
# Department of Health

## 2002-2003 Business Plan

**April 4, 2002**

# Table of Contents

**Priorities of 2002-03 Cont.**

# 1. Mission

***Through leadership and collaboration,***
***to promote, maintain, and improve the health of Nova Scotians and***
***ensure an appropriate and affordable health care system.***

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

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

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

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

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

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

Our Mission requires that all health care and services be:

- Integrated
- Community-Based
- Sustainable

# 2. Planning Context

## 2.1 Introduction

Through its election platform, business plans and budget, the Government of Nova Scotia has articulated a policy direction which provides an important context for the mission, strategic priorities and core business functions of the Department of Health. In its statement of direction and priorities for 2002-2003, the Government set a goal to "put crucial services -- health, education and social services -- on a sustainable foundation. The sustainability of Nova Scotia's health system is key to the Government's overall social and fiscal policy objectives.

This business plan integrates the budget of the Department of Health with its priorities for health status improvements, health care and service delivery, human resource planning and management, communications, information management, and outcomes.

## 2.2 Health Care Spending

According to the Canadian Institute for Health Information (CIHI), Nova Scotia's per capita health care expenditures are the second lowest among the Canadian provinces. However, as a proportion of total provincial government program spending (less debt service), Nova Scotia allocates the *2nd highes*t level of funding to health care (38.8%). In 2000, Nova Scotia had the 5*th highest* level of health care spending as a percentage of gross domestic product (GDP).

Following a five year transition from the Expanded Programs Financing (EPF) and the Canada Assistance Plan (CAP) Programs, 2001/02 was the first year for full implementation of the equal per capita funding formula for the Canada Health and Social Transfer (CHST). If transfer payments had been maintained at the 1994/95 levels, the province would have received an additional funding amount of close to $1 billion over the six year transition period. The level of federal contribution has declined from 18% under EPF and CAP to approximately 14% of social services, education and health spending with the CHST.

## 2.3 Health Cost Drivers

The proportion of persons aged 65 years and over in the population has increased from 9% in 1966, to 12% in 1986, and is forecast to increase to 18.5% by 2016. Conversely, the proportion of the population of children and infants is decreasing (11.3% of the population in 1966, 6.8% in 1986 and is forecast to decrease to 5.1% by 2016). With an aging population, there is increasing pressure to expand the basket of publicly insured services to include, for example, home care, long term care, pharmaceuticals and health promotion activities. It is expected that the financial impact of this shift in the age of the population will not be felt until at least the mid 2020s and will likely be temporary, reflecting the constantly changing demographic landscape.[1]

In comparison to other provinces, Nova Scotia has the:

- second lowest provincial life expectancy at birth
- second highest level of years life lost for cancer
- second highest for respiratory illnesses and third highest for heart diseases
- highest rate of persons with disabilities
- third highest rate of deaths due to lung cancer; highest for breast cancer; highest (provincial) rate of death for respiratory illness and all cancer
- second highest prevalence rate of diabetes, highest rate of high blood pressure

[1] *Health Policy Research Bulletin*, Vol#1 Issue 1, March 2001, Health Canada

- highest rate of smokers in the country
- highest risk in the country for depression; second highest in the country for high life stress.

This extraordinary burden of illness and disability is directly related to the health system cost pressures. The health care system in the province is a major employer of Nova Scotians. Health care is a labour intensive service and is sensitive to fluctuations and cost pressures associated with the labour market; specifically, the workforce of health care professionals. The health expenditure cuts or freezes occurring in the mid 1990s were achieved in part by wage cuts or freezes. Recent labour negotiations were driven in part by demands to offset the limits placed on compensation which has played a role in the recent increases in health care expenditures. Highly competitive labour markets have the potential to drive further increases in wages and other incentives.

## 3. Strategic Directions

After an internal and external consultation and analysis process, the Department of Health has set the following strategic directions for itself and for the provincially funded health system in 2002-2003 and beyond:

- Design and implement a plan for continuing care which addresses integration, sustainability and accountability.

- Develop and implement a broad based health human resource strategy.

- Develop and implement a strategy to ensure the accountable provision of quality and integrated health services by District Health Authorities (DHAs).

- Design and implement a primary health care system that meets the needs of Nova Scotians.

