Annual Accountability Report for the Fiscal Year 2004-2005

NOVA SCOTIA
Health

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Annual Accountability Report For The Year 2004-2005

Department of Health

Accountability Statement

The accountability report of the Department of Health for the year ended March 31, 2005, is prepared pursuant to the Provincial Financial Act and government policy and guidelines. These authorities require the reporting of outcomes against the Department of Health's business plan information for the fiscal year 2004-2005. The reporting of department outcomes necessarily includes estimates, judgements and opinions by department management.

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

The Honourable 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 2004-2005. The Government of Nova Scotia and the Department of Health set goals and established priorities for 2004-2005 in our business plan and budget. The outcomes reported here show that we remain committed to those goals and priorities and we do so at a cost which is sustainable for Nova Scotia.

I am proud of the many accomplishments in 2004-2005. Among our major achievements were:

Being Accountable to Nova Scotians: The Department of Health and Health Promotion released *Working Together Toward Better Care:* Minister's Report To Nova Scotians 2004-2005, the second year update on the *Your Health Matters* plan. The report outlined progress made in priority areas, and highlighted key challenges currently facing the healthcare system.

Positive Changes to Long Term Care: The Department of Health has implemented significant changes to the way long term care is funded and how residents pay for long term care. These and other program changes were launched on January 1, 2005 to promote independence, fairness, equity, and choice for people who require long term care. Residents who live in nursing homes, residential care facilities, and community based options under the Department of Health's mandate are no longer required to pay for their health care costs. As well, residents no longer have to use their assets to pay for their long term care accommodation costs.

Treatment for Children with Autistic Disorders: Funding of $4 million for early intensive behavioral intervention treatment was announced in November 2004. The program provides treatment to young children with Autistic Disorders. The program will be offered through District Health Authorities and the IWK Health Centre by qualified professionals. It is expected to take three years before the program will be fully operational across the province.

Expansion of Childhood Vaccine Program: The province invested an additional $9 million over three years to introduce new vaccines and expand existing programs. The new vaccines are being given to both babies and older children to protect against meningitis, pneumonia, blood infection, chickenpox, whooping cough, tetanus, and diphtheria.

The successes are notable. So are the challenges. Providing Nova Scotians with the care they need, when they need it at a cost that is sustainable for the province is a significant and ongoing challenge. Despite this, we continue to make significant and encouraging progress. We're making confident change for quality care - that is our commitment to families, to healthcare 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 2004-2005 fiscal year. This report should be read in conjunction with the 2004-2005 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 2004-2005, financial performance, and health system performance measures and outcomes.

Through leadership and collaboration to ensure an appropriate, effective and sustainable health systems that promotes, maintains and improves the health of Nova Scotians.

This is the mission of the Department of Health. The Department is committed to the ongoing improvement of 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 six key areas of care and service delivery. These are briefly outlined below:

Primary Health Care

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

Primary health care is about positively influencing the many factors that affect health. It includes a team-based approach to health-care delivery, all-day access to essential health services, care for people of all ages and cultures in their communities, and the appropriate use of technology.

Enhancing primary health care evaluation and research capacity throughout the province will strengthen Nova Scotia's ability to continue to improve the primary health care system beyond the transition phase.

The Primary Health Care Transition Fund continues to support District Health Authorities (DHAs) as they develop and implement primary health services. Major priorities include the creation of new ways to develop sustainable primary health care networks, increasing the number of community-based primary health organizations, and transitioning the primary health care system to an electronic patient record.

The Primary Health Care section provides policy and planning support for the redesign of a community-based primary health care system for Nova Scotia. Elements include: increasing the number of community-based primary health care organizations, more interdisciplinary teams, inclusion of midwives in interdisciplinary teams, better linkages to other parts of the health system, and increased emphasis on health promotion.

The Strengthening Primary Care in Nova Scotia Communities Initiative (SPCI) demonstrated new ways to fund, deliver and manage primary care in each of four Nova Scotia communities. New approaches included collaborative practice between nurse practitioners and physicians, electronic information systems and alternatives to fee-for-service payment for physicians. The evaluation of SPCI will inform ongoing primary health care renewal activities.

