DEPARTMENT OF HEALTH

ANNUAL ACCOUNTABILITY REPORT
FOR THE YEAR 2003 - 2004

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Annual Accountability Report For The Year 2003-2004

Department of Health

Accountability Statement

The accountability report of the Department of Health for the year ended March 31, 2004, is prepared pursuant to the Provincial Financial Act and government policies and guidelines. These authorities require the reporting of outcomes against the Department of Health's business plan information for the fiscal year 2003- 2004. The reporting of departmental outcomes necessarily includes estimates, judgements and opinions by departmental management.

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

The Honourable Angus MacIsaac
Minister of Health

Cheryl Doiron
Deputy Minister of Health

Message From The Minister of Health

As Minister of Health, I am pleased to be able to table the Department of Health's Accountability Report for the year 2003-2004. The Government of Nova Scotia and the Department of Health set goals and established priorities for 2003-2004 in our business plan and budget. The outcomes reported here show that we remain committed to those goals and priorities and do so at a cost which is sustainable for Nova Scotia.

I am proud of our many accomplishments in 2003-2004. Among our major achievements were:

- **Minister's Report To Nova Scotians:**
  The Department of Health and the Office of Health Promotion released the *Ministers' Report to Nova Scotians* - the first year update on the *Your Health Matters* plan. The report outlined progress made in priority areas, and highlighted key challenges currently facing the health-care system.

- **Positive Changes To Long-Term Care:**
  Government announced that as of January 1, 2005, individuals residing in long-term care facilities under the mandate of the Department of Health will have their full health care costs covered. This will complete the Department of Health's multi-faceted approach to matching resources in nursing homes with the needs of residents.

- **Nursing Strategy:**
  The Province continued implementation of the nursing strategy aimed at enhancing the quality of work life of nurses, retaining experienced nurses in the system, and supporting nurse recruitment. Over the past two years, the number of registered and licensed practical nurses in the Province has increased by 130. The strategy has also helped over 100 nurses per year relocate to Nova Scotia. In addition, significantly more nurses are employed in permanent versus casual positions, and Nova Scotia is currently retaining over 80 per cent of its new graduates - about 90 per cent of whom have found full-time employment.

- **Children and Youth Mental Health:**
  An increase of $2 million in the Mental Health budgets of District Health Authorities and the IWK was announced in November 2003. The money will be used for additional staff for child and youth programs, crisis response, new case managers, and a new youth sex offender program. In 2003, two intensive community based treatment teams for children and youth were established, one in Cape Breton and the other at IWK Health Centre. The 50 DHA-operated mental health clinics provide services to children and youth and facilitate access to specialized mental health services at the IWK Health Centre.

- **Enhanced Cardiac Care:**
  Thanks to a new cardiac catheterization lab made possible with $5 million in funding from the Department of Health in 2003-2004. Capital Health's wait times for elective cardiovascular surgery have been cut by more than half compared to last year, putting the District well within national wait time standards.

- **More Primary Health Care Nurse Practitioners:**
  During 2003-2004, the recruitment process was initiated for eight new primary health care nurse practitioners. Six nurse practitioner positions were filled in Wolfville, Annapolis, Inverness, New Glasgow, Advocate and Kennetcook.

Our goal is to provide Nova Scotians the care they need, when they need it. Doing this at a cost that is sustainable for Nova Scotia is an ongoing challenge. Amidst the many challenges in health care, we continue to make significant and encouraging progress. We're making confident change for quality care - that is our commitment to families, to health-care workers, to seniors, to patients, and to all Nova Scotians.

Introduction

This Annual Accountability Report for the Department of Health is based on the goals and priorities set out in the Department's Business Plan for the 2003 - 2004 fiscal year. This report should be read in conjunction with the 2003-2004 Business Plan (available on the Department of Health web site at http://www.gov.ns.ca/health/).

The report is structured in tandem with the Business Plan and details key departmental and health system accomplishments for 2003 - 2004, financial performance, and health system performance measures and outcomes.

The mission of the Department of Health is 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**
  An integrated health system ensures the coordination of services and allows providers to work together to improve the health status of the population.
- **Community-Based**
  A community based health system assures input by communities in planning and identifying strategies and services to improve the health status of the population and ensures that teams of providers participate in carrying out these strategies and services.
- **Sustainable**
  A sustainable health system is one that is accountable for providing quality services to the population it serves and is affordable in the long term.

Core Business Areas

The Department of Health has 7 key areas of care and service delivery. These are briefly outlined below:

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 is concerned with all the factors that promote health as they apply to a given population, not just personal health services. It addresses the factors that determine health. These include things such as income, social status, social support networks, education, employment, working conditions, social environment, physical environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture. These factors are recognized and addressed within a system that has appropriate linkages, both with other components of the health care system and with all other related sectors and aspects of provincial and community development, such as community groups, family caregivers, volunteer organizations, government departments and agencies, and others.

Primary health care is developed with the full participation of the people it serves. It empowers people to take care of their own health and to take an active part in planning, policy making, and delivering health services in their community. Primary health care requires a strong foundation of community-based services that enable people to maintain and strengthen their health. Primary health care services include health and education and promotion, prevention, rehabilitation, and support and treatment for illness and injury.

Primary care is one aspect of primary health care. It is the individual's or family's initial and continuing contact with the health care system. The focus of primary care is on service delivery. Primary care services include health promotion and disease prevention, acute episodic care, continuing care of chronic conditions, education and advocacy.

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 addiction education program;
- Community-based programs (outpatients) and structure treatment;
- Prevention and community education (in schools, workplaces and communities); and
- 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.

Public Health Services are delivered to Nova Scotians through the DHAs. The staff work 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.

A new Office of Health Promotion was announced in December 2002, and commenced operations in early 2003.

Primary health care provides policy and planning support to re-designing of a community-based primary health care system for Nova Scotia. Changes might include: 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.

Mental Health Services

Mental Health services are funded by the Department of Health and delivered by nine District Health Authorities and the IWK Health Centre. These authorities administer a network of 50 community-based clinics, inpatient beds, day treatment centres, club house psycho social rehabilitation programs, and drop-in centres. The services are part of a continuum of treatment that is provided to individuals across the life span and is community based and consumer and family focussed.

All District Health Authorities and the IWK Health Centre offer acute and longer term treatment and support. Specialized services are offered in some jurisdictions (e.g., forensic, sex offender treatment, neurodevelopmental delay, early onset psychosis, mood disorder treatment, eating disorders, psycho social rehabilitation and psycho geriatrics).

Acute and Tertiary Care

Acute or hospital care is comprised of secondary and tertiary care services delivered by the nine HAS and the ILK Health Centre. Acute Care is delivered in thirty-seven (37) facilities which are governed and managed by the HAS. 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 provide specialized services such as Neurosurgery, Specialized Pediatrics, Burn ICU, Cardiac Surgery, Transplantation Programs, Cardio-Thoracic Surgery, Immunology and Haematology, as well as all the services available in the community and district facilities. The centres also provide the highest level of emergency services.

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 children's dental program, and other services for specific populations such as optometry, prosthetics and dental surgery.

Emergency Health Services

Emergency Health Services (EHS) is the division of the Department of Health 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 (including 911), 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 with special training in emergency care.

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; and
- 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.

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.

Priorities and Departmental Accomplishments for the Year 2003 - 2004

Population Health and Primary Care

Priority	Accomplishments
Additional Primary Health Care Nurse Practitioner Positions During 2002-2003, eight new nurse practitioner positions for Nova Scotia's primary health care system were funded to augment primary health care services currently provided and to fill a longstanding service gap in many Nova Scotia communities. DHAs will continue their development of innovative primary health care initiatives.	The Department of Health is committed to bridging current and future gaps in the health system through the responsible allocation and coordination of primary health care transition funding. Funding allocated to the DHAs to support the development of innovative primary health care Initiatives totalled $4.25 million during the 2003-2004 fiscal year. Initiatives funded included: ▸ Funding primary health care coordination in each District; ▸ Stakeholder consultation and citizen engagement; ▸ Support for collaborative practice agreements; ▸ Video conferencing equipment to support collaborative practice activities and continuing education; ▸ Collaborative practice workshop - nurse practitioners and family physicians; ▸ Diversity and Social Inclusion Initiative; and ▸ Renovations and equipment for nurse practitioners. The recruitment process was initiated for the acquisition of eight (8) new primary health care nurse practitioners. During the 2003-2004 fiscal year, six nurse practitioner positions were filled in the following geographic locations: ▸ Wolfville ▸ Annapolis ▸ Inverness ▸ New Glasgow ▸ Advocate ▸ Kennetcook

Priority	Accomplishments
Diversity and Social Inclusion Awareness in Primary health care Nova Scotia's vision for primary health care recognizes the need for primary health care services that value and respond to the "cultural, racial and spiritual experiences of individuals, families and communities." It requires that equity of access be established for those who have historically faced barriers for reasons including race, ethnicity, language and culture, understanding that these and related factors affect health. Diversity and Social Inclusion in Primary Health Care is an initiative to raise awareness of diversity and social inclusion issues (primarily related to race, language and culture) across a broad range of stakeholders within the Primary health care system. In 2003-2004, the Department of Health will involve primary health care leaders and culturally diverse populations in the development of guidelines and policies that address diversity and social inclusion issues in Primary health care.	The Department of Health demonstrated commitment to increasing awareness of diversity and social inclusion in primary health care and related issues. As we head into the third year of a three year initiative, accomplishments which will support the development of guidelines and culturally competent care include the establishment of linkages with each of Nova Scotia's provincial programs. Proposal development and key activities related to Cancer Care Nova Scotia and Diabetes Care Nova Scotia have taken place as a direct result of support from this initiative. These activities include plenary sessions on cultural diversity and the evaluation of community cancer education initiatives within diverse communities.