- Implement a management strategy to address capital issues as related to information, equipment and facilities.

- Develop policies and standards that promote health and prevent illness based on evidence, best practice, and intersectoral collaboration.

- Develop and implement a plan for the care of mentally ill adults, youth and children.

- Identify strategies which facilitate improved disease management across the continuum of health care and service.

# 4. Core Business Areas

## 4.1 Population Health and Primary Health Care

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, health services, culture and gender. The goals of a population health approach are to maintain and improve the health status of the entire population and to reduce inequities in health status between population groups.

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

Population Health and Primary Health Care provides leadership, direction and support to the following services:

Addiction Services comprise a menu of components that are available according to the individual's needs and readiness. Services are delivered by the DHAs and include:

- Withdrawal management (detoxification and treatment orientation programs)
- Community based programs (outpatients and structure treatment)
- Prevention and community education (in schools, workplaces and communities)
- Problem gambling (specialized services including prevention and education)

Tobacco Control works in partnership with many other groups to implement a comprehensive tobacco strategy for Nova Scotia. Elements include taxation, legislation, treatment/cessation programs, community-based programming, youth smoking prevention initiatives, media awareness and evaluation. The provincial *Tobacco Access Act* and federal *Tobacco Act* are enforced through ongoing education and support in the community. Aspects of enforcement include retailer visits, signage and education.

Public Health Services are delivered to Nova Scotians through the DHAs. The staff works in partnership with communities, families and individuals to prevent illness, protect and promote health and achieve well-being. Activities are directed at an entire population, priority sub-populations or individuals in some circumstances. Major functions include population health assessment, health surveillance, population health advocacy, health promotion, disease/injury prevention, and health protection.

Primary Health Care provides policy and planning support to re-designing a community-based primary health care system for Nova Scotia. Changes might include for example: increasing the number of community based primary health care organizations, more interdisciplinary teams, better linkages to other parts of the health care system and increased emphasis on health promotion. The currently operating Strengthening Primary Care in Nova Scotia Communities Initiative is piloting new ways to fund, deliver and manage primary care in four Nova Scotia communities using collaborative practice between nurse practitioners and physicians, electronic information systems and alternatives to fee for service payment for physicians.

### 4.2 Mental Health Services

Mental Health services are funded by the Department of Health and delivered by nine DHAs and the IWK Hospital. They administer a network of 50 community based clinics, inpatient beds, day treatment centres, clubhouse psychosocial rehabilitation programs and adult and youth drop in centres. The services are part of a continuum of care at the community level. All of these services are consumer and family focused.

Each of the DHAs and the IWK offer acute psychiatric care. Specialized services including forensic, children and youth, psychogeriatric and psychosocial are both hospital and community-based. Mental health services also include early intervention programs for children and youth deemed at risk, intersectoral initiatives for children and youth, specialized long term rehabilitation programs, programs for sex offenders and consultation services.

### 4.3 Acute and Tertiary Care

Acute or hospital care is comprised of secondary and tertiary care services delivered by the 9 DHAs and the IWK Health Centre. Acute Care is delivered in thirty-seven (37) facilities which are governed and managed by the DHAs. Funding is provided by the Department of Health in accordance with the *Canada Health Act* and the *Health Services and Insurance Act*.

Each District has Community and District facilities with services which vary according to the type and level of emergency care provided, the hours of operation and access to ambulatory care provided, and the type and level of service provided to their inpatient populations. Inpatient services range from general practitioner services at the community facility level through to varied specialist services at the district level. Specialist services in district hospitals may include Cardiology, Respirology, Gastroenterology, High Risk Obstetrics, Otolaryngology, Orthopaedics, Ophthalmology, Pathology, Psychiatry, Pediatrics, Urology, Plastics, Maxillofacial Facial Surgery, Oncology, Neurology, dermatology and Endocrinology.

The Queen Elizabeth II Health Sciences Centre and the Izaak Walton Killam Hospital in Halifax are the two PHCCs. These centres provide specialized services such as Neurosurgery, Specialized Pediatrics, Burn ICU, Cardiac Surgery, Transplantation Programs,

Cardio-Thoracic Surgery, Immunology, and Hematology, as well as all the services available in the community and district facilities. The PHCCs also provide the highest level of emergency services.