Mental Health Services

The Department of Health, Mental Health Division, is responsible for policy, standards, monitoring and funding mental health services. Mental Health services for children, youth and adults are delivered through the province's nine DHAs and the IWK Health Centre. Delivered across the life span, core programs include:

- secondary prevention and promotion,
- outpatient and outreach services,

- acute, short stay and long term psychiatric in-hospital treatment,
- specialty mental health services, and
- community supports.

Services are consumer and family-focused and community-based where possible. Some mental health services are delivered through a "shared care" approach in collaboration with primary care services.

All DHAs and the IWK Health Centre provide outpatient and outreach services through a network of more than 50 community-based mental health clinics. In-patient psychiatric units are located in all districts except the Cumberland Health Authority which accesses services from the adjoining Colchester-East Hants DHA. In addition, there are a number of day-treatment programs, psychosocial rehabilitation programs, and specialty mental health services available throughout the province. Specialty services include seniors mental health, eating disorders, adult and youth forensic services, sex offender treatment, early psychosis and neurodevelopmental services.

Acute and Tertiary Care

Through collaborative relationships with the nine DHAs, the IWK Health Centre, and several provincial health care programs, the Acute and Tertiary Care Branch ensures that affordable, appropriate, and effective acute care services are available to Nova Scotians. The Branch also liaises and supports the operations of provincial and ancillary programs ensuring that provincial standards for clinical care are developed and maintained across the province.

Acute and Tertiary Care Services Acute care services are delivered in 39 facilities throughout Nova Scotia. These include the 37 under governance and operation of the DHAs as well as the St. Anne's Community and Nursing Care Centre in Arichat and the IWK Health Centre in Halifax. Funding is provided by the Department of Health in accordance with the Canada Health Act and the Health Services and Insurance Act.

Inpatient services provided by DHAs range from general practitioner services at the community facility level to varied specialist services at the district level. Specialist services in district facilities may include cardiology, respirology, gastroenterology, obstetrics, otolaryngology, orthopaedics, ophthalmology, pathology, psychiatry, pediatrics, urology, plastic surgery, maxillofacial surgery, oncology, neurology, dermatology and endocrinology. Varying configurations of emergency and ambulatory care services are provided in community and district facilities across the province.

The Queen Elizabeth II Health Sciences Centre and the IWK Health Centre in Halifax are the province's two Provincial Health Care Centres (PHCCs). In addition to providing primary and secondary care services to metro area residents, they provide specialized services such as neurosurgery, secondary and tertiary care pediatrics, high risk obstetrics, burn intensive care, cardiac surgery, transplantation programs, cardio-thoracic surgery, immunology, hematology, as well as all the services available in the community and district facilities. The PHCCs also provide the highest level of emergency services.

Ancillary Programs The Acute and Tertiary Care Branch is responsible for the policy development, program content, tariff negotiations with the professional provider associations and day-to-day management of a group ancillary health services. Dental programs/services include children's oral health, cleft palate/craniofacial surgery, dental surgery, and services for mentally challenged clients. Prosthetic services include arm and leg, ocular, and mastectomy prostheses, and maxillofacial prosthodontics. Optometry and Interpreter Services for the Deaf and Hard of Hearing are also included.

These programs and services are not mandated as insured services under the Canada Health Act but are provided by the Province to assist those individuals who most require assistance.

Hospital Facility Construction and Renovations Working with the Department's Financial Services Branch, the Acute and Tertiary Care Branch plays a key role in the development and priority-based approval of DHA role studies, master programs and functional programs.

Provincial Health Programs The Acute and Tertiary Care branch is responsible for provincial programs that address health issues across sectors of the health system and which are beyond the mandate of any single DHA or health organization. Provincial Programs develop service standards, monitor their achievement, and provide advice to the Department of Health based on best practices, stakeholder input and research-based evidence.