Priority	Accomplishments
Provincial Blood Transfusion Program This new program will be responsible for implementing and evaluating initiatives related to transfusion therapy and alternatives to help ensure blood related products are efficiently, effectively and safely administered across the province. The program has three initial specific objectives: • To establish and maintain a program to optimize the utilization of blood products and their alternatives. • To establish and maintain a surveillance program for adverse reactions and major errors related to transfusion therapy. • To ensure appropriate standards regarding blood transfusion therapy are being implemented and maintained within health care facilities in Nova Scotia.	The Provincial Blood Coordinating Program (PBCP), previously known as the Provincial Blood Transfusion Program, was created in January 2003 to provide leadership in maximizing the safe and appropriate management of blood products and their alternatives for the health and safety of Nova Scotians. In 2003-2004, the Blood Coordinating Program: • Convened a Palivizumab Working Group. • Convened an Atlantic Collaborative Working Group for optimizing the use of intravenous immune globulin and implemented a monitoring program. • Developed processes for determining red blood cell utilization and wastage within Nova Scotia. • Implemented Health Canada's Transfusion Transmitted Injuries Surveillance System in Capital District Health Authority and ILK (52% of the transfusions administered in Nova Scotia). • Convened a provincial quality specialists working group for CSA standards implementation. • Estimated the cost associated with CSA standards implementation in Nova Scotia. • Developed provincial guidelines for Palivizumab administration and related monitoring program.
Chronic Disease Prevention Strategy Infrastructure Understanding that chronic diseases are the leading causes of death in Nova Scotia, the Department of Health is developing a provincial Chronic Disease Prevention Strategy through the Unit for Population Health and Chronic Disease Prevention at Dalhousie University. Recommendations for action will be presented during 2003-2004. Effective coordination is required during the implementation of the strategy to ensure integration within the Department, with the Office of Health Promotion, across government and around the province.	Under the coordination of the Unit on Population Health and Chronic Disease Prevention, Dalhousie University, a Chronic Disease Prevention Strategy was developed and submitted to the Department. The strategy is being used as the framework for work undertaken by the Office of Health Promotion in the area of prevention of chronic disease. A broad stakeholder group was active in the development of the Chronic Disease Prevention Strategy.

Priority	Accomplishments
Primary Health Care (Phase 3) Service Planning The Department of Health has undertaken several phases of health services planning. In 2003-2004, the Primary health care (Phase 3) Service Planning Steering Committee will develop, pilot and initiate the implementation of a planning methodology for determining the optimum size, scope, composition and distribution of primary health care and emergency services in Nova Scotia. The goals of service integration, system sustainability and evidence-based decision-making will guide the development and application of the methodology.	In 2003-2004, the Primary Health Care Service Steering Committee initiated Phase III. The steering committee received a draft primary health care planning framework focussed on communities and community access to health care services. Upon approval, the framework will be circulated to local primary health care planners in Nova Scotia, giving them the opportunity to utilize the methodology and provide feedback.
Enhanced Home Visiting Program The Early Childhood Development Strategy in Nova Scotia has three priority goal areas: • establishment of a comprehensive (Public Health) home visiting program; • stabilization and enhancement of the current child care system; and • development of a coordinated system of early childhood development. Healthy Beginnings is a home visiting program in which public health nurses contact the families of the 10,000 babies born in Nova Scotia annually. The expanded program includes enhanced identification and assessment of families post-natally, universal screening at birth, in-depth assessment of families identified as potentially 'at risk' and intensive home visiting for families requiring additional support. In 2003-2004, public health nurses and trained community members will begin to provide these services.	The Healthy Beginnings: Enhanced Home Visiting Initiative identifies families facing challenges and offers these families home visiting support for up to 3 years and/or referral and linkage to other health related community resources. Provincial Program Standards have been developed to support District Health Authority implementation. Implementation teams have been established at the District Health Authority level to guide local implementation and evaluation. Development of the 'Healthy Beginnings' database and evaluation framework is currently underway and implementation is planned for 2004-2005.

Priority	Accomplishments
Blood-Borne Pathogens Human immunodeficiency virus (HIV), hepatitis B virus (HB), and hepatitis C virus (HCF) are preventable diseases that have major health and social impact on individuals, families and communities throughout the province. While treatment modalities are different for each of these diseases, prevention strategies (such as awareness, early identification, harm reduction practices such as needle exchange program, immunization, etc.) and social support activities (such as community support) are similar for all of them. The Blood Borne Pathogens Project will facilitate a system of prevention and support services that address the needs and contribute to decreased prevalence and incidence of HIV, hepatitis B, hepatitis C and other blood borne pathogens.	Understanding that Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV) and other Blood Borne Pathogens (BBPs) are preventable, the Department of Health began the Prevention of Blood Borne Pathogens Project in July 2002. During 2003-2004 provincial standards for prevention and harm reduction services were developed. A broad range of stakeholders participated in the development of standards for health education and social marketing; counselling, testing and referral; needle exchange; and, Methadone maintenance treatment. Standards provide a point of reference for assessing gaps and provides a framework to guide long-term improvement in prevention services, as well as a foundation for the implementation of new services where necessary.

Mental Health Services

Priority	Accomplishments
Mental Health Strategic Directions In early 2003, the Department of Health released its strategic direction for mental health services and standards. The standards address appropriate numbers of and qualifications for staff, timely access to emergency care and treatment, and follow-up with patients after a hospital discharge. During 2003-2004, the Department of Health will work with teams of mental health care providers and consumers to begin implementation of core service standards in key areas such as community supports and crisis services. A plan for monitoring the quality, appropriateness and effectiveness of mental health services will be developed.	System level standards for mental health core services across the life span have now been developed. $2 Million in annualized funding was provided in 2003-2004 to begin implementation of these standards based upon established priorities. Specialty service standards were also developed for seniors, concurrent disorders, neurodevelopmental delay, early onset psychosis and youth court ordered assessments (March 2004). Monitoring and evaluation of components of the mental health system, including compliance to standards and the development of performance indicators have been implemented. In support of consumer involvement in the mental health system, honorariums for involvement in departmental mental health planning and funding for consumer led mental health initiatives have been established. Provincial training programs for service providers in mental health diagnosis and various treatment approaches have been initiated. A new website (www@gov.ns.ca/health/mhs) provides a status report on the province's mental health system. In addition, a campaign was initiated to address the media's portrayal of persons with mental illness. The District Health Authorities conduct annual self-assessments against the newly established standards. This assessment informs the business planning process and will help set priorities to meet both existing, and newly developed standards. Two priorities identified for 2003-2004 were: • Community support programs • Increased crisis services A portion of the $2 Million spent in 2003-2004 was utilized to enhance community supports to the mentally ill and crisis services.

Priority	Accomplishments
Child and Youth Mental Health Initiatives Two new mental health community-based treatment teams are being developed to serve children and youth who require this level of intensive service. The teams will be located at the Cape Breton DHA and at the IWK Health Centre. Addressing a longstanding gap in mental health services, they are a step-up from outpatient treatment and a step-down from inpatient services. Consultation with the new community-based treatment teams will be facilitated through the increased use of telehealth technology. A new 12-bed Residential Rehabilitation Treatment Centre will open in Halifax in 2003. It will provide professional care and security that previously could be provided only outside Nova Scotia for most children. This centre will be available to those who require medium to longer term care.	$2 million in funding for standards have supported the enhancement of mental health services across the province. These enhancements include increased use of telehealth to facilitate communication with the new community-based treatment teams. In addition, the Honourable Angus MacIsaac, Minister of Health, opened a new twelve (12) bed residential rehabilitation program at the IWK Health Centre in January 2004. This centre will provide professional care and security to those who require medium to longer term care.
Youth Criminal Justice Act The new federal Youth Criminal Justice Act's proclamation has impacts for mental health services in Nova Scotia. A clinical mental health team at the Nova Scotia Youth Centre has access to the resources of the ILK mental health program and will be available to the rest of the province via telehealth services at DHA sites.	Similar to the community-based treatment teams in Cape Breton and the IWK Health Centre, a fully operational mental health team has been established at the Nova Scotia Youth Centre in Waterville. In addition, a forensic community case management program has been developed to support youth released to the community on a conditional discharge by the Criminal Code Review Board. Addressing a long standing gap in mental health services, a new treatment program has been developed and established for sexually aggressive youth. Standards have been developed and implemented. A related training program for clinicians and members of the judicial system has been developed and delivered across the province.

