Accountability Report
2014–2015

Department of Health and Wellness

NOVA SCOTIA

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Annual Accountability Report for the Year 2014 - 2015

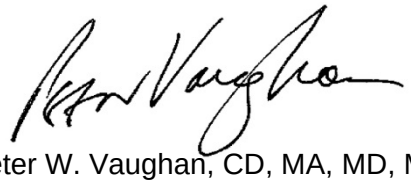
Department of Health and Wellness

Accountability Statement

The Accountability Report of the Department of Health and Wellness (DHW) for the year ended March 31, 2015, is prepared pursuant to the *Finance Act* and government policies and guidelines. These authorities require the reporting of outcomes against the Department of Health and Wellness Statement of Mandate for the fiscal year 2014-2015. The reporting of the Department of Health and Wellness outcomes necessarily includes estimates, judgments and opinions by Department of Health and Wellness management.

We acknowledge that this accountability report is the responsibility of the Department of Health and Wellness management. The report is, to the extent possible, a complete and accurate representation of outcomes relative to the goals and priorities set out in the Department of Health and Wellness 2014-2015 Statement of Mandate.

The Honourable Leo A. Glavine
Minister of Health and Wellness



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

Message from the Minister of Health and Wellness

I am pleased to present the 2014-15 Accountability Report for the Department of Health and Wellness.

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

This year, we saw the creation of the Nova Scotia Health Authority (NSHA). This marks an important change in our health system. In the past, district health authorities worked in silos, the new NSHA will ensure a streamlined approach to patient care across the province. We will see greater collaboration and greater consistency in the delivery of health services throughout Nova Scotia.

The Department is committed to modernizing health care through innovation. We have received government approval to expand the implementation of the Personal Health Record and start planning for One Person One Record; a person-centric health information system for Nova Scotia. This will establish a foundation for easier sharing of health information beyond the hospital walls into other areas of care in our communities and with Nova Scotians. Over the next year the department will work with the NSHA and the IWK to advance this important project.

It is important that we invest wisely and strategically to meet the current and future needs of our senior population. We know the demand for health care among this demographic will continue to grow over the next decade and we've already started to make changes.

In 2013, we began increasing the budget for home care support and related services. We now spend $241 million a year on home care and related services, an increase of $44 million since 2013. More recently, in February 2015, we made changes to our long-term care waitlist policy. Under the new policy, people on the waitlist can no longer refuse a bed placement and still remain on the list. This means we can support more people who need a long-term care bed sooner.

The work of our department goes well beyond treating illness through the health system. We also set healthy public policy and work in collaboration with many partners to help prevent illness and injury, and promote healthy living.

Last year, we passed Canada's first e-cigarette legislation which treats these products like tobacco. It is now illegal to sell e-cigarettes to minors, and to display or promote them in stores where minors are allowed. It is also illegal to use e-cigarettes in indoor public places and workplaces.

This spring, we became the first place in the world to implement a ban on the sale of flavoured tobacco, including menthol. These tobacco control measures will help us protect the health and safety of young Nova Scotians.

These and other changes could not have happened without the expertise and dedication of our staff, and I am proud of the work they do that benefits Nova Scotians. The department continues to be committed and focused on increasing access to health care services, and promoting healthy, active lifestyles.

Thank you,

Minister, Health and Wellness
Leo A. Glavine

2014-2015 DHW Variance Analysis - Actuals vs. Estimate

Division	2014/2015 Estimate ($ thousands)	2014/2015 Actuals ($ thousands)	Variance Estimate/ Actuals ($ thousands)
Administration	64,968.0	61,759.9	(3,208.1)
Physician Services	798,896.0	789,318.3	(9,577.7)
Pharmaceutical Services	264,869.0	263,485.9	(1,383.1)
Insured Services	32,414.0	36,043.1	3,629.1
Emergency Health Services	124,192.0	124,609.0	417.0
Continuing Care	3,101.0	3,214.6	113.6
Home Care Services	233,803.7	237,385.0	3,581.3
Long Term Care	560,094.0	554,225.2	(5,868.8)
Addictions & Mental Health	12,396.0	8,935.9	(3,460.1)
Active Living	10,563.0	11,222.5	659.5
Primary Care Program	19,340.3	15,099.1	(4,241.2)
Public Health Programs	17,459.0	15,280.5	(2,178.5)
Provincial Programs & Initiatives	134,730.0	128,429.3	(6,300.7)
Other Programs	23,405.0	23,604.3	199.3
District Health Authorities	1,710,960.0	1,735,235.0	24,275.0
Capital Grants & Amortization	93,729.0	69,096.6	(24,632.4)
Total	4,104,920.0	4,076,944.4	(27,975.6)
Funded Staff	486.9	431.5	(55.4)
Staff Funded by External Agencies	(19.6)	(12.1)	7.6
Total FTE net	467.3	419.5	(47.8)

Variance Analysis – 2014-15 – Actual compared to Estimate

The Department of Health and Wellness expenses were $28 million or 0.7 per cent lower than estimate primarily due to savings of $24.6 million in capital grants as a result of delays with major construction projects, $9.6 million in Physician Services due to utilization savings in Fee for Service and Chronic Disease Management, $5.9 million in Long Term Care due to later than planned bed openings, $6.3 million in provincial programs and initiatives due to delays and redefinition of scope in information technology projects, $4.2 million due to various project delays related to the Primary Health Information Management program, other Primary Healthcare Programs, and lower than anticipated call volumes for 811 Telecare service, $3.5 million in Addictions and Mental Health mainly due to later than planned implementation of addiction services programs and Together We Can initiatives, $3.3 million in Administration due to operational efficiencies, $2.2 million in Public Health due to lower utilization rates for vaccine programs and surpluses based on lower than projected spending in chronic disease and injury prevention initiatives, and $1.4 million in Pharmaceutical Services due to lower utilization of high cost drugs.