Current Provincial Programs are:

- Cancer Care Nova Scotia
- Nova Scotia Diabetes Care Program
- Reproductive Care of Nova Scotia
- Nova Scotia Breast Screening Program
- Nova Scotia Cardiac Advisory Council
- Nova Scotia Provincial Blood Coordinating Program
- Nova Scotia Hearing and Speech Program

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.

Pharmaceutical Services provides programs, drug policy advice and research to promote, maintain and improve the health of Nova Scotians through appropriate drug use. The main program area is the Nova Scotia Seniors' Pharmacare Program which provides prescription drug insurance to 100,000 seniors in the province.

Continuing Care Services

Continuing care contributes to the integrated continuum of health services by providing a range of home, community and residentially based services to support individuals with identified health needs. Care is provided in a manner that enables the individual to live as independently as

possible in the community or in a residentially- based service. In most cases, the need for care and support is for the longer term (continuing care). However, short term needs are also addressed by both home care and residentially-based programs. While the majority of clients are seniors, services are also provided to younger adults.

Continuing care services include home care, long term care, adult protection and care coordination. Services are coordinated through single entry access that ensures care needs are identified through the use of a consistent assessment process. Referrals are made to the appropriate care providers. Assessment, care coordination and ongoing case management are a responsibility of the Continuing Care Branch. The Branch collaborates with approximately 140 provider organizations, including non-profit home support agencies, VON[1], and Nursing Homes/Homes for the Aged. Nursing Homes and Homes for the Aged are variously owned and operated by municipalities, private-for-profit owners, and non-profit organizations.

Home Care programs provide support to approximately 23,000 Nova Scotians. Services include both short term (acute) and longer term professional nursing care provided by registered nurses (RNs) and licensed practical nurses (LPNs). Home support services include personal care, nutritional care, essential housekeeping, and home oxygen. Community supports include adult day and volunteer programs, meals-on-wheels, and limited community rehabilitation services.

Residentially-based programs, providing support to approximately 8,500 Nova Scotians, include licensed Nursing Homes and Homes for the Aged, licensed Residential Care Facilities and a number of Community-Based Options that provide services to up to three clients, and operate within interim guidelines.

Adult protection support services are extended to adults 16 years of age or older who are abused or neglected (including self-neglect). Provided under the authority of the Adult Protection Act, these services are currently provided to approximately 1,300 clients annually. Of those, 75% are over the age of 65.

Health Protection, Public Health and Addictions, and Emergency Health Services

Health Protection is the responsibility of the Office of the Provincial Medical Officer of Health. Legislated responsibility includes the protection and promotion of the public's health in the areas of :

- Communicable disease control,
- Environmental health, and
- Emergency preparedness and response.

The Office of the Provincial Medical Officer of Health, in collaboration with academic expertise at Dalhousie University, functions as an expert resource in community health science and an epidemiological resource for the department, the health districts, and other relevant government and community groups.

[1]Victorian Order of Nurses

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.

Addiction Services is responsible for defining core services, development and review of standards and best practices for service delivery, development of provincial policy, monitoring and audit of programs, consultation with services in the districts, and facilitation of provincial program development. Programs and services are to Nova Scotians through the DHAs. Services at the DHA level span the continuum from prevention, community education, early identification and referral, to treatment and rehabilitation. Included are withdrawal management (detoxification and addiction education programs), community-based programs (outpatients and structured treatment), problem gambling services, and community education.

DHAs deliver addiction services using a "client centered" treatment philosophy. This includes client self-determination coupled with service options that are diverse, flexible and accommodating. The process is aimed at optimizing the health of individuals harmfully involved with alcohol, drugs, and/or gambling through the provision of a comprehensive range of integrated bio-psycho-social treatment services. Programs and services may be available on a residential, day, or outpatient basis, and may include individual, group and/or family programming. Targeted programming is offered where appropriate and may include programming for adolescents, women, families and/or driving while impaired offenders.