Acute and Tertiary Care

Priority	Accomplishments
Osteoporosis Education and Treatment Guidelines Health system stakeholders are involved in action planning for the recommendations made in the Report of the Provincial Osteoporosis Committee completed in 2002. Two new DEXA (Dual Energy X-ray Absorptiometry) machines, used for diagnosing osteoporosis, will become fully operational in 2003-2004. These are located in Sydney and Yarmouth. The quality assurance program required to operate the machines at a consistent and recognized level of quality across the province will be developed and implemented. As well, comprehensive education about treatment considered best practice and the appropriate use of the DEXA technology (commonly termed bone densitometry) will be provided to health care professionals across Nova Scotia.	Osteoporosis affects approximately 43,000 women and 15,000 men over the age of fifty (50) in Nova Scotia. The province is committed to reducing the incidence of fractures and associated effects on individuals with osteoporosis. Sydney and Yarmouth now have fully operational DEXA machines to serve individuals in their own communities. Meanwhile, Truro has extended the number of hours it will operate its DEXA machine. In addition, the DEXA Working Group has developed a quality assurance program required to operate the machines at a consistent and recognized level of quality across the province. During 2003-2004, education of physicians and nurses began surrounding treatment, best practices and the appropriate use of DEXA technology. Physician education has been completed and “Phase 1" of our nurse education strategy (via telehealth) was completed. Ongoing nurse education strategies and the education of other providers and the public will be rolled out in the fall, 2004.
MRI Access and Utilization Magnetic Resonance Imaging (MRI) scanners are used to detect and diagnose soft tissue problems in the brain, spinal cord, heart, major blood vessels and the musculoskeletal system. Health system stakeholders will be involved in developing protocols to ensure that all Nova Scotians have reasonable access to publicly funded MRI services. These protocols will facilitate health service providers in making, transferring, receiving and processing requests for testing in an efficient manner.	In 2003-2004, a consultant was contracted to conduct consultations and research to support planning for the future of Magnetic Resonance Imaging in Nova Scotia. Consultations were conducted, resulting in a magnetic resonance imaging needs assessment. This report identifies protocol requirements and implications for implementation.

Priority	Accomplishments
Provincial Approach To Cardiac Health Cardiovascular disease is one of the most common causes of death in Nova Scotia. It contributes directly to disability, work loss and premature death. Building on the success of ICONS (Improving Cardiovascular Outcomes in Nova Scotia), the Department of Health is working with a broad range of stakeholders from across the province to develop a coordinated approach to the planning and delivery of cardiac Services across the province.	The department established the Provincial Cardiac Advisory Council in January 2004. The Council initiated the development of a strategic plan while work continues to complete an inventory of existing programs and services across the province. Efforts to develop a project communications framework are near completion.
Enhanced Cardiac Care The Department of Health will provide additional funding to enhance cardiac care in Nova Scotia. The funding will support the Capital District Health Authority's plan to add equipment, staff and other resources to give patients faster access to cardiac tests and surgeries. This investment will benefit patients in all parts of the province who use cardiac facilities in the Capital District.	In 2003-2004, the Department of Health invested $4.9 million to enhance cardiac care in Nova Scotia. This funding enabled Capital Health to open a fourth cardiac cathetorization lab and hire additional staff in targeted areas. The health system experienced an increase in operating room staff time and related materials, resulting in a reduction in wait times for cardiac tests and procedures. In December 2002, people needing elective cardiovascular surgery waited forty-three (43) weeks. In December 2003, they waited only nine (9) weeks.
Wait List Strategy Reliable and comparable information on wait lists and wait times is essential to good health care planning, service delivery and public accountability. The Department of Health is working with health providers and administrative staff from across the province to develop a coordinated and consistent approach to data collection and measurement which can be used to shorten wait lists, eliminate backlogs and identify priority equipment needs.	In April 2003, the Department of Health established a steering committee and related working groups to determine data requirements and collection methods which can be used to shorten wait lists, eliminate backlogs and identify priority equipment needs. The steering committee focussed on: • surgical services (i.e. orthopaedic services); • diagnostic services (i.e. MRI, CT scans); and • referrals from general practitioners to specialists The Department of Health released the committee's report in January 2004. The committee recommended: • standards for wait time definitions; • standards to determine the urgency of a case; and • a method to collect data

Priority	Accomplishments
Tissue and Organ Donation Nova Scotia is one of only two Canadian provinces without a comprehensive approach to tissue and organ donations. Evidence from other jurisdictions suggests that donation rates and health outcomes can be improved through better coordination and management of donation, retrieval and utilization.	In 2003, a provincial steering committee submitted a strategy to improve organ and tissue donation rates to the Department of Health.
Acadian and Francophone Access to French Language Health Services Following a recent report on the availability of french language health services in Nova Scotia, the Department of Health, working with the Department of Acadian Affairs, is developing a plan to improve access to french language health services for the approximately 37,000 Nova Scotians whose first language is French.	Committed to increasing health services to french speaking Nova Scotians in their first language, the Department of Health hired a French-language Health Services Coordinator in the Spring 2003. This position is funded in part by the Minister responsible for Acadian Affairs. The Department of Health has undertaken networking and awareness raising through attendance at conferences and collaboration with experts concerned with french language health services.
Hospital Renovations Some recent projects include a new hospital in Amherst, major renovations to Yarmouth Regional Hospital, an expansion of the Dartmouth emergency room and renovations to the Middleton Hospital to facilitate its new role. Decisions on future projects will be based on consultation with the District Health Authorities and the priorities of the Department of Health.	Based on consultations with DHAs and the priorities of the Department of Health, decisions were made to: • further develop the Cobequid Community Health Centre; • develop a functional program for the replacement of the Colchester Regional Hospital (complete); and • conduct a role study and master program review at Annapolis Valley Health (ongoing)

Insured Health Programs

Priority	Accomplishments
Multi-Year Funding for Front-Line Health Care Beginning in 2003-2004, the Department of Health will increase funding for hospitals and other services provided by the District Health Authorities by at least seven per cent per year. This will add almost $124 Million over the next three years to support Front-line Health Care, in addition to funding already provided for salaries and negotiated salary increases.	The first year in a multi-year funding initiative resulted in the addition of $20 Million to non-salary funding for the Nova Scotia health system. This initiative was scheduled for inclusion in the District Health Authority business planning process for 2004-2005.
Atlantic Common Drug Review The Atlantic Expert Advisory Committee has made recommendations on 50 new drugs since January, 2002. Nova Scotia actively participates in the project and has accepted all of the process's recommendations to date. The Atlantic Common Drug Review Process will continue during 2003-2004.	The Atlantic Expert Advisory Committee has made recommendations on 115 new drugs since January 2002, an increase of 65 since the last report. A National Common Drug Review was initiated in September 2003. This national process reviews new chemical entities while the Atlantic Common Drug Review continues to review line extensions and new indications for existing drugs. In 2003-2004, Nova Scotia actively participated on national, atlantic, and provincial initiatives that support evidence-based drug reviews for formulary management.
Academic Drug Detailing Academic drug detailing provides continuing education for doctors on the most effective and appropriate use of drugs. Current efforts will be directed to new applications and extended into 2003-2004.	The Department of Health funds, coordinates and evaluates the Academic Drug Detailing Program while the Continuing Medical Education Program at Dalhousie University operates it. Academic Drug Detailers continue to visit over 50% of Physicians in Nova Scotia on a voluntary basis. In 2003-2004, 14% of primary care physicians were seen by an Academic Detailer for one topic only, while 43% of primary care physicians were seen for more that one topic. 43% of primary care physicians did not see an Academic Detailer.

Priority	Accomplishments
Affordable Drugs The Department of Health is committed to keep drugs affordable for the 95,000 seniors insured through the provincial Pharmacare program. In 2003, a significant investment will freeze the premium and co-pay at current levels. Also, seniors will no longer pay more than $30 toward the cost of an individual prescription.	The Department of Health remained committed to keeping drugs affordable for the 95,000 Nova Scotia seniors insured through the provincial Pharmacare program. In 2003-2004, the Pharmacare program froze premiums and co-pays at current levels while ensuring that seniors did not pay more than $30 dollars towards the cost of an individual prescription.
Physician Alternative Funding Alternatives to the traditional fee-for-service approach to physician remuneration are being developed. Negotiation of alternative funding arrangements with academic components in the Capital DHA and ILK Health Centre is nearing completion. The Department is working with the HAS, Dalhousie University, and the Medical Society of Nova Scotia to ensure effective service delivery and efficient resource utilization through alternative funding arrangements.	Alternative funding is a shift from the conventional, fee-for-service, method of funding for physician payment. Alternatives to fee-for-service payment are typically used to ensure sufficient access to care in situations where fee-for-service arrangements may not guarantee physicians the resources to provide much needed care. In 2003-2004, alternative funding plans were developed and implemented by the academic division at Capital Health and the IWK Health Centre. Work is ongoing to expand alternatives to the traditional fee-for-service approach in other settings. The Department of Health developed an audit plan to address one of our 2003-2004 strategic directions - Accountability. The audit plan includes both financial and value-for-money audits.

Priority	Accomplishments
Patient Safety Safety concerns within health care systems are the focus of significant international attention. While advancing technology has afforded great improvements in our ability to prevent, diagnose and treat disease, the increasingly complex nature of health care has also increased the likelihood of errors and failures. Although most health care encounters are free of mishaps, perfection is not possible. To augment the considerable emphasis placed on safety by our health care provider organizations and professionals, unified national and provincial efforts to minimize unplanned and undesired harmful occurrences are warranted. Within its overall framework for quality, the Department of Health will identify priority action on issues of patient safety and continue to participate in national action planning.	The Provincial Healthcare Safety Working Group was formed to identify provincial safety priorities. These priorities will inform the development of an action plan for Nova Scotia. Electronic information sharing mechanisms were established for professionals working in quality management across the province. This enables colleagues to share policies, procedures and other tools that will enhance safety for patients and healthcare providers alike. In 2003-2004, quality related activities included: • A safety symposium for health care professionals; • Development of several tools for use by all Nova Scotia hospitals in their ongoing efforts to review safe medication practices; and • Introduction of a provincial blood coordination program to ensure that national standards on the use of blood products are implemented. Other related accomplishments include: • Nova Scotia representation on the board of the Canadian Safety Institute. • Implementation of national surveillance guidelines on severe respiratory infections.

