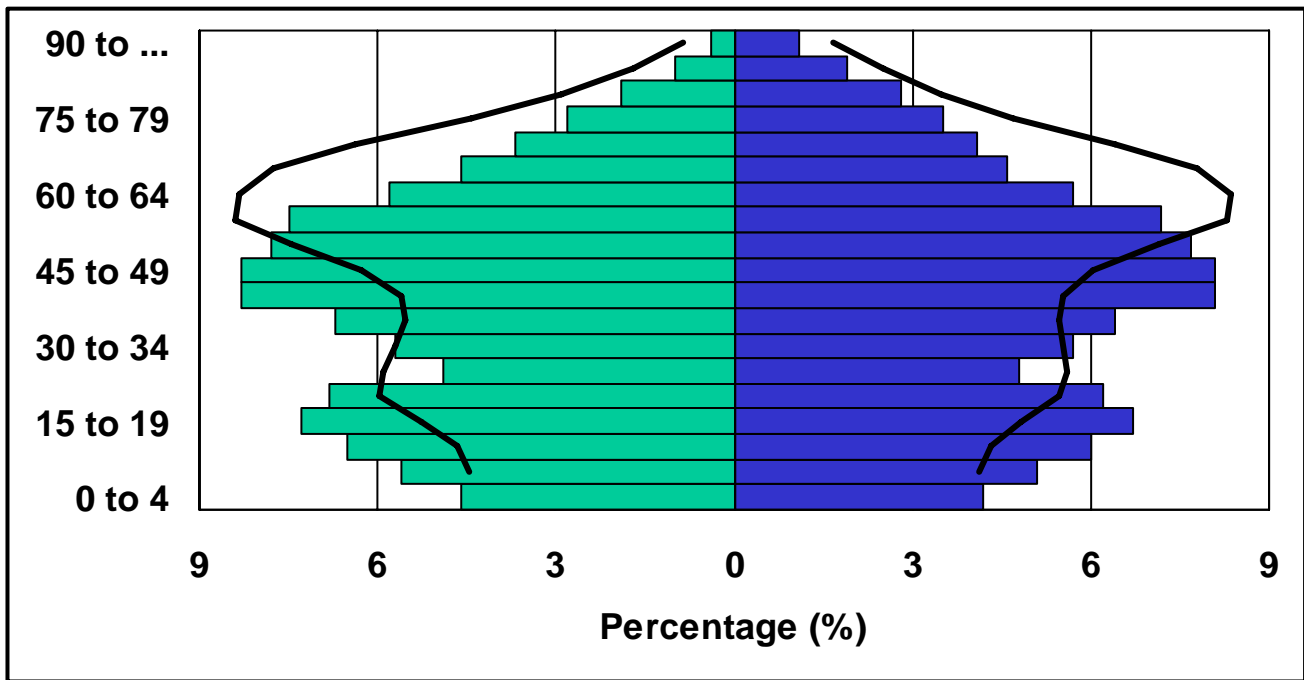
8. Population Pyramid for CBDHA (DHA 8) for 2005 and 2016



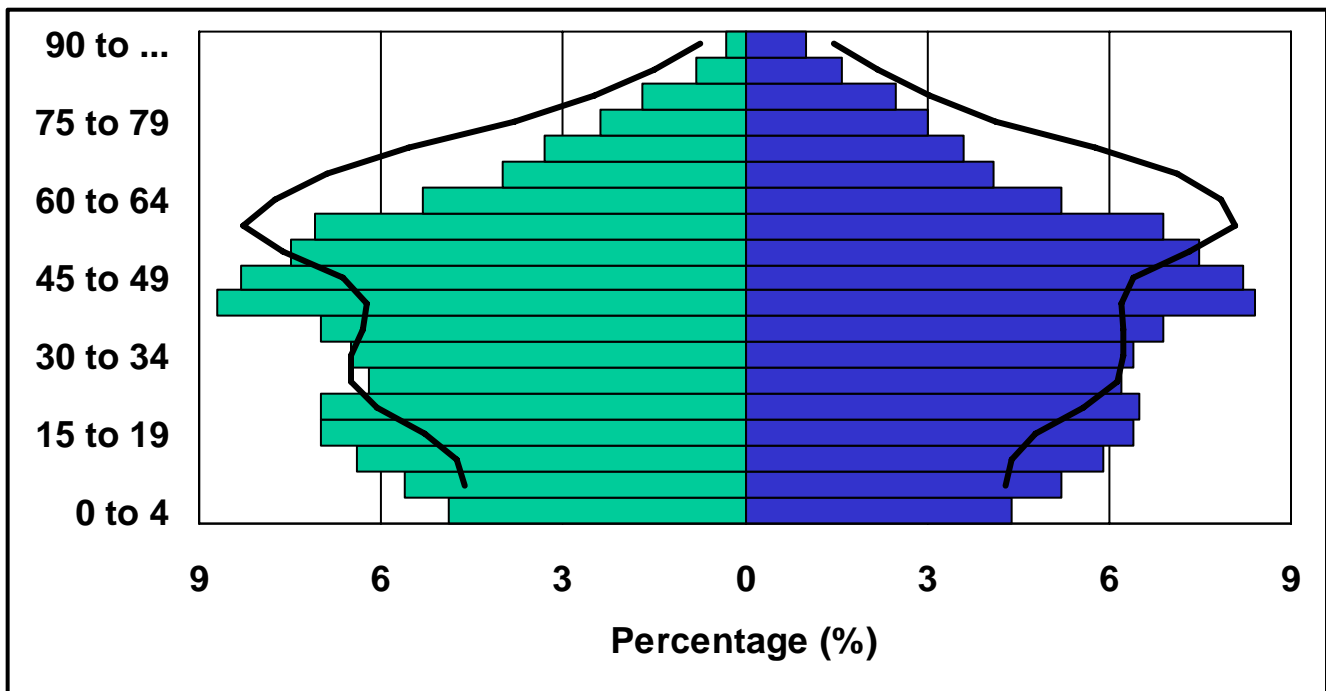
9. Population Pyramid for CDHA (DHA 9) for 2005 and 2016