Overages that partially offset these surpluses included, $24.3 million in grants to District Health Authorities due to operational pressures, $3.6 million in Home Care Services due to increased utilization in nursing and caregiver benefit program, $3.6 million in Insured Services due to increased visits by Nova Scotians for hospital services in other provinces, and $1.4 million for other miscellaneous overages in Emergency Health Services, Continuing Care, Active Living, and other Programs.

The FTE variance is the result of vacancy management by the department.

2014-2015 Department of Health and Wellness Performance Measures/Outcomes

Each year, outcome measures are reviewed during the development of the Statement of Mandate. Complete reports on the measures for the 2014-2015 fiscal year can be found on the pages that follow. As this report reflects on measures established in the 2014-15 Statement of Mandate, this report does not reflect the broad system change that has occurred, namely, the consolidation of the nine former district health authorities and the creation of the Nova Scotia Health Authority (NSHA). This system change has resulted in a significant change in the department's approach to, and emphasis on, accountability for the health system.

In 2015-2016, the Department began to implement an accountability framework to better define expectations of the NSHA and the Izaak Walton Killam Health Centre (IWK). A series of key performance indicators and first year goals have been developed and will be followed by outcome-based targets. These indicators will enable the department to monitor overall system performance and our collective impact on the health of Nova Scotians.

The following measures established in the 2014-15 Statement of Mandate provide an overview of important information about health services in Nova Scotia (NS) and the health of Nova Scotians. In this report, the years in which data is available varies by measure. Some federal agencies collect data based on deadlines that differ from Nova Scotia's deadlines. In addition, the data contained in this report comes from various sources. These data sources have different reporting frequencies and time periods. Capacity to report on data in a timely fashion is constantly undergoing improvement.

As we prepare for the year ahead, a number of measures have been modified, discontinued or awaiting data.

Discontinued / Modified Performance Measures from the 2014-15 Statement of Mandate

Measures	Rationale
Modified Measure	
Percentage of gamblers who are harmfully involved in gambling and access formal treatment for gambling-related issues through Addictions Services	As part of our ongoing quality improvement, the measure was reassessed and determined to not be as robust as the previously used measure, *Problem Gambling Severity Index (PGSI)*, used for measuring problem gambling in the population. Going forward, we will be using the *PGSI* measure, which is scheduled to be publically released in 2015-16.
Discontinued Measure	
Percentage of junior high school girls active enough for health benefits: accumulating at least 60 minutes of moderate to vigorous physical activity 5 days per week	We are unable to use this indicator now, or in the future. The survey used to collect the data was not replicated for other years and therefore comparisons over time are not possible. We are exploring other options to track physical activity levels for this population, in the future.

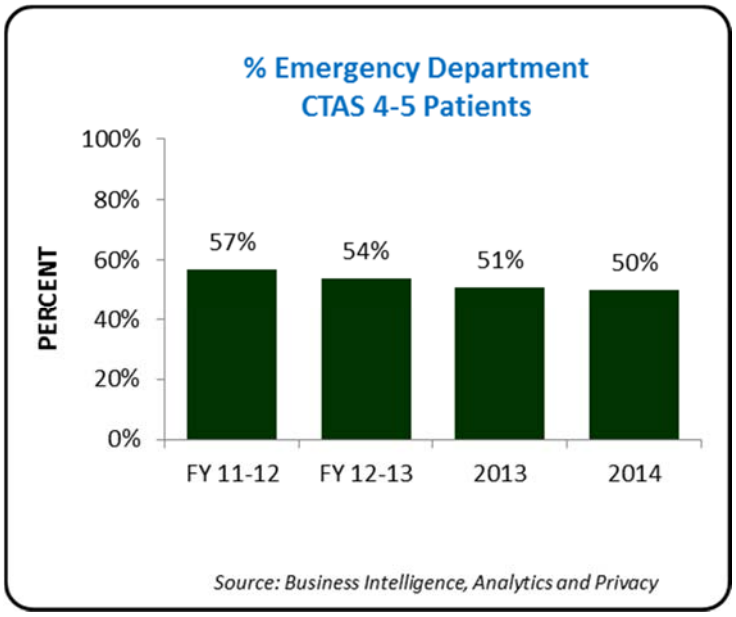
Outcome: Access to Primary Care in an Appropriate Setting

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

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

What Does the Measure Tell Us?