Emergency Health Services

Priority	Accomplishments
Emergency Health Services Legislation A major priority for Emergency Health Services in 2003-2004 is the establishment of a legislative framework for all aspects of emergency health services delivery in Nova Scotia.	In 2003-2004, consultations were conducted with stakeholders. Draft legislation was developed for submission in the Fall 2004.

Continuing Care Services

Priority	Accomplishments
Consultation On Services To Seniors In 2003-2004 the Department of Health will consult on the options and services available to seniors, how they can most effectively be delivered, and what regulations are appropriate to protect seniors. This work will guide decisions on growth and delivery of services for seniors, as well as lead to changes in the Homes for Special Care Act.	In consultation with the Seniors' Secretariat, the Department of Health developed a plan and related research questions to determine what information we need to make good decisions regarding services for seniors. Consultations led by the Seniors' Secretariat are scheduled to begin in 2004-2005.
Single Entry Access To Continuing Care Services In 2000, the Department of Health began coordinating the wait list for nursing-home and residential-care beds through the Single Entry Access initiative. Building on the single entry access management information system, decision support capability will be further developed to assist in ongoing planning and monitoring of continuing care services to clients.	In 2003-2004, decision support capabilities were enhanced through further development of the decision support system. In an effort to assist in ongoing planning and monitoring of continuing care services, enhancements were made to the decision support system including the generation of weekly reports that detail information regarding chronic home care clients. Stakeholders may now obtain information on a regular or ad hoc basis with the introduction of a data generation system that automatically updates information systems on a weekly basis Next steps include refining management information requirements and the development of reports to meet these needs.
Challenging Behaviors in Continuing Care Setting Some residents of long term care facilities suffer from dementia and other diseases that can give rise to challenging behavioural issues. They can hurt themselves, or may hurt people around them. A complete review and assessment of the Challenging Behavior Working Group Report and accompanying stakeholder input will be undertaken and program enhancements begun during 2003-2004.	A complete review and assessment of the Challenging Behavior Working Group Report and accompanying stakeholder input was conducted. This review and assessment resulted in the development of a program which addresses the needs of individuals presenting with challenging behaviors. In 2004-2005, the Department of Health will hire a Program Coordinator, contract experts to deliver training to front line continuing care staff across the province, and develop a plan to support the successful implementation of the new program.

Priority	Accomplishments
Health Services Planning (Phase II) The evidence-based methodology for determining the optimum size, scope and distribution of continuing care services across Nova Scotia will be finalized.	An evidence-based methodology for determining the optimum size, scope and distribution of continuing care services across Nova Scotia was produced in a report developed by the Health Services Planning Steering Committee (Phase II). This methodology is intended to ensure that decisions on the future of the Nova Scotia health system are evidence-based. This report will help continuing care staff develop a plan to address the growing number of seniors in Nova Scotia.
Long Term Care System Management The Department of Health will continue development of a multi-faceted approach to matching resources in nursing homes to the needs of residents. This will include the continuation of all additional exemptions approved by government in November 2002 for financial assessments. In 2003-2004, the Department of Health will take the next steps in a multi-year plan to reduce the daily rate that some seniors now pay in nursing homes.	In 2003-2004, the Department of Health continued to move forward on its multi-year plan to reduce the daily rate that some seniors pay in nursing homes. A daily subsidy of $12.75 was introduced towards health care costs of these seniors. The Department of Health will complete the multi-year plan in 2004-2005 as a result of the government's announcement that, as of January 1, 2005, individuals residing in long term care facilities under the mandate of the Department of Health will have their full health care costs covered.
Palliative Care A provincial steering and several working groups have been established to develop a provincial approach to delivering palliative care services to Nova Scotians. A service delivery model based on national standards and previous work in rural palliative home care will be developed during 2003-2004. Implementation will involve collaboration amongst DHA-based palliative care providers, family physicians, and continuing care providers.	Hospice palliative care addresses the physical, psychological, social, spiritual, and practical needs of individuals who are dying and their families. Hospice palliative care stretches across care settings and involves a variety of health professionals as well as family care givers and volunteers. Efforts to develop a service delivery model resulted in service delivery guidelines which were approved in March, 2004, by the Executive Steering Committee. These guidelines are intended to be used by DHA-based palliative care providers, family physicians, and continuing care providers.

Health Information Management

Priority	Accomplishments
Health Information Policy and Privacy Canada Health Infoway is partnering with the Nova Scotia Department of Health to develop a "privacy toolkit" for use in the development of electronic health records across Canada. Nova Scotia is developing a health information privacy framework for use in hospitals and other health service delivery venues.	The Department of Health, in partnership with Canada Health Infoway, successfully completed Phase I of the Infoway Toolkit project. Due to a changing legislative landscape and a shift in our partner's priorities, Phase II will be addressed at a later date. Subsequently, the Department became part of a national task group responsible for developing a pan-Canadian privacy framework. This framework will apply to health sectors in all jurisdictions. In addition, policies and guidelines were developed for information obtained and stored by the department as well as the systems used to maintain the information.
Electronic Health Records The importance of strategic investment in the development and implementation of the Electronic Health Record (EHR) has been recognized in both the Romanow and Kirby reports and in the First Ministers' Health Accord. A comprehensive hospital information system will enable the health records of Nova Scotians to travel with them wherever they access hospital-based care in the province. The Nova Scotia Hospital Information System (NShIS) will implement clinical information systems across the province to enable health care providers to access the information they need to provide quality health care. Following the system's implementation in the Guysborough/Antigonish/Strait Health Authority, the system will be expanded to Cape Breton during 2003-2004.	In 2003-2004, The Nova Scotia Hospital Information System (NShIS) was implemented in the Guysborough/Antigonish/Strait District Health Authority and expanded to include Cape Breton. The NShIS implementation process involves major operational areas such as laboratory services, radiology, pharmacy, and patient processing (i.e. admission/registration/discharge, scheduling and patient care documentation).

Priority	Accomplishments
Health System Performance Measurement Accountability is an important part of the Health Accord which Nova Scotia fully supports. Among other accountability and progress reports on the Department's web site, Nova Scotia participated in a nation-wide reporting project which resulted in the publication of "Reporting to Nova Scotians on Comparable Health and Health System Indicators" (www.gov.ns.ca/health/pirc/) in 2002. The Department of Health will undertake to produce more focussed reports in the near future. In collaboration with health system stakeholders, the Department will develop a more detailed and Nova Scotia-specific health indicators report for publication in 2003. Among other things, the report will include information on wait times for several key health services.	The Department has taken a leading role in the development of inter-provincially comparable indicators based on priorities identified in the February 2003 First Ministers Meeting Accord. The implementation of Management Information System (MIS) reporting throughout District Health Authorities has increased our capacity to assess the efficiency of health system performance. In addition, focussed reports based on health status and population health issues were published. Some of these reports include profiles from the Canadian Community Health Survey focussing on mental health issues in Nova Scotia, satisfaction with, and access to, health care services, chronic disease and physical activity as well as detailed hospital utilization reports combining clinical, workload and financial information.

Health Human Resources

Priority	Accomplishments
Nursing Strategy and Enrollment Increase The Nursing Strategy includes initiatives to support recruitment, retention and renewal of the nursing workforce in Nova Scotia. A continued focus on orientation, continuing and specialty education, enhanced recruitment efforts and appropriate workforce utilization will help address the major challenges for nursing. In 1999, the government began funding an additional 75 nursing seats each year. As a result, 187 nurses will graduate in 2003, more than double the number in 1998. Another 50 to 60 seats will be added in 2003-2004, half in the joint program at St. Francis Xavier University and the University College of Cape Breton, and half in the new accelerated nursing program at St. Francis Xavier. St. Francis Xavier will also begin a bridging program to allow licensed practical nurses to become registered nurses more quickly.	The Nursing Strategy continues to make a positive contribution to nursing recruitment, retention, and renewal throughout the province by: providing a comprehensive, coordinated approach to continuing and specialty education; support for recruitment and orientation initiatives; appropriate workforce utilization; and improved quality of work life. Overall, the number of employed nurses was higher in 2003-2004 than 2002-2003. Furthermore, significantly more nurses were employed in permanent versus casual positions. Nova Scotia retained over 80% of its new graduates, about 90% of whom have found full-time employment. Beginning in 2003, 60 more nurses were added to nursing education programs in Nova Scotia. The Nursing Strategy funded: • 25 additional seats in the Joint St. Francis Xavier-University/College of Cape Breton Nursing Program; • 25 seats in a new 20-month accelerated program at St. Francis Xavier, and • 10 seats in a new bridging program to help LPNs become registered nurses more quickly. In 2003-2004, the Nursing Strategy also: • Awarded $200,000 in nursing grants to help nurses undertake 22 short-term projects to enhance nursing practice and patient care, improve quality of work life, and promote innovation and creativity. • Sponsored the development of strategies to enhance nursing leadership across the province. • Established a provincial working group to provide advice and develop recommendations to enhance the sustainability of our rural nursing workforce.