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

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

Priorities and Departmental Accomplishments for the Year 2004-2005

Population Health and Primary Health Care

Priority	Accomplishments
Primary Health Care Nurse Practitioner Positions Sustaining funding is secured for the 13 Primary Health Care Nurse Practitioner positions established in 2003. These serve to augment primary health care services currently provided and fill a longstanding service gap in many Nova Scotia communities. DHAs will continue their development of innovative primary health care initiatives including increasing the number of multi-disciplinary teams (family physicians, nurse practitioners, family practice nurses and other community partners) using a variety of collaborative practice models.	The Department of Health has committed to facilitate implementation and integration of Primary Health Care Nurse Practitioners in the DHAs. In 2004-05 there were 13 funded Primary Health Care Nurse Practitioner positions.
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. Ongoing activities in 2004 - 2005 will include involvement of 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.	Nine DHA led stakeholder workshops were held from early 2004 to Spring 2005. Planning, support, and guidance from the workshops was provided by the Primary Health Care section and funding was secured through the Primary Health Care Transition Fund. Recommendations for culturally inclusive policies were included in reports delivered after each workshop. Planning for the final workshop of the initiative began in early 2005 in partnership with the IWK Grace Health Centre. The objective of the final workshop was to engage primary health care providers in the development of guidelines for cultural competence in the delivery of primary health care. Members of the Primary Health Care section have sat on the steering committee for the Tui'kn Initiative as well as the Health and Sports and Recreation working committees of the Tripartite Forum.

Priority	Accomplishments
Primary Health Care Evaluation Nova Scotia is building upon its existing capacity for Primary Health Care evaluation and research to evaluate the impact of changes made as a result of renewal activities. Enhancing primary health care evaluation and research capacity throughout the province will strengthen Nova Scotia's ability to continue to improve the primary health care system beyond the transition phase. In February 2004, the Primary Health Care Section invited a broad range of stakeholders to a consultation on the development of evaluation framework for primary health care in Nova Scotia. The workshop was a key step in beginning the capacity-building process and engaging stakeholders in evaluation planning.	An evaluation framework for primary health care in Nova Scotia was developed through the engagement of stakeholders, DHAs, and the Nova Scotia Department of Health, Primary Health Care section. The Primary Health Care section contracted the completion of a PHC Evaluation Scope Definition, Literature Review, and Implementation Steps and the Primary Health Care Evaluation Logic Model was approved. Terms of Reference for the Evaluation Working Group were developed and the November 2004 Request for Proposals was issued to conduct the evaluation work for the Primary Health Care section. A contract was tendered for evaluation consultants responsible for the facilitation and development of evaluation consultants responsible for the facilitation and development of evaluation questions, primary health care indicators, measurement tools, and capacity building with the DHAs To date, Nova Scotia is working on developing evaluation questions specific to the components of the evaluation framework. DHAs, key stakeholders, organizations such as the Canadian Health Services Research Foundation (CHSRF), Health Canada, and the Canadian Institute of Health Information (CIHI) have been engaged in this development process. Following this process is the development and selection of primary health care indicators and measurement tools.

Priority	Accomplishments

Continuing Professional Education for Primary Health Care providers
Nova Scotia is the lead province in the Atlantic Region collaborative initiative *Building a Better Tomorrow*. The core initiative is the development and delivery of continuing professional education modules to primary health care providers in all four Atlantic Provinces in an effort to facilitate change. It will support providers' transition to a renewed primary health care system and complements renewal activities currently underway in the Atlantic Provinces. Key areas of focus in 2004-05 will be consultation and content design.
	The following was accomplished in 2004-05:
	• An environmental scan on Interdisciplinary Education was completed with specific recommendations to assist with content design;
	• The Atlantic project was created along with provincial Education Advisory Committees;
	• Human resources were secured to oversee project management;
	• A memorandum of understanding was confirmed with university partnership though Dalhousie University CME Office with a link to Memorial University Centre for Collaborative Health Professional Education;
	• A comprehensive Atlantic needs assessment was completed with leadership from the Dalhousie University CME office;
	• Priority learning needs were defined, as follows:
	  • understanding primary health care
	  • conflict resolution
	  • team building
	  • building community relationships
	  • program planning and evaluation
	• Planning for provincially specific education modules was initiated (electronic patient records and/or collaborative practice);
	• Module development and pilot testing was initiated;
	• Provincial delivery planning was initiated;
	• Provincial trainer recruitment was initiated and a "Facilitating Adult Learning" session for facilitators was designed and tested;
	• The evaluation framework was drafted with leadership from Memorial University;
	• Relationships were created with provincial stakeholders, i.e., professional associations/regulatory bodies, universities, and colleges.