This measure details the volume of CTAS 4-5 patients who visit Emergency Departments (EDs) for less urgent or minor injuries in EDs across the province (Tertiary, Regional, Community, and Collaborative Emergency Centres). Some of these patients could be cared for appropriately in a primary care setting rather than the ED.



Where Are We Now?

Following a slight decline since 2011/12, the percentage of CTAS 4-5 patients being treated in the EDs across the province has remained constant in 2014 over the previous calendar year with a range of 36% to 67%.

Where Do We Want To Be In the Future?

DHW continues to work with the Nova Scotia Health Authority to work toward strengthening access to primary care, particularly in rural communities throughout the province. In doing so, DHW hopes to reduce the number of ED visits for care that could be treated in a primary care setting. Along with the Mental Health and Addictions strategy, "*Together We Can*" and the Health Human Resource Planning, further health services planning is underway to design services that best meet the needs of families and their communities, including improving primary care access.

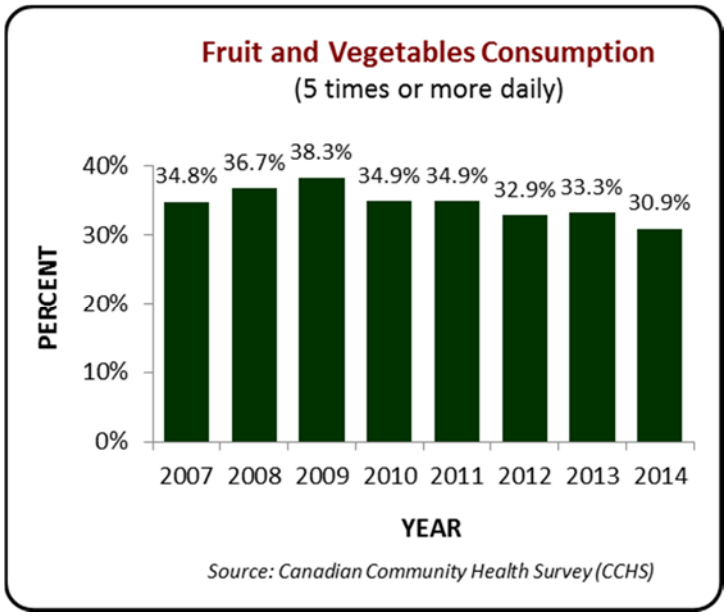
Outcome: Nova Scotians Eating Healthy

Measure: Percentage of Nova Scotia Population (12 years +) Who Report Eating Fruit/Vegetables 5 or More Times Per Day

Fruits and vegetables consumption in sufficient quantity is an important part of a healthy diet. Studies have shown that fruits and vegetables play a protective role in preventing chronic disease, including heart disease, stroke, type 2 diabetes, hypertension and many cancers.

What Does the Measure Tell Us?

This data shows the extent to which Nova Scotians (12 years +) and older are meeting their recommended consumption of fruit and vegetables per day.



Where Are We Now?

The rate for fruit and vegetable consumption in 2007 was 34.8% and there was a trend upward until 2009 (38.3%). Since then, we have observed a decline in fruit and vegetable consumption to 30.9% in 2014.

Where Do We Want to Be in the Future?

By 2015-16, Nova Scotia would like see an increase in the percentage of the population (12 years+) who report eating fruits and vegetables 5 or more times per day. The DHW aims to see a consistently increasing trend in this percentage, over the long term. The following strategies are in place to improve the outcomes for this measure over the long term:

- Continue to support implementation of the *Healthy Eating Nova Scotia (HENS)* strategy.
- Support implementation of *Thrive!* and actions related to healthy eating.
- Support research investigating diet quality of 3-5 year olds, including fruit and vegetable consumption.
- Work in partnership with Department of Agriculture and others interested in promoting vegetable and fruit consumption.

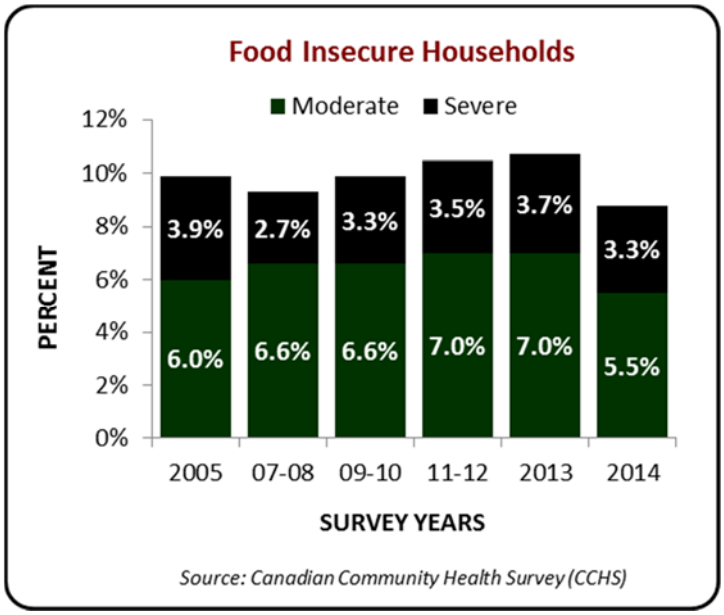
Outcome: Access to Healthy Food Choices

Measure: Percentage of Food Insecure Households

Food security, the ability to obtain sufficient food for a healthy lifestyle, is an important component to leading a healthy lifestyle.