Priority	Accomplishments
Medical Laboratory Technologists Nova Scotia needs more medical laboratory technologists. In 2003-2004, Nova Scotia will purchase additional seats in the program offered through the New Brunswick Community College system and will offer these Nova Scotian students bursaries of $4,000 in each year of the two-year program of studies. Other options for meeting this need will be identified and explored during 2003-2004.	The Department of Health purchased a customized 25 seat training program for Medical Laboratory Technologists (MLT). In addition, a new bursary program was established . This program will pay the tuition of those medical laboratory students who sign a return in service agreement, committing them to work in the Nova Scotia health care system for two years following their graduation. Each student accepted into the program is eligible to receive $8,000 for tuition for the two-year period. The MLT program began in January 2004. Students will complete their first year at the New Brunswick Community College (NBCC-Saint John Campus) and the majority of their second year will be completed in Nova Scotia.
Medical School Enrollment Increase Eight new seats will be added to the first-year class at the Dalhousie Faculty of Medicine in 2003-2004. The Department of Health is working closely with the Faculty of Medicine at Dalhousie University to develop a long term plan for continued enrollment growth in accordance with the needs of Nova Scotians.	The Department of Health is committed to enhancing undergraduate and post-graduate training opportunities for physicians in Nova Scotia. Eight (8) new seats were added to the Dalhousie Faculty of Medicine in 2003-2004.
Physician Resource Planning Nova Scotia's Physician Resource Planning Steering Committee has completed the development of a methodologically robust and flexible approach to physician service planning across the province. Consultations on the approach and application will be carried out during 2003-2004, resulting in the implementation of a provincial physician resource plan.	The Nova Scotia Physician Resource Planning Steering Committee remains committed to the work of this project. Work continues to ensure that the efforts of the committee result in a physician resource plan that operates within a provincial and local scope.

Financial Results 2003 - 2004
($ in thousands)

2003-2004 Estimate	Cost Centers	2003-2004 Actuals	Est./Act.Variance
28,386,000	Total-Administration	27,390,661	(995,339)
425,694,000	Medical Payments	448,583,760	22,889,760
95,692,000	Pharmacare Program	96,473,925	781,925
33,889,000	Other Insured Programs	31,800,192	(2,088,808)
(27,554,000)	Revenue and Recovery	(22,999,112)	4,554,888
65,624,000	Emergency Health Services	64,170,254	(1,453,746)
87,836,000	Other Health Care Initiatives	80,420,218	(7,415,782)
20,836,000	Other Programs	11,576,546	(9,259,454)
1,029,916,000	Total - District Health Authorities	1,089,304,815	59,388,815
25,894,000	Care Coordination	23,748,141	(2,145,859)
101,199,000	Home Care Services	91,792,754	(9,406,246)
222,542,000	Long Term Care	224,054,369	1,512,369
1,500,000	Capital Grants - Health	0	(1,500,000)
2,111,454,000	********Department of Health*******	**2,166,316,523**	**54,862,524**

Financial Results 2003-2004 Estimate vs. Actuals

Estimate: **$2,111,454,000**
Actual: **$2,166,316,524**
Total Variance: **$ 54,862,524**

Variance Explanations:

Administration: Decrease due to vacancies and 2.5% savings achieved through the Budget Management Plan.

Medical Payments/Physician Services: Increase due to negotiations in the Alternative Funding Programs and physicians, and utilization increases in the fee for service area.

Revenue and Recovery: An overall net decrease is due to increase in out-of-province hospital payments from Nova Scotia to other provinces; decrease in third party liability recoveries and increase in recoveries from other provinces.

Emergency Health Services: Decrease due to cost saving incentive and HST recovery anticipated to be higher than planned.

Other Healthcare Initiatives and Other Programs: Net decrease is due to transfer of funds to DHA's; decrease in amortization costs due to change in amortization rate/thresholds in the Tangible Capital Assets Policy and remainder of savings achieved in the Budget Management Plan.

DHA/PHCC's: Additional funding to meet wage and operational pressures and transfers of funds from other programs and other healthcare initiatives areas within the department.

Care Coordination/Home Care Services: Additional savings in care coordination/home care services as a result of delays in hiring staff; a reduction in contracted service volumes and savings achieved in the Budget Management Plan.

Long Term Care Program: Overall increase in nursing home occupancy rates and public clients.

Capital Grants: Decrease due to capital grants payments of $30M being eliminated through the consolidation process at the Department of Finance.

2003 - 2004 Department of Health Outcomes Report

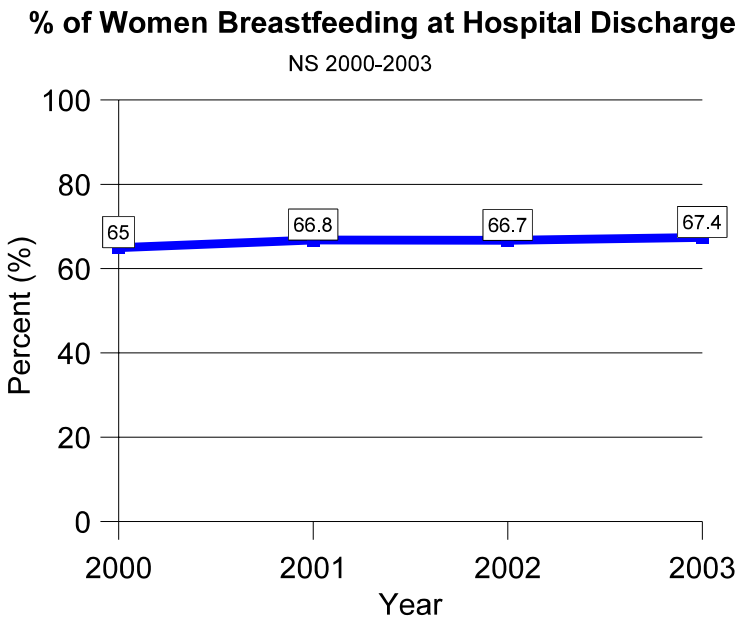
Outcome Measures - New, Revised and Discontinued

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

Measure	Explanation
Proportion of Non-Smoking Population Regularly Exposed to Environmental Tobacco Smoke in the Home, Public Spaces and Work Places	Revised: In the 1.1 cycle of the Canadian Community Health Survey (CCHS) in 2000/2001, there was a single question about exposure to environmental tobacco smoke. However, in the 2.1 cycle in 2003, the question was refined to distinguish between smoke exposure at home, in vehicles and in public places. As a result of this change, the 2003 data are not comparable.
Percentage Reporting Body Mass Index in Excess of the Healthy Range	Revised: In 2003, Statistics Canada standardized the BMI measure to incorporate both Canadian and International Standards. The BMI information presented here is representative of this amalgamated standard rather than specific to the standard presented in the last year's report.
Percentage of the Population (Aged 18 or Older) Receiving Homemaking Nursing or Respite Services	Revised: The total population measured in the CCHS as receiving home care services is aged 15+.
Average Number of Community-based Visits for Clients with Serious Mental Illness	Discontinued: This measure has been removed from this year's report due to concerns related to data quality in the administrative systems used to capture the information.
Number of Clients with Serious Mental Health Problems that are Treated Outside of Inpatient Hospital Settings	Discontinued: This measure has been removed from this year's report due to concerns related to data quality in the administrative systems used to capture the information.
Amount of time Clients wait for service - Long Term Care and Home Care	New: This is a new measure. Data are not yet available.

Percentage of Women Breastfeeding at Hospital Discharge

One of the Department's core business areas is population health and primary health care. A desired outcome that falls within the scope of this business area is healthy babies, children and families. One measure of this outcome is the percentage of women breastfeeding at hospital discharge.



What Does the Measure Tell Us?
This measure is the number of women known to be breastfeeding at hospital discharge as a percentage of the number of women whose breastfeeding status (yes or no) is known. Breastfeeding enhances the healthy development of newborns by contributing to healthy brain and nervous system development, protecting babies against infectious diseases, and leading to improved mother-child bonding.

Where Are We Now?
Data from 2000 to 2003 shows a slow increase in women breastfeeding at the time of hospital discharge.

Where Do We Want to Be in the Future?
By 2004-2005, the Nova Scotia government aims to increase the percentage of women breastfeeding at hospital discharge to 73%. Strategies to achieve this target include continuing to promote, support and protect breastfeeding through extensive local public health services; continuing to work on provincial and District Health Authority breastfeeding and baby-friendly initiative policy development, and developing breastfeeding education standards for professionals.

Proportion of Non-smoking Population Regularly Exposed to Environmental Tobacco Smoke in the Home, Public Spaces, and Work Places

One of the Department's core business areas is population health and primary health care. A desired outcome that falls within the scope of this business area is healthy babies, children and families. Certain environmental conditions are known to be harmful to health. One of these is environmental, or second-hand tobacco smoke.

What Does the Measure Tell Us?
This measure describes how many non-smoking Nova Scotians (aged 12 years and over) were exposed to environmental tobacco second-hand smoke on most days during the previous month. Living or working in a smoke-filled environment can lead to serious health problems, such as lung cancer and heart disease. At least 200 non-smoking Nova Scotians die every year from exposure to environmental tobacco smoke. Many more suffer from bronchitis, ear infections, pneumonia, heart problems, and other diseases. Asthma, allergies, and environmental illnesses are all aggravated by tobacco. Reducing exposure to tobacco smoke is key to preventing these illnesses.