### 4.4 Insured Health Programs

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

Other publicly funded health programs include Seniors and other pharmacare programs, a childrens dental program, and other services for specific populations such as optometry, prosthetics and dental surgery.

### 4.5 Emergency Health Services

Emergency Health Services (EHS) is the division of the Department of Health which is responsible for the continual development, implementation, monitoring and evaluation of pre-hospital emergency health services for the province. Since 1995, the ambulance system has undergone a transformation from primarily a transportation system to a pre-hospital medical system with a province-wide fleet of well equipped ambulances. The ambulances are staffed by registered paramedics who perform life saving procedures and can administer a wide range of medications.

The main components of EHS are a communications centre, a ground ambulance service, an air medical transport program (EHS LifeFlight), a provincial trauma program, and the Atlantic Health Training and Simulation Centre. All system components are monitored by physicians specially trained in emergency care.

### 4.6 Continuing Care Services

Continuing Care is a system of delivering an integrated continuum of health and social services to support the independence and well being of individuals with an identified need. Services include: nursing homes, homes for the aged, residential care facilities, small option homes, community residences, adult protection, home oxygen and acute and chronic home care services. In most cases, the need for care and support is long term, however, short term needs are also met through the home care program. The Department of Health is primarily responsible for services to seniors but younger adults are also served through our nursing homes, home care services and adult protection programs.

The Continuing Care Program has three main components:

- Administration - Provides executive and operational management functions for Continuing Care services including planning, budgeting, human resource and support activities.
- Assessment/Coordination Services - Performs intake, assessment, service planning, resource authorization and ongoing case management functions on behalf of Continuing Care clients ensuring that appropriate services are identified, implemented and monitored.
- Care Services - The health care and support services available to individuals through Continuing Care programs include nursing care, personal care, home support, rehabilitation, respiratory therapy services, palliative care and respite. Care may be provided in a client's home or in a facility where the client is accommodated.

4.7 Provincial and Other Health Programs

The Department of Health funds a number of arms-length agencies which plan and coordinate service delivery and standards-setting to ensure consistency and quality of care and service delivery. Agencies such as Cancer Care Nova Scotia, the Nova Scotia Trauma Program, Diabetes Care Nova Scotia and the Reproductive Care Program bring together experts in care provision to establish standards based on best practice, research evidence and stakeholder input. Through these agencies, strong networks of professionals participate in the rapid transmission and uptake of new knowledge and standards. Data are collected to enable monitoring of compliance with standards and outcomes of service delivery.

In keeping with its mission, the Department also provides grants and funding to a variety of agencies and organizations across the province to provide advocacy and specific health related services to targeted populations.

## 5. Priorities for 2002-2003

The following are the priorities of the Department of Health and the health system for 2002-2003. They are categorized by Strategic Direction (see Section 3). These priorities are important, not because of the relative size of the budget associated with any one of them, but because each represents an essential component of the strategic direction under which they fall. Their accomplishment is critical to the Department's achievement of its mission.

5.1 Design and implement a plan for continuing care which addresses integration, sustainability and accountability.

*5.1.1* Implement single entry access (SEA) to home care, long term care and adult protection services across Nova Scotia. SEA begins with client intake through a single toll-free telephone number and is supported by an integrated and automated information management system for intake, assessment and wait list management functions. SEA will make it simple and fair for people in need of care and their families to access the right level of care.

*5.1.2* Develop and apply a rigorous and evidence-based methodology for determining the optimum size, scope, contribution and distribution of continuing care services across Nova Scotia. (Health Services Planning, Phase 2).

*5.1.3* Build capacity among current long term care providers for dealing more appropriately and effectively with resident behavioral issues.

*5.1.4* Develop and implement an approach to predicting and managing home care service growth through contracted agencies which ensures the continued sustainability of the home care program.

*5.1.5* Develop an appropriate, consistent and equitable funding formula for the residential long term care sector.

*5.1.6* Develop and implement a process to transfer service delivery of the departmentally administered home care programs to the governance and administration of the DHAs.

*5.1.7* Develop and implement a process for the integration of the Department of Health's long term care sector with the DHAs through the establishment of affiliation agreements.