What Does the Measure Tell Us?

This data shows the extent to which Nova Scotian households are food insecure.



Where Are We Now?

Nova Scotia has the highest rate of food insecurity in the Maritime Provinces. The rate for food insecure households has had an upward trend since 2007. When interpreting this data for trends, many years of data are needed. Although it appears that food insecurity has decreased between 2013 and 2014 from 7.0% to 5.5% for moderate and 3.7% to 3.3% for severe, it is too soon to say whether this is actually a downward trend or a yearly variation.

Where Do We Want To Be In The Future?

By 2015-16, Nova Scotia would like see a decline in the percentage of food insecure households. Strategies to achieve this target include:

- Continue to support implementation of the *Healthy Eating Nova Scotia (HENS)* strategy.
- Support implementation of *Thrive!*
- Continue to work in partnership with others interested in promoting and supporting food security.
- Continue to monitor income-related food insecurity for possible opportunities to provide support within the demands of mandate and budget, and in conjunction with other Departments/Agencies.

Outcome: Improve the Health Status of Mothers and Babies

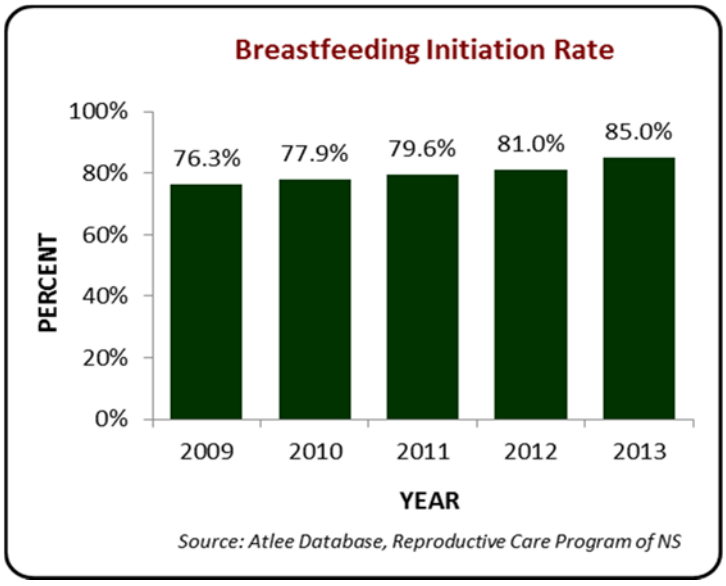
DHW aims to improve the health status of mothers and babies by increasing the breastfeeding initiation rates in Nova Scotia.

Breastfeeding supports the healthy development of newborns by: contributing to healthy brain and nervous system development; protecting babies against infectious diseases; and enhancing emotional development. Beyond infancy, the benefits continue to contribute to protection against childhood cancers, obesity, diabetes, allergy, and Crohn's disease.

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

What Does the Measure Tell Us?

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



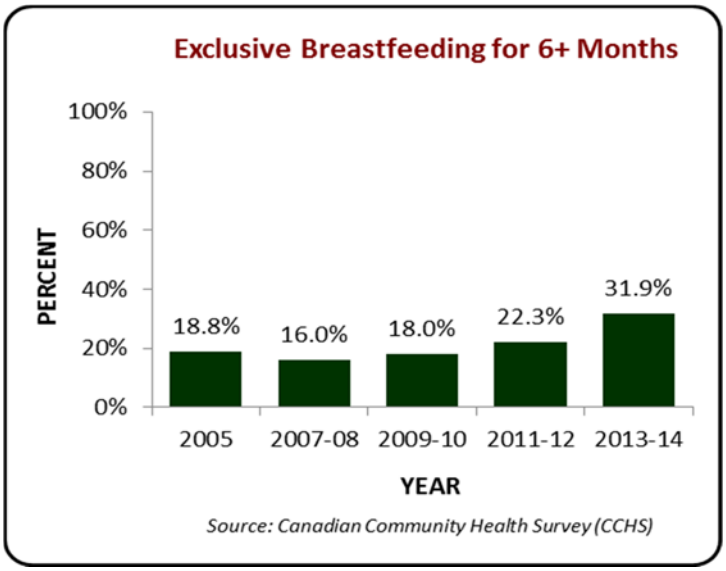
Where Are We Now?

The baseline of breastfeeding initiation for NS in 2006 was 72.7% and has shown a continuous rise to 85.0% in 2013. *The 2014 data is expected to be complete and available in fall of 2015*.

Measure B: Breastfeeding Duration Rate – Percentage of Infants Who Exclusively Breastfed for At Least Six Months

What Does the Measure Tell Us?

This data is from the Canadian Community Health Survey (CCHS). This measure is the percentage of infants who exclusively breastfed for 6 months of age.



Where Are We Now?

The percentage of mothers breast-feeding exclusively for 6 months or longer, is on an upward trend in NS. The rate in 2005 was 18.8% and in 2013-14 was 31.9%. Data from 2013 and 2014 combined was the latest statistically reliable data available.