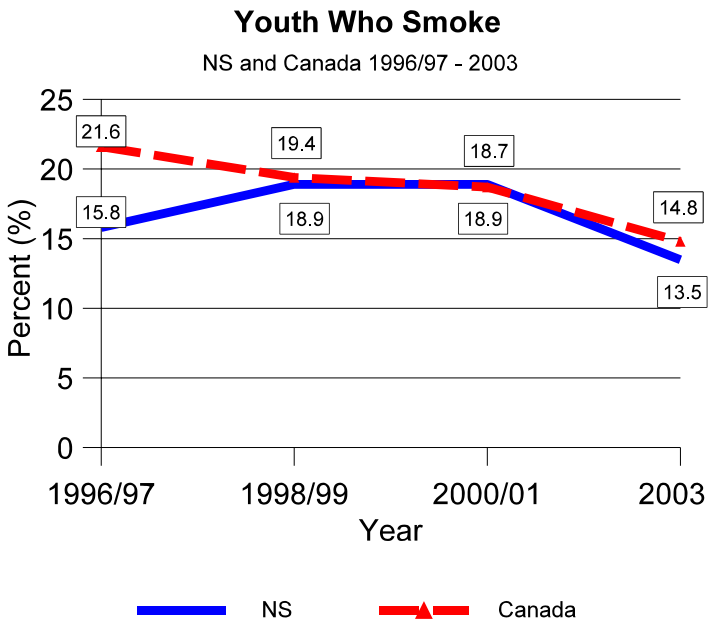
Where Are We Now?
In 2000/01, approximately 32% of Nova Scotian non-smokers reported being regularly exposed to second-hand tobacco smoke. This contrasts with approximately 28% of Canadians who reported exposure to second-hand smoke. In 2003, 15.6% of Nova Scotians reported being exposed to environmental tobacco smoke in public places. This is significantly less than the 19% of Canadians who reported the same. More Nova Scotians, however, report exposure to environmental tobacco smoke at home (12.5%). 10.5% of Canadians reported exposure to environmental tobacco smoke at home.

In the 1.1 cycle of the Canadian Community Health Survey (CCHS) in 2000/2001, there was a single question about exposure to environmental tobacco smoke. However, in the 2.1 cycle in 2003, the question was refined to distinguish between smoke exposure at home, in vehicles and in public places. As a result of this change, the 2003 data are not comparable.

Where Do We Want to Be in the Future?
Nova Scotia is implementing 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 we hope to have decreased the second-hand tobacco smoke exposure rate to the Canadian average or less.

Percentage of Youth Who Smoke

One of the Department of Health's core business areas is Population Health and Primary health care. Smoking is the number one cause of preventable death and disability. High rates of smoking translate into high rates of chronic disease such as lung cancer, heart and respiratory disease. Reducing youth smoking is key to the prevention of smoking related illness and to the promotion of healthy populations.



What Does the Measure Tell Us?

This measure describes the percentage of youth (aged 12 to 19 years) who smoke in Nova Scotia and Canada. Habits adopted during the teen years tend to be maintained well into adult life. Therefore, this measure informs us about smoking among young people as well as the number of adults who may be smokers in the future. Preventing or limiting smoking among young people has important long term benefits such as reduced smoking among adults and the prevention of serious illness.

Where Are We Now?

According to the Canadian Community Health Survey, in 2003 13.5% of Nova Scotia's youth (aged 12 to 19 years) smoked, compared to 15.8% in 1996-1997, a 2.3% decline from 1996 to present. In Canada, the smoking rate in youth declined from 21.6% to 14.8%.

Where Do We Want to Be in the Future?

Our aim is to decrease the percentage of youth who smoke. Strategies to achieve this target include continued implementation of all components of the Comprehensive Tobacco Strategy.

Percentage Reporting Body Mass Index in Excess of the Healthy Range

One of the Department's core business areas is Population Health and Primary health care. A desired outcome within this area is decreased overweight and obesity.

A healthy body weight (for height) is associated with a reduced risk of health problems. Overweight and obesity are associated with increased risk of health problems and conditions such as high blood pressure, diabetes, gall bladder disease, and pregnancy complications. Body weight is influenced by genetic, gender, age, and lifestyle factors such as poor eating habits and inadequate physical activity. Canada's Guidelines to Healthy Eating (1992) recommend that Canadians "achieve and maintain a healthy body weight by enjoying regular physical activity and healthy eating". Nova Scotians need to be supported through education and skills, policy, and enhanced community capacity to adopt and maintain healthy body weights, healthy eating and physical activity behaviours.

What Does the Measure Tell Us?
The Body Mass Index (BMI) is a valid measurement of weight in relation to health for healthy adults aged 20-65 years. This is a common method for calculating if an individual's weight is in a healthy range based on their body weight and height. BMI is not recommended for use as the sole measurement of either body composition or level of physical fitness. According to current guidelines, a BMI between 20 and 25 is considered within a healthy weight range.

Where Are We Now?
Since 1994, Nova Scotians have consistently reported being more overweight and obese than the average Canadian. The Nova Scotian rate has declined slightly since 1994, from 54.8% of the population reporting being overweight or obese to 54.1% of the population reporting the same in 2003. The Canadian rate has increased slightly, going from 47.4% in 1994 to 48.2% in 2003. In the 2002-2003 Business Plan, BMI was reported using the Canadian Standard for BMI. Since that time, methods to define and assess BMI have been revised to amalgamate the International and Canadian standards.

Source: Statistics Canada, CCHS

Where Do We Want to Be in the Future?
By 2004-2005, with partners at multiple levels and in multiple sectors, the Nova Scotia government aims to decrease to the number of Nova Scotians whose body weight increases their risk for health problems to 52%. Toward this end, the Department of Health has continued to develop and strengthen strategic linkages in the community and other sectors. In addition, the Department will collaborate with the Nova Scotia Alliance for Healthy Eating and local public health services to promote behaviours, capacity, and policies that support and protect healthy eating and physical activity.

Physical Inactivity: Percentage of Nova Scotians (12 Years and Older) Who Are Considered Inactive

One of the Department of Health's core business areas is Population Health and Primary health care. A desired outcome within this area is an increase in health-related behaviour. Physical inactivity is an important indicator of unhealthy behaviour. Studies show that inactivity is a major risk factor for heart disease and depression and that regular physical activity can provide important health benefits.

What Does the Measure Tell Us?
Physical inactivity is measured by calculating the proportion of the population aged 12 years and older who report being physically active less than once per week or never. The province's goal is to increase physical activity among Nova Scotians.

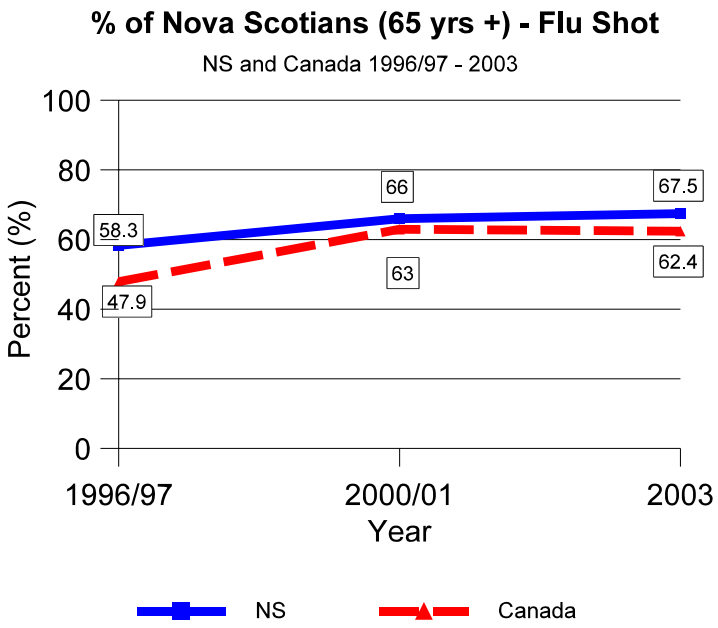
Where Are We Now?
In 2003, 49.7% of Nova Scotians reported being physically inactive, as compared with 46.9% of Canadians. There has been a 12.8% reduction in Nova Scotians reporting physical inactivity since 1994/5.

Source: Statistics Canada, CCHS & NPHS

Where Do We Want to Be in the Future?
Maintaining regular physical activity is associated with many benefits, including improved cardiovascular and mental health. The province's goal is to increase physical activity through joint initiatives such as the Provincial Physical Activity Strategy for Children and Youth, the Chronic Disease-prevention Strategy, and curriculum revisions to increase physical activity in schools. The Department of Health participates in these initiatives.

Percentage of Nova Scotians (65 years and older) Who Received a Flu Shot in the Past Year

One of the Department of Health's core business areas is Population Health and Primary health care. A desired result of work within this area is the reduction of diseases which can be prevented by vaccine. Vaccination coverage is important in promoting and maintaining public health and preventing the spread of infectious disease.



Source: Statistics Canada, CCHS & NPHS

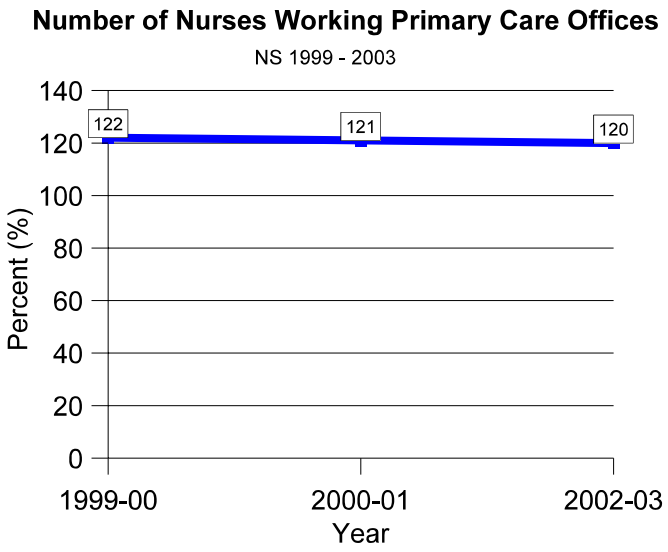
What Does the Measure Tell Us?
Vaccination coverage is measured by calculating the percentage of people (aged 65 years and older) who reported having their last flu shot during the past year. By increasing the number of people who receive flu shots, we can decrease the burden of illness on vulnerable populations - such as the elderly - and reduce the strain on the health system at the same time.