5.2 Develop and implement a broad based health human resource strategy.

*5.2.1* Develop, pilot, recommend and oversee the implementation of a comprehensive physician resource plan for Nova Scotia. The Physician Resource Planning Steering Committee has a mandate to develop and apply a rigorous methodology for determining the optimum number and geographic distribution of physicians by type of services (general practice and specialties) and by level of service (primary care, hospital-based, academic, etc.).

*5.2.2* Develop and implement short term strategies aimed at recruiting and retaining health professionals and, where possible, "repatriating" Nova Scotian health professionals from other provinces, other countries and other careers.

*5.2.3* Lead an interprovincial collaborative effort aimed at maximizing efficiency and effectiveness of health human resources planning among the four Atlantic provinces.

*5.2.4* Conduct a comprehensive study of alternate physician payment models, examining the strengths and weaknesses of each in terms of recruitment, retention, payment basis, scheduling, and other relevant factors.

*5.2.5* Continue with implementation of a comprehensive provincial nursing strategy. Emphasis on continuing and specialty education, orientation, recruitment, cooperative learning experiences and bursary programs will remain and be enhanced, where feasible. New initiatives such as RN re-entry to practice, leadership development for clinical and managerial practice, and review of entry level competencies will be considered.

5.3 Develop and implement a strategy to ensure the accountable provision of quality and integrated health services by District Health Authorities (DHAs).

*5.3.1* Develop a funding methodology for DHAs which ensures equity and consistency based on intensity of the service delivered and on the burden of illness in the population served.

*5.3.2* Study the current DHA governance and service delivery structure in terms of its efficiency, effectiveness and sustainability for the future. The study will include the identification of "best practices" in similar organizations in other jurisdictions and an assessment of the potential for further sharing of administrative and clinical support services.

*5.3.3* Continue the health services planning process[2] by initiating Phase 3 planning for primary care, ambulatory care and emergency services.

*5.3.4* Provide leadership to DHAs to establish a review of clinical pharmacy practices to identify and eliminate any unnecessary duplication and improve drug utilization practices.

*5.3.5* Work with Community Health Boards (CHBs) and DHAs to clarify and further develop their respective roles and functions to better reflect those anticipated in the *Health Authorities Act*.

*5.3.6* Develop a policy framework and consistent provincial approach to revenue generation by DHAs in connection with their provision of non-insured services.

*5.3.7* Continue to expand the Province's capacity for renal dialysis to cope with the growing demand for this critical service.

[2] Phase1 (hospital/acute care services) was completed in February, 2001.
Phase 2 (continuing care services) will be completed in 2002.
Phase 3 (primary care, ambulatory care and emergency services) will commence in 2002.

*5.3.8* Improve access to orthopedic services in northern Nova Scotia through support for an expanded orthopedic program at the Pictou County DHA.

*5.3.9* Increase DHA operational funding by 10% and allocate it across the DHAs on the basis of current needs and demonstrated efficiencies.

*5.4.0* Develop an accountability framework for DHAs which meets the requirements of the *Health Authorities Act* and which is focused on service quality, resource utilization management, standards development, monitoring processes, financial accountability, and outcomes.

5.4 Design and implement a primary health care system that meets the needs of Nova Scotians.

*5.4.1* Develop and implement a community-based primary health care system for Nova Scotia though the work of a broad based advisory committee and task teams working on such things as provider roles, funding, linkages, governance, etc.

*5.4.2* Continue funding and supporting the four primary care demonstration sites in Springhill, Pictou, Caledonia and north end Halifax.

*5.4.3* Determine the effectiveness and efficiency of a primary health care model for rural and remote communities. Supported by an off-site physician, Long and Brier Islands will pilot a collaborative and community-based approach involving an on-site nurse practitioner and paramedic providing primary care.

*5.4.4* Recruit nurse practitioners to work in primary health care settings in Nova Scotia.

5.5 Implement a management strategy to address capital issues as related to information, equipment and facilities.

*5.5.1* Continue implementation of the Hospital Information Systems (hIS) project to satisfy the need for timely and relevant clinical and management information for evidence-based decision-making.

*5.5.2* With funding participation from Health Canada, continue support of Health Infostructure Atlantic (HIA) in its development of information systems to support Single Entry Access (SEA)/case management and expanded tele-radiology functions.