Where Do We Want to Be in the Future?

By 2015-16, Nova Scotia aims to continue its upward trend from the base year for initiation rates and by 2016-17, continue its upward trend from the base year for exclusive breastfeeding at 6 months of age. Strategies to achieve these targets include:

- Implementation and monitoring of the Provincial Breastfeeding Policy.
- Work to ensure the components of *Thrive!* related to breastfeeding are implemented.
- Complementing work underway at the national level for promotion, protection and support for breastfeeding and the *Baby Friendly Initiative*.

Outcome: Reduce Tobacco Use

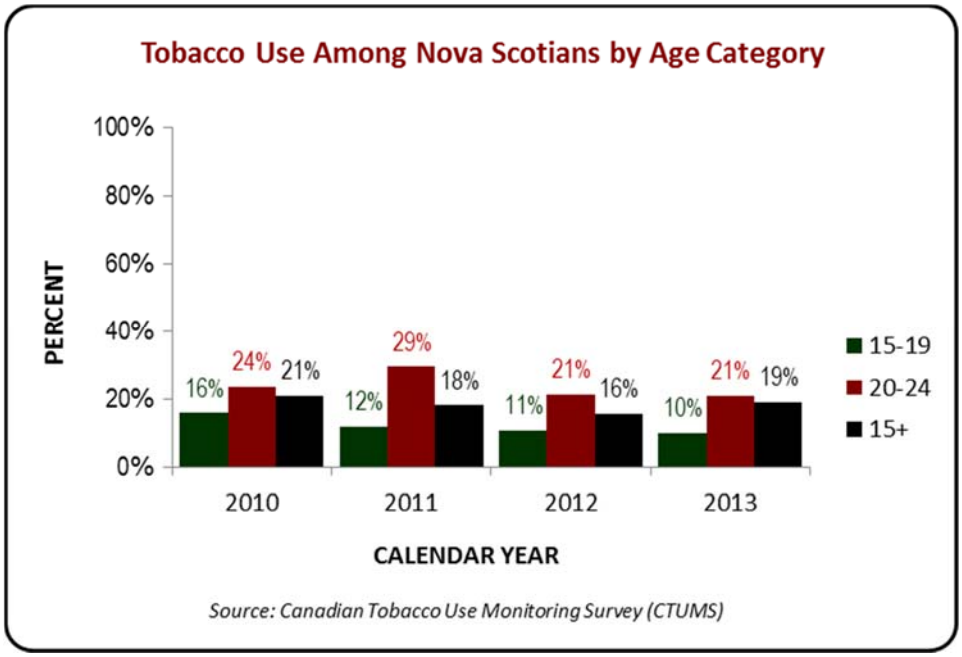
Measure: Percentage of People Who Smoke in Different Age Categories

High smoking rates translate into high rates of chronic disease. Reducing youth smoking is a key to the prevention of smoking related illnesses and to the promotion of a healthy population. Ensuring that we prevent tobacco use among children and youth is critically important. Experimentation and use at a young age increases the risk that tobacco use may continue into adult years.

The Canadian Tobacco Use Monitoring Survey (CTUMS), which is a telephone self-report survey based on the calendar year, divides smoking rates into various age ranges. CTUMS was collected annually from 1999-2012. In 2013, CTUMS was expanded to include questions regarding alcohol and drugs and it is now called Canadian Tobacco, Alcohol and Drug Survey (CTADS). CTADS had its first round of data collection in 2014 and will continue on a biennial basis moving forward. The tobacco questions are consistent with and comparable to CTUMS.

What Does the Measure Tell Us?

This measure provides us with an understanding of the prevalence of smoking in the population and gives us the ability to monitor our progress in reducing tobacco use in accordance with Nova Scotia's *Comprehensive Tobacco Control Strategy*.



Where Are We Now?

Nova Scotia has seen significant reductions in tobacco use since 1999. In recent years, declines have continued in the 15-19 year age group from 16% in 2010 to 10% in 2013. Amongst those ages 20-24 smoking prevalence was 21% in 2013. This was unchanged from 2012 but a decrease from 24% in 2010 and 29% in 2011. For the first time in several years, Nova Scotia experienced an increase in overall smoking prevalence for the entire population surveyed (those ages 15+) from 16% in 2012 up to 19% in 2013.

Where Do We Want to Be in the Future?

As of 2013, Nova Scotia has achieved its goal of reducing smoking among those 15-19 years to 10%. The province will continue to work to reduce tobacco use rates among this population. By 2015, the province aims to achieve a 20% smoking rate among those ages 20-24 and a 15% smoking rate for all Nova Scotians ages 15 years and older.

Nova Scotia's *Comprehensive Tobacco Control Strategy* will help us achieve our targets by 2015/2016 through the following actions:

- Improving sales to minors compliance rates;
- Retaining high taxes and prices on tobacco products;
- Continuing to strengthen smoke free places legislation;
- Preventing advertising by the tobacco industry.