Where Are We Now?
In 2003, 67.5%of the Nova Scotian population over 65 years of age reported having had a flu shot in the last year, as compared with 62.4% of all Canadians 65 or older. This shows an improvement since 2000-2001 when 66.0% of Nova Scotians reported receiving flu shots. While Canada reports a .6% reduction in the number of those 65 years of age or older who received a flu shot, Nova Scotia's percentage of the population reporting flu immunization continues to increase. Decreases in the hospitalization of people with influenza and pneumonia may also reflect the success of immunization programs and aggressive public awareness campaigns.

Where Do We Want to Be in the Future?
Immunization against the flu is an important public health intervention. By 2004-2005, the province aims to increase to 80% the percentage of the population aged 65 years and older who receive influenza vaccinations.

Number of Nurses Working Primary Care Offices

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



What Does the Measure Tell Us?

This measure is one way of showing what type of, and how much access to health professionals the public has at primary care sites. Problematic with this measure, however, is the inability to discern whether nurses reporting working in primary care practices are actively nursing.

Where Are We Now?

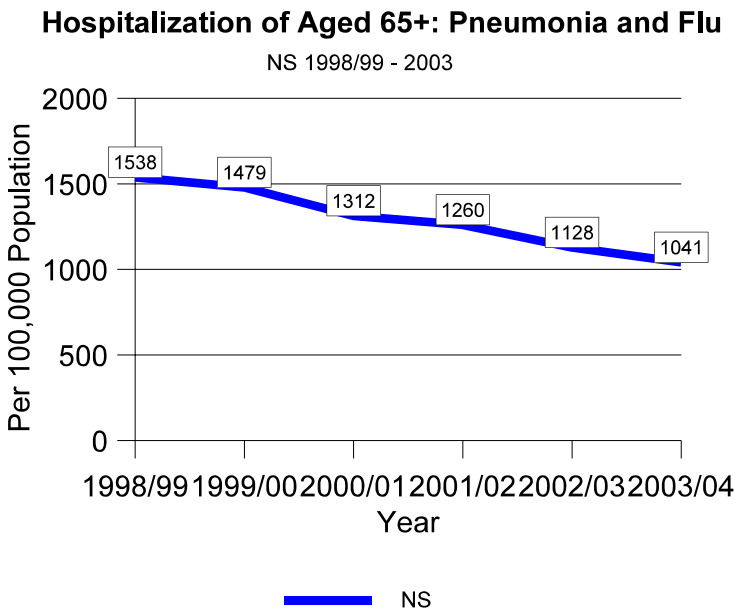
In 2002-2003, there were 120 nurses working in primary care offices. This is a slight decline from previous years.

Where Do We Want to Be in the Future?

A target for 2004-05 has not been set. Strategies to promote the number of nurses working in primary care offices include planning for the development of a renewed community-based health care system for Nova Scotia and support for the nurse practitioner education program. One of the goals of the Department of Health is to increase access to health services for the public by increasing the number of health providers and providing more access to the appropriate health care provider at the appropriate time. This could include providing access to a nurse in a primary care practice for wound care or providing increased primary care setting access to mental health care providers.

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

One of the Department of Health's core business areas is Acute and Tertiary Hospital Care. A desired outcome in this area is the appropriate use of all health care settings. One way to measure the appropriate use of health care settings is by calculating the number of hospitalizations for pneumonia and influenza among people aged 65 years or older. Many cases of influenza and pneumonia can be prevented through immunization.



Source: DAD, NS Dept. of Health

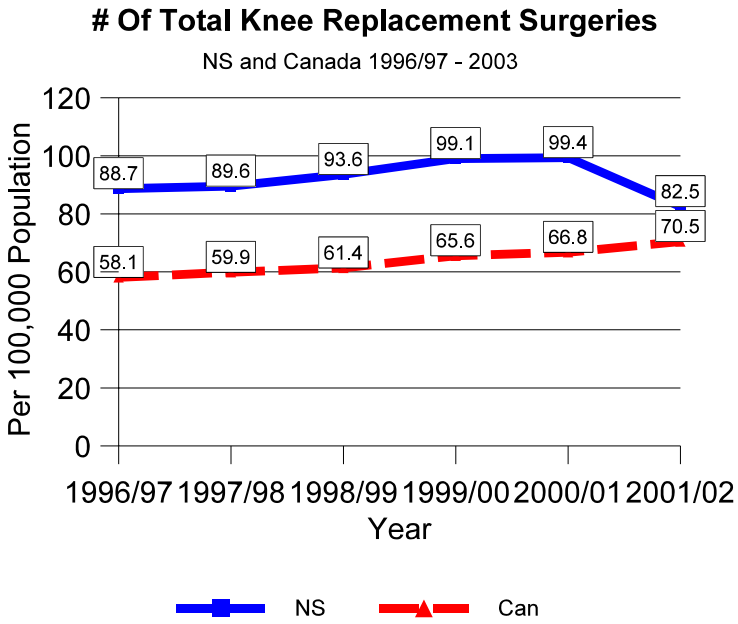
What Does the Measure Tell Us?
Calculating the age standardized rate of people aged 65 years or older who are hospitalized for pneumonia and influenza can help us to assess the success of programs to prevent illness altogether or contain its severity and permit management outside of hospital.

Where Are We Now?
During the year 2003-2004, 1041 people per 100,000 population aged 65 years or older were hospitalized for pneumonia and influenza. This shows a significant decrease since 1998-1999 when 1,538 people were hospitalized.

Where Do We Want to Be in the Future?
The Department's target is to reduce the number of hospitalizations for pneumonia and influenza to levels consistent with or below the Canadian average. Towards this end, the Department of Health will monitor opportunities to use outpatient services whenever appropriate to treat pneumonia and influenza and will continue to work towards increased vaccination coverage of the population aged 65 years or older.

Number of Total Knee Replacement Surgeries

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



Source: CIHI Health Indicator Reports

What Does the Measure Tell Us?

Rates for total knee replacement surgery are age-standardized measures of the number of knee replacement surgeries performed on inpatients in acute care hospitals per 100,000 population. The age standardized rate of total knee replacement surgeries performed reflects access to health services and improved quality of life.

Where Are We Now?

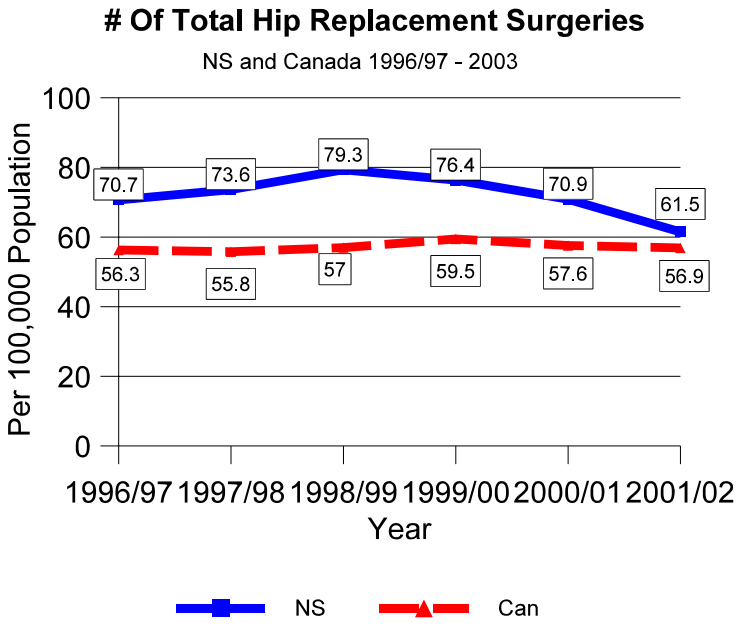
Total knee replacement surgery is known to result in considerable improvements in functional status, pain relief, and overall quality of life. The number of knee replacements increased steadily in both Nova Scotia and Canada from 1996/97 until 2000/01. In 2001/02, Nova Scotia's age standardized knee replacement rate per 100,000 dropped by approximately 17 cases per 100,000. At the same time, the Canadian rate continued to increase steadily. The gap between the Nova Scotian and Canadian knee replacement rate has been narrowed substantially but in 2001/02, Nova Scotia continued to have a higher age standardized rate (82.5 per 100,000) than the Canadian average (70.5 per 100,000).

Where Do We Want to Be in the Future?

The Department of Health aims to maintain Nova Scotian total knee replacement surgery rates at levels better than or consistent with the Canadian average (70.5 per 100,000 in 2001-02).

Number of Total Hip Replacement Surgeries

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



Source: CIHI Health Indicator Reports

What Does the Measure Tell Us?
Age standardized total hip replacement surgery rates are age-standardized measures of the number of Total Hip Replacement Surgeries performed on inpatients in acute care hospitals per 100,000 population. The number of Total Hip Replacement Surgeries performed reflects access to health services and improved quality of life.

Where Are We Now?
Total Hip Replacement Surgery is known to result in considerable improvement in functional status, pain relief, and other gains in health-related quality of life. Over the past six years, the age standardized rate of hip replacement surgeries in Nova Scotia decreased from 73.7 per 100,000 population in 1996-1997 to 61.5 per 100,000 population in 2001-02. During the same period, age standardized total hip replacement rates have increased across Canada from 56.3 per 100,000 population in 1996-1997 to 56.9 per 100,000 population in 2001-02. While our rate has decreased over the past six years, the trend suggests that Nova Scotians continue to have greater access to this procedure than other Canadians.