*5.5.3* Develop and implement a process for facility and equipment infrastructure management across the acute care and long tem care sectors.

*5.5.4* Develop and implement a plan for infrastructure assessment, repair and management in long term care facilities across Nova Scotia.

5.6 Develop policies and standards that promote health and prevent illness based on evidence, best practice, and intersectoral collaboration.

*5.6.1* Develop and implement a broad-based and comprehensive approach to disaster planning which encompasses bioterrorism, pandemic flu, and surveillance and alert strategies.

*5.6.2* Develop and implement an intersectoral approach to address the service gaps in addiction services for women and youth.

*5.6.3* Develop an enhanced home visiting component to the existing Early Childhood Development project in cooperation with the Department of Community Services and with funding support from the federal government.

*5.6.4* Reduce smoking rates in Nova Scotia and the burden of illness from tobacco-related illness through tobacco pricing and taxation, smoke-free policies and legislation, treatment and smoking cessation programs, community-based programming, youth smoking prevention approaches, media and public awareness, monitoring and evaluation.

5.7 Develop and implement a plan for the care of mentally ill adults, youth and children.

*5.7.1* Enhance the mental health system across the lifespan by developing strategies for mental health consumer involvement, reducing the stigma of mental illness and increasing public awareness. Core program standards and an evaluation framework will also be developed.

*5.7.2* Develop a framework for delivering mental health services for children and youth in residential treatment settings.

*5.7.3* Develop a strategy for an intersectoral response to the changes in the federal *Youth Justice (Young Offenders) Act.*

5.8 Identify strategies which facilitate improved disease management[3] across the continuum of health care and service.

*5.8.1* Re-orient the ICONS[4] program to integrate its functions as a component of a sustainable and comprehensive provincial cardiovascular program.

*5.8.2* Develop and implement a framework for provincial health programs which promotes the disease management principle of coordinating resources for patients with chronic conditions across the health care system and the life-cycle of illness.

*5.8.3* Develop and implement a coordinated, realistic and comprehensive strategy for blood borne pathogens ( HIV/AIDS, hepatitis B and hepatitis C) which addresses the needs of clients from prevention to palliative care.

*5.8.4* Develop, in partnership with a wide range of stakeholders, a chronic disease prevention strategy which integrates the Nova Scotia Tobacco Strategy and related national initiatives with evolving strategies such as the Physical Activity in Children and Youth (PACY)[5] strategy.

*5.8.5* Continue implementation of an Academic Detailing Service (ADS) aimed at improving physician prescribing practices, drug utilization management, and clinical effectiveness.

[3]Disease management aims to coordinate resources for patients with chronic conditions across the health system and the life-cycle of the illness. Published research supports the effectiveness of disease management approaches for cardiovascular and other diseases in achieving the best outcomes for the most people at the lowest cost.

[4]ICONS stands for Improving Cardiovascular Outcomes in Nova Scotia.. ICONS is a wide ranging 5-year disease management research project which has been funded by a major pharmaceutical company and administered by the QEII Hospital. It has achieved positive results in improving the consistency and quality of cardiovascular care in Nova Scotia hospitals and in improving outcomes for certain groups of patients.

[5]The PACY Strategy is coordinated by the Sport and Recreation Commission.

# 6. Budget Context

| Core Business Area | 2000-2001 Actuals | 2001-2002 Estimate | 2002-2003 Budget Request |
|---|---|---|---|
| Administration and Support | $29,297,000 | $31,479,000 | $31,962,000 |
| Emergency Health Services | 44,576,000 | 53,327,000 | 56,927,000 |
| Insured Health Programs | 460,738,000 | 485,460,000 | 511,035,000 |
| Population Health and Primary Care | 32,220,600 | 32,430,800 | 35,566,000 |
| Mental Health Services | 63,098,800 | 64,958,000 | 71,101,600 |
| Provincial Programs/Other Health Care Initiatives/Other Programs | 61,103,000 | 72,512,000 | 92,008,000 |
| Revenue and Recovery | (25,665,000) | (24,955,000) | (25,490,000) |
| Acute and Tertiary Care | 800,882,600 | 802,093,200 | 880,355,400 |
| Continuing Care Services | 268,309,000 | 285,220,000 | 325,770,000 |
| Capital Grants/Medical Equipment Trust Fund | 12,828,000 | 16,506,000 | 1,000,000 |
| **TOTAL** | **$1,747,388,000** | **$1,819,031,000** | **$1,980,235,000** |

## 7. Outcomes and Outcome Measures

In September, 2000, First Ministers of Health in Canada issued a *Communique on Health* in which they agreed to provide clear accountability reporting to Canadians. The Nova Scotia Department of Health will identify comparable indicators addressing health status, health outcomes and quality of service, to be published by each Province and Territory within a comprehensive national report.