Outcome: Reduce High Risk Alcohol Consumption

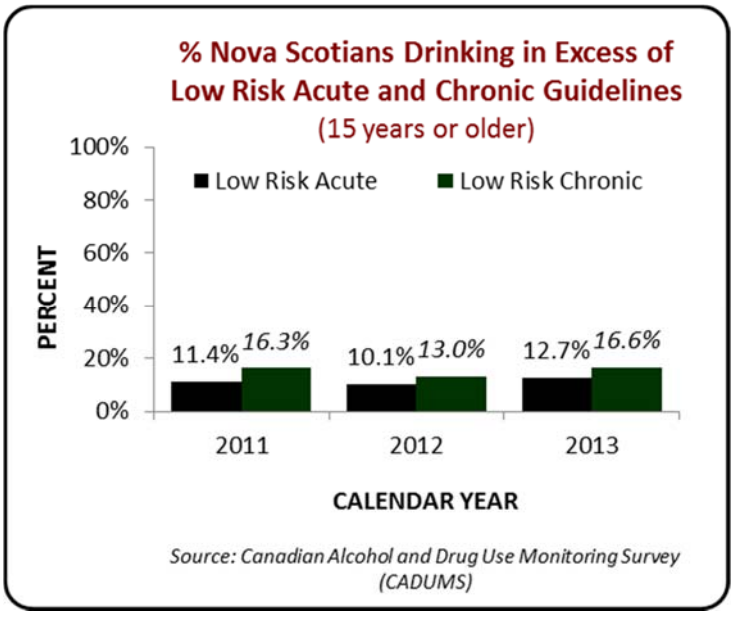
Measure: Percentage of the Nova Scotians Population 15 Years and Older Who Drink in Excess of the National Low Risk Chronic and Low Risk Acute Guidelines

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

The Canadian Tobacco, Alcohol and Drugs Survey (CTADS) is a biennial general population survey of tobacco, alcohol and illicit drug use among Canadians aged 15 years and older. It replaces the Canadian Tobacco Use Monitoring Survey (CTUMS) which was conducted from 1999-2012 and the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) which was conducted from 2008-2012. The CTADS merged the core tobacco content from CTUMS and the core drug and alcohol content from CADUMS. Caution is encouraged when comparing between survey results.

The first biennial CTADS data collection commenced in February 2013 and ended in December 2013. The CTADS is conducted by Statistics Canada on behalf of Health Canada

What Does this Measure Tell Us?



CTADS included the prevalence of those consuming alcohol in excess of the National Low Risk Alcohol Drinking Guidelines (the "Guidelines"). Within these Guidelines are two risk groups, acute and chronic. Acute risk refers to the risk for immediate injury such as, but not limited to, sexual violence, motor vehicle collisions, and physical violence, while chronic risk refers to risk for chronic disease such as, but not limited to, various types of cancers and heart disease. The 2013-14 DHW Statement of Mandate (SoM) focused on increasing the prevalence of those drinking within the Guidelines. However, the targets were changed in the 2014-15 SoM to focus on decreasing the prevalence of those drinking in excess of the Guidelines, to match the presentation of survey results.

Where Are We Now?

The rates for Nova Scotians drinking in excess of low risk acute and low risk chronic guidelines both increases from 2012. Both Nova Scotian rates were also slightly above the national rates (11.3% national versus 12.7% Nova Scotian for low risk acute, 15.7% national versus 16.6% Nova Scotian for low risk chronic).

Where Do We Want to Be in the Future?

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

There will be a continued focus on reducing the percentage of Nova Scotians 15 years and older who indulge in high risk alcohol consumption (i.e. in excess of national low risk guidelines).

Outcome: Better Access to Emergency Care in Tertiary, Regional, and Community Hospital Emergency Departments (EDs)

Measure: Percentage of Canadian Triage and Acuity Scale (CTAS) patients with total length of stay in the Emergency Department (ED) from triage to ED departure within the parameters Emergency Care Standards:

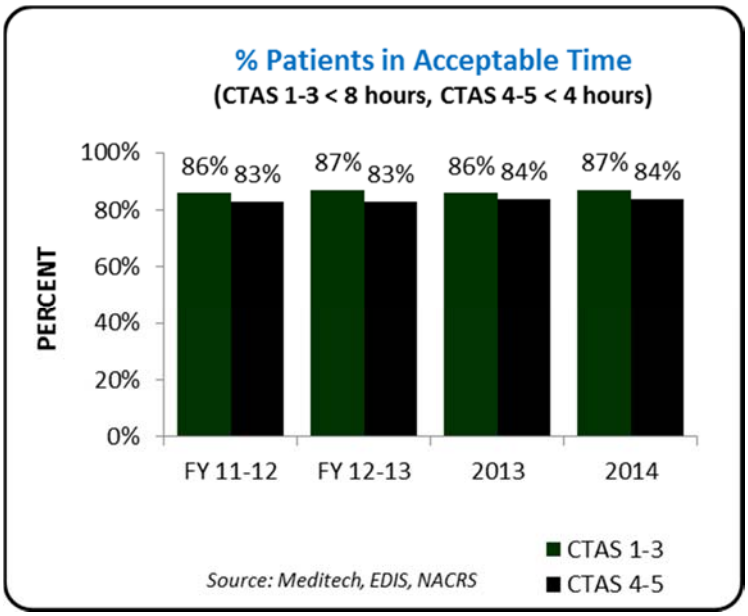
A. Within 8 hours for CTAS 1-3 patients

B. Within 4 hours for CTAS 4-5 patients

The Department of Health and Wellness (DHW) has established the Emergency Care Standards. The measures included here are a component of these standards which are currently being implemented in all Emergency Departments (EDs) across the province and address issues related to access and triage, staffing qualifications, quality and safety, patient satisfaction and performance.