Priority	Accomplishments
Primary Maternity Care In response to the recommendations of the Nova Scotia Advisory Committee on Primary Health Care Renewal, a Primary Maternity Working Group will be established in 2004 to develop a regulatory framework for inclusion of midwives in collaborative teams delivering primary maternity care in Nova Scotia. Issues to be explored include scope of practice, legislation/regulation, and integration with DHAs, collaborative teams, and payment strategies.	A Primary Maternity Care Working Group comprised of multiple stakeholders was formed in June 2004 to make recommendations on collaborative primary maternity care teams and on a regulatory framework to facilitate the inclusion of midwives in those teams. This group has met monthly through the year and a final report and recommendations is expected in June 2005.
Primary Health Care Transition Fund The Primary Health Care Transition Fund supports the DHAs as they develop and implement enhancement to primary health care services throughout the province. Priorities include the creation of new ways to develop sustainable primary health care networks/organizations; increased emphasis on health promotion, injury prevention and population health; and transitioning the primary health care system to an electronic patient record. These activities continue to be informed by the Nova Scotia Advisory Committee on Primary Health Care Renewal.	Nova Scotia's share of the Primary Health Care Transition Fund for 2004-05 was $4.8 million. The majority of these funds were distributed to the DHAs to allow for planning and implementation, as well as infrastructure support for Primary Health Care initiatives. Several provincial initiatives were also undertaken, including the launch of a Health Literacy Awareness Project, the Diversity and Social Inclusion Initiative, the Primary Health Information Management system, as well as the Building a Better Tomorrow program. In all nine DHAs, primary health care staff are working closely with the communities and primary health care professionals from multiple disciplines to identify the most appropriate, sustainable models for primary health networks/organizations in their respective areas. Some communities have chosen to implement new primary health networks/organizations. Other communities have needed to implement specific primary health care service enhancements in an effort to move towards the creation of sustainable primary health care networks/organizations in their districts, ensuring the needs of disadvantaged populations are addressed. A major thrust of the fund is to significantly expand upon the number of Nova Scotia Primary Health Care providers that use electronic patient records. Primary Health Care Information Technology initiatives have included the following activities:

Priority	Accomplishments
	• Developing an application service provider (ASP) infrastructure for Electronic Patient Record Systems which provides centralized delivery of EPR solutions to Primary Health Care clinics throughout Nova Scotia; • Contributing to Nova Scotia's Health System Interoperability Project by supporting primary health care provider access to Laboratory and Diagnostic Image Reporting. A core data set has been developed in collaboration with the Primary Health Care Transition Fund Information Management/Information Technology Advisory Committee. Provincial procedures have been put in place to support accreditation of software vendors and ongoing training in the use of primary health care information systems. The Primary Health Information Management Program (PHIM) successfully completed the RFP process selecting Nightingale Informatix Corporation as the sole ASP provider and Nightingale Informatix Corporation and Dymaxion Research Limited as the Local Client Server solutions. The majority of the ASP Hosting Infrastructure has been installed as per schedule. As outlined above in the "Supporting Change Costs Initiative", incentives for the acquisition and use of primary health care software and hardware will also aid in the transition to the electronic health record. These activities, consistent with Nova Scotia's information strategy, are laying the groundwork to support the future implementation of the primary health care component of an electronic health record.