These and other measures are contained in this business plan, as they relate to the core business areas of the health system.

The Department of Health is committed to working with health care providers, health system managers and other government departments in the ongoing development of meaningful performance measures.

| **Core Business Area:** Population Health and Primary Health Care | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Population Health | | | | | | |
| Healthy babies, children and families | ▸factors affecting health | ▸ percentage of women breastfeeding at hospital discharge | 65% (2000) | | 73% | Continue to promote, support and protect breastfeeding through extensive local Public Health Services.<br><br>Continue to work on provincial and DHA breastfeeding and Baby-Friendly Initiative policy development.<br><br>Develop breastfeeding education standards for professionals. |
| | | ▸proportion of non-smoking population regularly exposed to environmental smoke in public spaces and work places** | data will be available from Canadian Community Health Survey in May 2002. | | to be determined from baseline data | Implement the Comprehensive Tobacco Strategy which includes passage of provincial legislation requiring smokefree workplaces and public places. |

** Measures marked with double asterisks are or will be reported consistently by all provinces and territories as part of a national agreement on accountability reporting

| **Core Business Area:** Population Health and Primary Health Care | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Reduction in risky behaviour | ▸ youth smoking | ▸percentage of youth who smoke** | 25% ( 2000) | | 22% | Implement the Comprehensive Tobacco Strategy addressing 7 key components: taxation, smoke-free places legislation, treatment/cessation, community-based programs, youth prevention, media awareness and monitoring and evaluation. |
| | ▸ overweight or obesity | ▸percentage reporting Body Mass Index in excess of the healthy range** | 54.8% (98/99) | | 52% | Promote healthy eating and physical activity promotion through local public health services.<br><br>Collaborate with the NS Alliance for Healthy Eating and Physical Activity |
| | ▸physical inactivity | ▸population 12 yrs and over who report being active less than once per week or never** | 51.9% (98/99) | | 46.7% | Collaborate with Dept of Education in addressing curriculum revision and increased Physical Activity in schools<br><br>Implement<br>• provincial Physical Activity Strategy for Children and Youth (PACY-joint initiative)<br>• a chronic Disease Prevention Strategy |

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| **Core Business Area:** Population Health and Primary Health Care | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Decrease in diseases which can be prevented by vaccine | ▸ vaccination coverage | ▸ population over 65 who report having a flu shot in the past year ** | 62% (00/01) | | 80% | Immunization for prevention of influenza is a key public health intervention. Increase coverage through collaboration with other agencies, increasing the number and variety of public health services clinics, continuance of the annual public awareness campaign and continued work with professional groups (such as Pharmacy Association, Medical Society and others) |

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| **Core Business Area:** Population Health and Primary Health Care | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Primary Health Care | | | | | | |
| Improved access to teams of primary care providers | ▸service access | ▸number of nurses working in primary care offices | 122 (01/02) | | to be determined | Complete planning for the development of a renewed, community-based primary health care system for Nova Scotia.*<br><br>Support nurse practitioner education program |

* Measures related to the initiative are under development and, in future, may include: % of population served by physician group practices, % of population served by interdisciplinary teams, % of primary care physicians receiving alternative payment arrangements

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| **Core Business Area:** Mental Health Services | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Maintain persons with serious mental health problems in their communities | ▸service accessibility | ▸ number of clients with serious mental health problems treated outside of inpatient hospital settings<br><br>▸ average number of community-based visits for clients with serious mental illness | (00/01)<br>adults<br>1886<br><br>children & youth<br>760<br><br>adults<br>14.5<br><br>children & youth<br>5.0 | | 2283<br><br>920<br><br>15.5<br><br>6.0 | Redirect resources to improve service availability for this target group<br><br>*This measure relates to the amount of time or service available to the clients who require ongoing and intensive attention* |
| Responsive services to persons who require hospitalization | ▸service efficiency | ▸proportion of all patient days spent in hospital accounted for by patients with serious mental illnesses | (00/01)<br>71% | | 75% | Continue to support shifting service options from inpatient hospital care to alternate settings where appropriate. |