What Does the Measure Tell Us?

These measures indicate the length of stay for ED patients based upon the severity of a patients' condition in all EDs across the province (Tertiary, Regional, Community, and Collaborative Emergency Centres).



STANDARD A
Length of Stay within 8 Hours for CTAS 1-3 patients

- CTAS 1 refers to patients with a life- or limb-threatening condition;
- CTAS 2 refers to patients with severe pain or unstable vital signs;
- CTAS 3 refers to patients with moderate illness that may require tests.

Patients who are triaged in CTAS 1-3 may require more complex care which may include tests and specialist consultations. Therefore, to meet this Standard, these patients must be admitted to hospital or discharged from the ED within 8 hours of triage.

STANDARD B
Length of Stay within 4 Hours for CTAS 4-5 patients

- CTAS 4 refers to patients who have a possible bone fracture or large cuts;
- CTAS 5 refers to patients with a minor illness or injury;

Patients who are triaged in CTAS 4-5 often require less complex care and to meet this Standard, these patients must be admitted or discharged from the ED within 4 hours of triage.

Where Are We Now?

For the calendar year 2014, the percentage of patients triaged as CTAS 1-3 with a length of stay within 8 hours improved over the previous calendar year from 86% to 87% with a range of 82% to 98%.

For the calendar year 2014, the percentage of patients triaged as CTAS 4-5 with a length of stay within 4 hours remained constant over the previous calendar year at 84% with a range of 79% to 99%.

Patient flow issues (or the ability of the health system to enable patients to access different kinds of health services in a timely manner) continue to impact length of stay in emergency departments. Over the past year health care providers and administrators have worked diligently to address patient flow across the health system.

Where Do We Want To Be In the Future?

Aligning with the Emergency Care Standards, our goal is to ensure that the total length of stay in the ED from triage to departure (hospital admission or discharge) for CTAS 1-3 patients should be 8 hours or less 90% of the time and 4 hours or less for CTAS 4-5 patients 90% of the time. While many health care facilities are achieving this standard, there is still work to be done to improve length of stay in the province. Length of stay in the ED is often an indicator of larger system patient flow issues and as such, DHW, along with the Nova Scotia Health Authority and the IWK, are working collaboratively to address patient flow issues throughout the health care system.

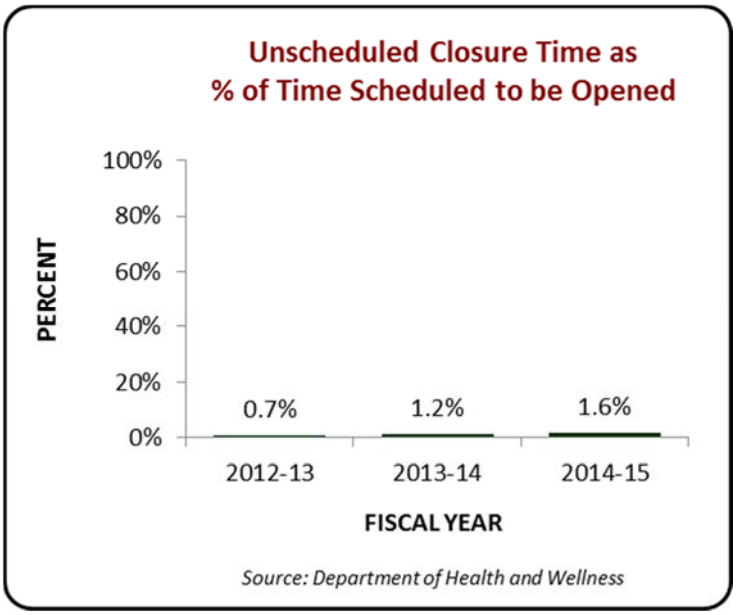
Outcome: Access to Appropriate Care in Collaborative Emergency Centres (CECs) When Needed

Measure: Unscheduled closure time for Collaborative Emergency Centres (CEC)

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

What Does the Measure Tell Us?

This measure counts the total number of unscheduled hours that CECs were closed during 2014-15. This tells us the number of hours that residents could not access care in their local facility.



Where Are We Now?

Over the 2014-15 fiscal year, eight CECs were opened. During that time, they experienced a cumulative total of 995 unscheduled hours of closure out of a possible 62,172 total eligible hours. In other words, CECs were closed 1.6% of their scheduled open hours. Conversely, CECs were open 98.4% of their scheduled hours.

Where Do We Want To Be In the Future?

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

Outcome: Improved Mental Health Outcomes

Measure: Percentage of Adult and Child/Adolescent Mental Health Clients Seen Within the Provincial Wait Time Standard

What Does the Measure Tell Us?