Mental Health Services

Priority	Accomplishments
Mental Health Strategic Directions In 2003, the Department of Health provided $2 million in funding to the DHAs and the IWK Health Centre to implement core services standards in key areas of community supports, crisis services, and child and youth services. During 2004-2005, the Department of Health will work with teams of mental health clinicians and consumers to continue the implementation of core service standards for eating disorders, neurodevelopmental disorders, and services to seniors.	In February 2003, the government approved the Mental Health Standards for Nova Scotia and the Mental Health Strategic directions. It was estimated that it would take five to ten years to implement the Mental Health Standards. Nova Scotia was the first province in Canada to develop mental health standards. A Mental Health Standards Specialty Sub-Committee has developed a provincial service delivery model focused on eating disorders. An Eating Disorder Network to support the facilitation of standardized assessments, triage and access to services has been developed. This Network is committed to continuing staff development, building capacity at the district level, and networking with other health care providers. Other examples of specialty services are Sexually Aggressive Youth Treatment, Early Psychosis Program, Forensic Mental Health, and Neurodevelopmental Disorder. The Mental Health Steering Committee developed standards for specialized services for Neurodevelopmental Disorders and a treatment model for an Early Intensive Behavioural Intervention treatment program for children with Autism. This treatment program will be delivered through the DHAs/IWK and Nova Scotia Hearing and Speech. A project manager was recruited in January 2005 and the implementation advisory committee was formed in February 2005. Mental Health is a Department of Health priority for additional funds as resources permit.
Improving the Quality of Mental Health Services A plan for monitoring the quality, appropriateness and effectiveness of mental health services will be initiated. Included in this plan will be a mental health profile for each DHA and the IWK Health Centre utilizing information from Statistics	The third annual self-assessment against the Nova Scotia Mental Health Standards was completed for 2004-05. The self-assessment identified province-wide variation in service delivery relative to pre-established standards and assessed the variation's impact. This year, new specialty standards were added

Priority	Accomplishments
Canada's *Community Health Surveys*, the Department's ambulatory mental health information system, and hospital discharge abstracts. Pilot testing of standardized outcome and satisfaction measures will enable a uniform approach to evaluating treatment effectiveness and client satisfaction of mental health services.	to the process and a province-wide survey. The Nova Scotia division of the Canadian Mental Health Association graded Nova Scotia on mental health services. Governments efforts were praised in a number of areas: 1. Nova Scotia is the first province to develop core standards 2. Core standards have generated increased funding for mental health services 3. Annual funding has been established for consumer-led initiatives Areas identified for improvement were: 1. Timely, accessible community-based resources such as crisis service 2. Further partnership between formal and informal services 3. Public understanding of mental health and mental illness 4. Provincial advocate for mental health 5. Cooperation between Department of Health and Department of Community Services

Priority	Accomplishments
Child and Youth Mental Health Initiatives New mental health community-based treatment teams have been established at the Cape Breton DHA and at the IWK Health Centre to serve children and youth who require this level of intensive services. A new 12-bed provincial Mental Health Rehabilitation unit for youth provides mental health services to youth between the ages of 12 and 19 years who require longer-term inpatient treatment. This service had previously been provided only outside of Nova Scotia.	$3.1 million has been provided to IWK Health Centre and Cape Breton DHA to establish the Adolescent Centre for Treatment at the IWK Health Centre and two intensive community-based treatment teams at the IWK Health Centre and Cape Breton DHA. Autism Treatment Funding of $4 million for early intensive behavioural intervention treatment was announced in December 2004. The program will provide treatment to young children with Autistic Disorders. The program will be offered through District Health Authorities and the IWK Health Centre by qualified professionals. Details of the treatment rollout plan are still in development, but it is expected that it will take about three years before the program will be fully operational within nine DHAs and the IWK Health Centre. The first step in the process is to recruit and train appropriate staff. Some children will receive treatment through this training process. Pediatric Rehabilitation Program A $300,000 provincial investment will allow the IWK Health Centre to hire more therapists to help children with cognitive, developmental, and physical disabilities. Rehabilitation services at the IWK Health Centre are offered by a team of professionals, i.e., physical therapists, occupational therapists, psychologists, speech-language pathologists, nurses, and doctors, working to address the individual needs of children and youth. "Kids N Care" The Department of Community Services and Department of Health have developed protocols for referral between Secure Care, Colchester East Hants Health Authority and IWK Health Centre. A part-time psychologist and primary care physician have been hired for Secure Care. The Children's Response Program (CRP), a mental health program for children under 12 years has been operated by the IWK. Health Centre. Funding has been transferred from the Department of Community Services to the Department of Health for this program.