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| **Core Business Area:** Acute and Tertiary Care | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Access to quality hospital services | ▸service effectiveness | ▸hospitalizations of people age 65 or older for pneumonia and influenza | 1,312 per 100,000 population | | reduce below the Canadian average 1,273 per 100,000 (98/99) | Continue to work towards increased coverage of population over 65 receiving immunization against pneumonia and influenza.<br><br>Review opportunities to use outpatient services whenever appropriate to treat these conditions. |
| | ▸service accessibility | ▸number of total knee replacement surgeries** | 87 per 100,000 population (00/01) | | no lower than the Canadian average 61 per 100,000 (98/99) | Continue to collaborate with all other provinces across Canada to track information on these procedures which have been shown to substantially improve the quality of life of those receiving them |
| | | ▸number of total hip replacement surgeries** | 59 per 100,000 population (00/01) | | 57 per 100,000 (98/99) | |

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| **Core Business Area:** Acute and Tertiary Care | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Best use of inpatient hospital services | ▸service efficiency | ▸percent of people admitted to hospital for conditions or procedures that experts say often allow outpatient treatment instead* ** | 7.64% (00/01) | | reduce from baseline | Continue to monitor effective utilization of hospital beds and review alternate settings for care with other health system provider organizations<br><br>Further develop data quality for this measure |
| | | ▸proportion of people admitted to hospital for conditions where appropriate outpatient care may prevent the need for hospitalization# ** | 350 per 100,000 population | | no higher than the Canadian average 411 per 100,000 (98/99) | Continue to monitor effective utilization of hospital beds and review opportunities to use outpatient services most effectively |

* referred to as *May Not Require Hospitalization* by Canadian Institute for Health Information
# referred to as *Ambulatory Care Sensitive Conditions* by Canadian Institute for Health Information

** Measures marked with double asterisks are or will be reported consistently by all provinces and territories as part of a national agreement on accountability reporting

| **Core Business Area:** Insured Health Programs | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Appropriate number and distribution of health care providers | ▸supply and distribution of health personnel | ▸health human resource positions filled in under served areas | 85% (2002) | | 80% or higher | Continue to support physician recruitment initiatives throughout the province through:<br>website listing vacancies<br>recruitment guide<br>advertising<br>incentives<br><br>Test alternative collaborative approaches to providing primary health care in under served areas<br><br>Conduct health human resource planning that addresses the supply and distribution of health care professionals and other workers |

** Measures marked with double asterisks are or will be reported consistently by all provinces and territories as part of a national agreement on accountability reporting

| **Core Business Area:** Emergency Health Services | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Access to quality emergency health services | ▸response times | ▸percent response times from ambulance dispatch to arrival at the emergency scene was 9 min. or less | 66% (2000/01) | | 68% | Continue to improve monitoring and feedback to staff for the purposes of refining processes |
| | ▸service effectiveness | ▸survival rates for out of hospital cardiac arrests | 6.9% (2000) | | 6.9% | Maintain training and ongoing procedural review and development.<br><br>Explore development of a bystander care initiative. |

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| **Core Business Area:** Continuing Care Services | | | | | | |
|---|---|---|---|---|---|---|
| **Outcome** | **Indicator** | **Measure** | **Base Year Measure (state year)** | **Target 2002/03** | **Target 2004/05** | **Strategies to Achieve Target** |
| Access to quality Home Care and Long Term Care Services | ▸wait-times for placement in continuing care | ▸amount of time clients wait for service | data will be available for -long-term care in 03/04 -home care in 04/05 | | to be determined from baseline data | Establish single entry access in Nova Scotia including the continued development of strategies and policies for:<br>human resources<br>financial management<br>policy review<br>forms and documentation<br>data collection & standards |
| | ▸services received | ▸estimated percent of population ( age 15 or over) receiving homemaking, nursing or respite services** | data will be available from Canadian Community Health Survey in May 2002. | | to be determined from baseline data | |

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