Timely access to services is important in supporting people living with mental illness in their communities. Monitoring how long patients have to wait to be seen for mental health services is an indicator of where we need to focus our efforts.

Where Are We Now?

In the 2014-15 Statement of Mandate the former Health Authorities and the Izaak Walton Killam Health Centre (IWK), with the exception of former Capital Health (now Central Zone), presented Wait Time data for children/youth and adults based on level of urgency (urgent, semi-urgent and regular). Former Capital Health presented data based on the median and 90th percentile of the actual times waited.

Midway in 2014-15, these indicators were changed to more consistently align with Provincial Standards. Since the change occurred mid-year and the former Health Authorities were in the process of adapting to the new provincial focus of data collection, the quality and comparability of data have been deemed inadequate to properly report on the measure for this Accountability Report.

However, Mental Health wait time data (using the Provincial Standards), for Adults and Children/ Adolescents is currently available to the public at: http://waittimes.novascotia.ca/categories-procedures/89358

Where Do We Want To Be In the Future?

As part of continuous quality improvement, Mental Health Children's Services and Addictions (MHCSA) branch have been working towards a provincial mental health and addictions information system to streamline data collection and reporting on mental and addictions system. Recent restructuring from nine districts to the one Nova Scotia Health Authority and the IWK, provides them an opportunity to move forward with that plan. This is in keeping with Auditor General's recommendations and Mental Health Strategy-*Together We Can,* to improve mental health and addictions system in NS.

Outcome: Access to Health Information is Available

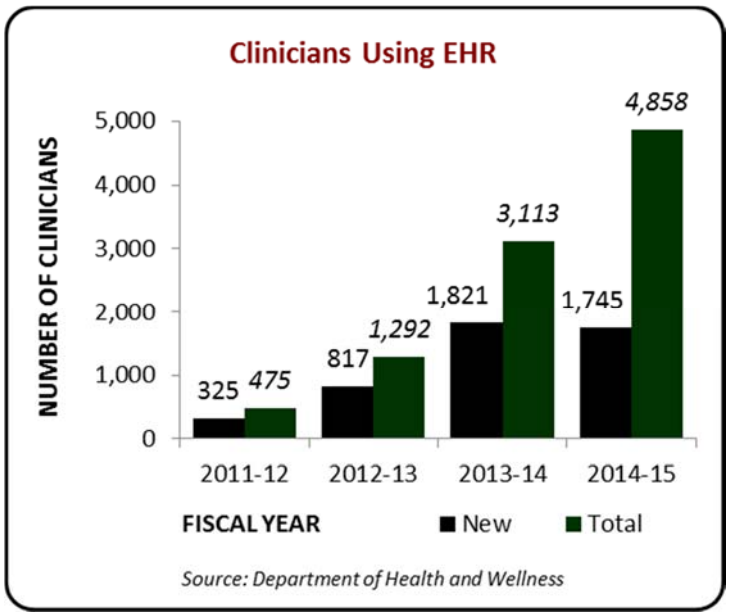
Measure: Electronic Health Record (EHR) Initiative – Number of Clinical Users of Secure Health Access Record (SHARE)

SHARE is a secure and private lifetime record of an individual's health and care history. Access to this information by health care providers will allow for better care and faster treatment for patients in Nova Scotia.

The Department of Health and Wellness (DHW) continues to collaborate with the Nova Scotia Health Authority (NSHA) and the Izaak Walton Killam Health Centre (IWK) on the continued adoption and roll-out of the SHARE Provider Viewer and Clinical Repository. The number of clinicians who are using SHARE is a good measure of the success of the EHR.

What Does the Measure Tell Us?

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



Where Are We Now?

As of March 31, 2015 we have 4858 Clinical Users on SHARE, which is an increase of 1745 Clinical Users from March 31, 2014.

Where Do We Want to Be in the Future?

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

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

DHW aims to have an additional 500 Clinical Users on SHARE by the end of fiscal 2015-2016 resulting in a target of 5358 Clinical Users on SHARE by March 2016.

Appendix A

Annual Report under Section 18 of the *Public Interest Disclosure of Wrongdoing Act*

The *Public Interest Disclosure of Wrongdoing Act* was proclaimed into law on December 20, 2011.

The Act provides for government employees to be able to come forward if they reasonably believe that a wrongdoing has been committed or is about to be committed and they are acting in good faith.

The Act also protects employees who do disclose from reprisals, by enabling them to lay a complaint of reprisal with the Labor Board.

A Wrongdoing for the purposes of the Act is:

a) a contravention of provincial or federal laws or regulations

b) a misuse or gross mismanagement of public funds or assets

c) an act or omission that creates an imminent risk of a substantial and specific danger to the life, health or safety of persons or the environment, or

d) directing or counseling someone to commit a wrongdoing.

Please use the following format to satisfy the disclosure obligation:

The following is a summary of disclosures received by the Department of Health and Wellness

Information Required under Section 18 of the Act	Fiscal Year 2014-2015
The number of disclosures received	0
The number of findings of wrongdoing	0
Details of each wrongdoing (insert separate row for each wrongdoing)	Not Applicable
Recommendations and actions taken on each wrongdoing (insert separate row for each wrongdoing)	Not Applicable

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Health and Wellness