10. Population Pyramid for DHAs 1 to 8 for 2005 and 2016



11. Population Pyramid for Nova Scotia for 2005 and 2016



How Did We Do?

Your comments and feedback about the “2005-2006 Annual Statistical Report” are valuable to us. Please complete this questionnaire and send it to:

2005-2006 Annual Statistical Report Feedback

Nova Scotia Department of Health

Information Analysis & Reporting

1690 Hollis Street, 3rd Floor, PO Box 488

Halifax, NS B3J 2R8

OR Fax: (902) 424 0506 OR Email: boydc@gov.ns.ca

Instructions

For each question, please put an X beside the most appropriate response. There are no right or wrong answers; we are only interested in your opinions. Individual responses will be kept confidential.

Overall Satisfaction with the Report

How did you find out about “The 2005-2006 Annual Statistical Report”



News Media



Government Alert



Internet search



Colleague / Peer



Other, please specify _____

To what extent have you read through the report?



I have read through the entire report



I have read certain chapters and browsed through the entire report



I have browsed through the entire report



I have not read any part of the report in any detail

How satisfied are you with the following aspects of the report?

- | | | | | |
|---------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| a. Clarity | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| b. Format | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| c. Use of Figures | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| d. Graphs | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| e. Level of Detail | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| f. Length of Report | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

Usefulness of the Report

Please indicate how useful you found the following sections of the report.

Section 1	<input type="radio"/> Very Useful	<input type="radio"/> Somewhat	<input type="radio"/> Not useful	<input type="radio"/> Did not read
Section 2	<input type="radio"/> Very Useful	<input type="radio"/> Somewhat	<input type="radio"/> Not useful	<input type="radio"/> Did not read
Section 3	<input type="radio"/> Very Useful	<input type="radio"/> Somewhat	<input type="radio"/> Not useful	<input type="radio"/> Did not read
Section 4	<input type="radio"/> Very Useful	<input type="radio"/> Somewhat	<input type="radio"/> Not useful	<input type="radio"/> Did not read
Section 5	<input type="radio"/> Very Useful	<input type="radio"/> Somewhat	<input type="radio"/> Not useful	<input type="radio"/> Did not read
Section 6	<input type="radio"/> Very Useful	<input type="radio"/> Somewhat	<input type="radio"/> Not useful	<input type="radio"/> Did not read
Section 7	<input type="radio"/> Very Useful	<input type="radio"/> Somewhat	<input type="radio"/> Not useful	<input type="radio"/> Did not read

Other Comments

How do you plan to use the information in this report?

What did you find most useful about this report?

What did you find least useful about this report?

Is there anything you would like to see included in future reports?

How could we improve this report for future releases?

Have you read other provinces reports? If so, how did we compare?

Reader Information

Where do you live?

- | | |
|--|--|
| <input type="checkbox"/> Nova Scotia | <input type="checkbox"/> Newfoundland |
| <input type="checkbox"/> Prince Edward Island | <input type="checkbox"/> New Brunswick |
| <input type="checkbox"/> Quebec | <input type="checkbox"/> Ontario |
| <input type="checkbox"/> Manitoba | <input type="checkbox"/> Saskatchewan |
| <input type="checkbox"/> Alberta | <input type="checkbox"/> British Columbia |
| <input type="checkbox"/> Northwest Territories | <input type="checkbox"/> Yukon |
| <input type="checkbox"/> Nunavut | <input type="checkbox"/> Outside Canada (please specify) |

What is your main position or role?

- | | |
|--|---|
| <input type="checkbox"/> General Public | <input type="checkbox"/> Health Care Provider |
| <input type="checkbox"/> Health Services / Manager Administrator | <input type="checkbox"/> Policy / Planning / Decision Support Analyst |
| <input type="checkbox"/> Board Member | <input type="checkbox"/> Educator |
| <input type="checkbox"/> Elected Official | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Government employee | <input type="checkbox"/> Policy Maker |
| <input type="checkbox"/> Student | <input type="checkbox"/> Other (specify) |

Thank you for completing and returning this questionnaire