Priority	Accomplishments
Mental Health Legislation A new Mental Health Act is being developed. The existing *Hospitals Act* is over thirty years old and needs revision to reflect the Charter of Rights and Freedoms and more current practices in mental health.	Advances in mental health treatment over the intervening 30 years have lead to: • de-institutionalization of patients • use of more effective medications • development of over 50 community mental health clinics throughout the province • designation of inpatient beds for mental health in hospitals across the province under the DHAs and IWK Health Centre. In the spring of 2004, the Mental Health Legislation Development Committee circulated a discussion paper to stakeholders on the proposed new legislation. Analysis of the more than 50 responses informed the drafting of the *Mental Health Act*. Features of the proposed new legislation include: • A stand-alone *Mental Health Act* • Introducing guiding principles into the law • Amending the involuntary admission criteria • Enhancing provisions regarding determinants of a patient's capacity to make treatment decisions • Introducing provisions for Community Treatment Orders Bill 109 was introduced in the Legislature in the Fall of 2004. The bill introduced substitute decision-makers who will be involved in all treatment decisions when necessary. In addition, leave certificates were introduced allowing patients to be gradually reintroduced into the community. The bill also introduced independent rights advisors who would operate at arm's length from governments and the DHAs/ IWK Health Centre to advise people who are involuntarily admitted, placed on a leave certificate or a community treatment order. The bill did not receive sufficient support to be passed. Opposition wanted to see legislation focused on resources and services. An information day on Mental Health Legislation was held in February 2005.

Acute and Tertiary Care

Priority	Accomplishments
Osteoporosis Standards Implementation and Monitoring An implementation plan for the recommendations of Provincial Osteoporosis Committee report is being developed. The overall goal is to reduce fractures and the associated effects on individuals and families who have or are at risk of osteoporosis.	Progress has been made on efforts to improve the prevention and treatment of Osteoporosis. Guidelines for bone density tests were received and modified based on evidence from the Osteoporosis Society of Canada and are now in place across the province. Work has also begun in the long term care sector to introduce calcium and vitamin D supplements to its residents. Education programs for family physicians, dieticians, pharmacists, nurses, physiotherapists, and other health professionals have been rolled out across the province to help health professionals prevent, recognize, and treat osteoporosis. The Department of Health has partnered with the Osteoporosis Society of Canada, Nova Scotia Chapter, to provide public education. Health professionals are stressing the year-round awareness of this disease, which affects so many Nova Scotians. A final report on the progress of implementation of the recommendations is expected in late 2005.
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. The Department of Health will facilitate a service and access review to better match resources with an unmet need in under-serviced areas of Nova Scotia.	Following an independent review of MRI capacity in Nova Scotia, recommendations for further MRI diffusion in rural Nova Scotia were approved by the Department of Health in September 2004. In December 2004, the Premier announced four new MRIs to be located at Antigonish, New Glasgow, Kentville and Yarmouth. A replacement of one MRI at Capital District will also occur. An implementation project is underway. A Project Management Committee with representation from the majority of the province's nine DHAs, the IWK Health Centre, and the Department of Health is working toward consistency in diagnostic services, technology, training, and referral processes across the province.