Where Do We Want to Be in the Future?
The Department of Health aims to maintain Nova Scotian Total Hip Replacement Surgery rates at levels better than or consistent with the Canadian average (56.9 in 2001-02).

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

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

What Does the Measure Tell Us?

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

Where Are We Now?

During 2001-02, 355 hospitalizations age standardized rate or people per 100,000 occurred in Nova Scotia for conditions where appropriate outpatient care may have prevented the need for hospitalization, as compared to 346 per 100,000 Canadians overall. Provincially and nationally, ambulatory care sensitive condition scores have steadily decreased over the last 6 years reflecting a consistent positive trend towards the more efficient use of health services.

Where Do We Want to Be in the Future?

Nova Scotia is aiming to limit the proportion of people admitted to hospital for ambulatory care sensitive conditions to levels consistent with the Canadian average. Towards this end the Department of Health will continue to monitor the effective utilization of hospital beds and review opportunities to use outpatient services most effectively.

Percentage of Health Human Resource Positions (doctors, nurses, etc.) Filled in Under-served Areas

One of the Department of Health's core business areas is Insured Health Programs which includes the services of many health care professionals. A desired outcome in this area is access to quality health care. One way to enhance access is by ensuring the appropriate number and distribution of health care providers.

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

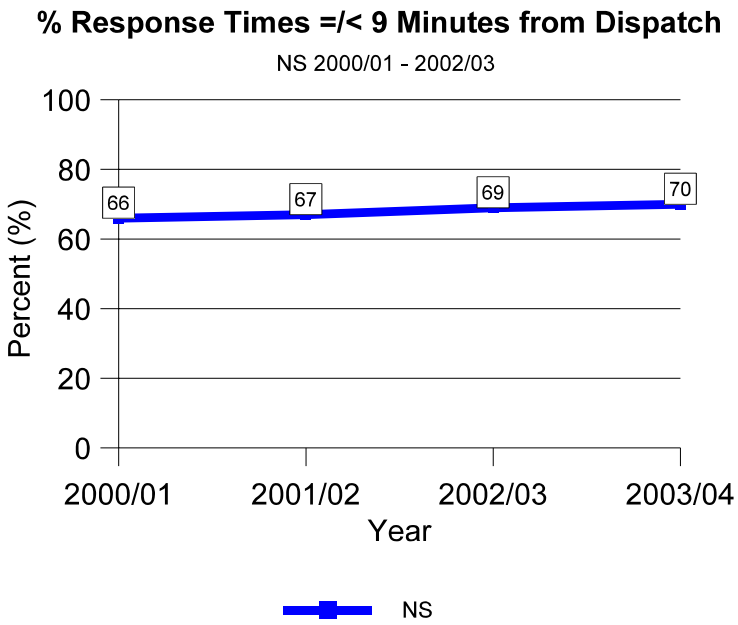
Where Are We Now?
In February 2004, there were less positions identified as positions in under-served areas; 42 under-served areas were identified as compared to 44 identified in 2003. Thirty-four of the 42 physician positions were filled in these areas (81 per cent).

The total number of physicians in under-served areas changes rapidly because of natural fluctuations (deaths, retirements, and the voluntary relocation of providers within the province) and successful recruitment. Ongoing recruitment efforts are required to maintain or exceed the provincial target (80 percent). Nova Scotia is focussing on building multi-professional care teams. Four pilot Strengthening Primary (Health) Care Initiative (SPCI) sites transitioned to the District Health Authorities with sustainable funding and eight new Primary Health Care Nurse Practitioner positions were funded for collaborative practice in community clinics across the province. The Department of Health is engaged in health human resources planning to address the supply and distribution of health care professionals and other workers across the province.

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

Percentage of Response Times at 9 Minutes or Less from Ambulance Dispatch to Arrival at Emergency Scene

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



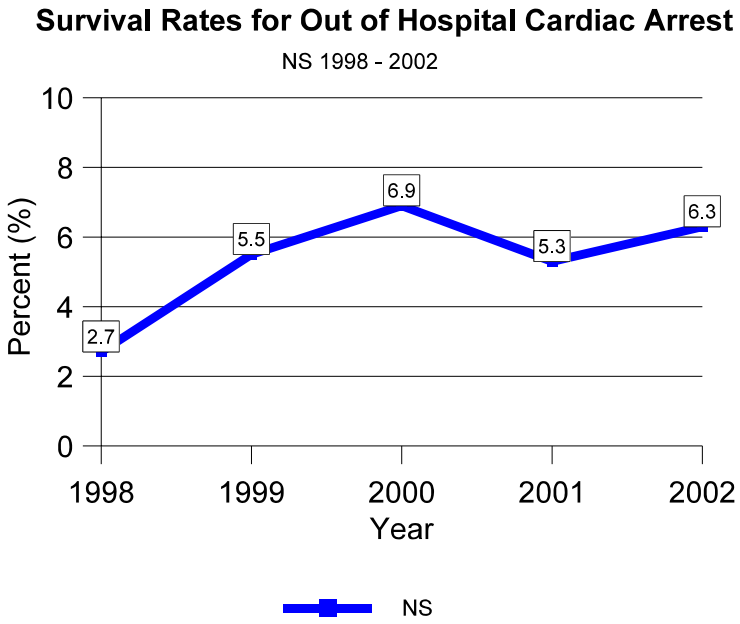
What Does the Measure Tell Us?
The industry standard for response time from ambulance dispatch to arrival at the emergency scene is 9 minutes or less. This standard is based on chances of survival after a cardiac arrest. That is, a person's chances of surviving a cardiac arrest improve if an ambulance arrives at an emergency scene within 9 minutes or less.

Where Are We Now?
In 2003-04, response times from ambulance dispatch to arrival at the emergency scene was 9 minutes or less 70% of the time. This shows an improvement since 2002-03 when response times of 9 minutes or less occurred 69% of the time, and exceeds the target that was established in setting up the ambulance service.

Where Do We Want to Be in the Future?
The Nova Scotia government has defined a target of 68% (by 2004-05) for response times of 9 minutes or less from ambulance dispatch to arrival at the emergency scene.

Survival Rates for Out-of-hospital Cardiac Arrests

One of the Department of Health's core business areas is Emergency Health Services. A desired outcome in this area is ensuring the effectiveness of emergency health services.



What Does the Measure Tell Us?
The effectiveness of emergency health services may be measured by calculating survival rates for those individuals who suffer cardiac arrests outside of hospital. Many factors affect out-of-hospital cardiac arrest survival such as the availability of timely and skilled intervention.

Where Are We Now?
In 2002, survival rates for out-of-hospital cardiac arrests were 6.3%. Because of the relatively small numbers, this is within the normal year-to-year variation. It is difficult to compare Nova Scotia's system with similar systems because of the different mix of urban and rural jurisdictions in other provinces. However, it is possible to compare Nova Scotia's out-of-hospital cardiac arrest survival rates over multiple years. An examination of Nova Scotian out-of-hospital cardiac arrest survival rates shows improvement in survival rates that since 1998.

Where Do We Want to Be in the Future?
Nova Scotia's goal is to improve survival rates for out-of-hospital cardiac arrests over time. Strategies to achieve this target include maintaining training, ongoing procedural review and development, and exploring the development of a bystander care initiative.

Percentage of the Population (Aged 15 or Older) Receiving Homemaking, Nursing or Respite Services

One of the Department of Health's core business areas is Continuing Care Services. A desired outcome in this area is ensuring access to quality Home Care and Long Term Care Services. Access to long term care and home care services may be measured by estimating the percentage of the population (age 15 or over) who receive homemaking, nursing, or respite services.

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

What Does the Measure Tell Us?
As more home care programs are implemented, it is expected that these services will be provided to increasing numbers of people. Estimating the percentage of the population (aged 15 years and over) that receives homemaking, nursing or respite service helps us to understand growth in, and access to, quality Home Care and Long Term Care Services.

Where Are We Now?
In 2000/01, 2.8% of individuals, aged 15 or older, received homemaking, nursing or respite services. In 2003, Nova Scotians reported that 2.9% of individuals, aged 15 or older, received homemaking, nursing or respite services.

Source: Statistics Canada, CCHS

Where Do We Want to Be in the Future?
It is our goal to ensure that Nova Scotians have appropriate access to home care services. More data are required before a formal target can be set. We have been working on the establishment of Single Entry Access so that clients receive a single entry to Home Care or Long Term Care services.

Percentage of All Patient Days Spent in Psychiatric Inpatient Units Accounted for by Patients with Serious Mental Illness

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

What Does the Measure Tell Us?
Persons with serious and persistent mental health problems are those who benefit most from hospital admissions. However, other individuals, for whom outcomes are not enhanced by hospital care, may also be admitted to hospital because alternative community-based services or supports are not available. With limited inpatient capacity, this may reduce the availability of hospital care for those who need it most. The percentage of all patient days spent in hospital accounted for by patients with serious mental illness is calculated by dividing the number of patient days on designated psychiatric inpatient units for patients with serious mental illness by the total number of patient days on designated psychiatric inpatient units.

Where Are We Now?
In 2003-04, 71.9 percent of patient days spent in psychiatric inpatient units were accounted for by patients with serious mental illness. This has been fairly consistent since 1999-00.

Where Do We Want to Be in the Future?
The Department of Health has a target of 75% by 2004-05. The strategy to reach this goal is to continue to support shifting service options from inpatient hospital care to alternate settings where appropriate.