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 in a Cardiac Advisory Council.	Throughout 2004-05, the Cardiovascular Health Advisory Council was named to guide the direction of the provincial program. The Council is made up of members of the public and administration and clinical leaders from the DHAs. A Strategic Plan with clearly articulated goals, partnerships, and activities has been developed. Information on cardiac disease continues to be collected to assist in the development of provincial standards for service delivery.
Provincial Blood Coordinating 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.	Various activities have been accomplished as a result of collaboration between the Nova Scotia Provincial Blood Coordinating Program (NSPBCP), the IWK Health Centre/DHAs and Canadian Blood Services. The IWK Health Centre/DHAs are represented on various working groups/committees associated with the NSPBCP. These include: • Palivizumab Working Group • Quality Specialists Working Group • Atlantic Collaborative for IVIG Working Group • Nova Scotia Nurses Transfusion Practice Working Group • Program Advisory Council • Provincial Blood Reference Group As a result, the following items have been developed: • Provincial Guidelines for Respiratory Synclinal Virus Prophylaxis • Report on Palivizumab Utilization in Nova Scotia 2003-2004 • Report on IVIG Utilization in Nova Scotia • NSPBCP Template for pre-printed physician orders for IVIG (adult and pediatric) • Provincial standard for adult IVIG administration • Provincial standard for the reporting of adverse reactions to blood, blood components and plasma derivatives • Blood Emergency Response Team • Action Plan for West Nile Virus and the Blood Supply

Priority	Accomplishments
	The guidelines, pre-printed forms and standards have been vetted through various stakeholder groups and are in various stages of implementation. The provincial standard for the reporting of adverse events was the focus of a Telehealth session to pathologists and an education day for the Quality Specialists. The NSPBCP is developing posters intended for display within the laboratory to support the implementation of this standard. The program was prepared to receive adverse reaction reports effective January 1, 2005. Stakeholders indicated that they wished to be kept informed of the various NSPBCP activities. In response to this the NSPBCP published its first newsletter in July 2004 and is targeting biannual publication of *Blood Counts*, the official newsletter title.
Provincial Approach to Stroke Care Following an impact analysis of the integrated provincial stroke strategy, the Acute and Tertiary Branch will facilitate stakeholder collaboration aimed at advancing optimal care and service for Nova Scotians who suffer from stroke. Accepted strategies will be implemented as part of an integrated model of service delivery.	Together, the Department of Health Acute and Tertiary Care Branch partners, the Atlantic Health Promotion Research Centre and the Heart and Stroke Foundation of Nova Scotia funded a research position that has helped to foster a greater understanding of district perspectives and challenges in implementing recommendations from the Stroke Strategy. The Acute Stroke Care Working Group will begin in Spring 2005 to address best practices in acute stroke management. Led by Department of Health, the working group will be comprised of clinicians and system planners from across the DHAs. A comprehensive demonstration project involving stroke prevention, emergency and acute care, and rehabilitation was determined to be an important next step.

Priority	Accomplishments
Dialysis Program Expansion A provincial approach to the development and long-term management of dialysis services is being developed. Dialysis services at both the Capital and Cape Breton DHAs are being expanded. This will require integration of dialysis with other programs such as diabetes and organ/ tissue donation.	In 2004, $10 million in new funding was announced to expand services in Halifax and to construct a new dialysis clinic in Cape Breton. The recognized authority for the establishment of dialysis services is Capital DHA, working in concert with Cape Breton DHA and Southwest Nova DHA. Capital DHA hosted a provincial meeting with these partners and Department of Health in October 2004 to discuss the challenges of providing dialysis to a growing population with renal disease. A Provincial Dialysis Group has been established and has identified satellite dialysis as a top priority. A subcommittee is organizing an external review of the current satellite program, which will include admission criteria, siting, and location. The review should be completed by June 2005 with recommendations to the Department of Health to follow shortly after.
Hospital Additions and Renovations Projects targeted for completion in 2004-2005 include the Women's and Children's Unit at South Shore Regional Hospital, and the Genetics Lab and the Medical Day Assessment and Treatment Unit at the IWK Health Centre. Projects getting underway include the new Cobequid Community Health Centre, the Dartmouth General Hospital Renal Dialysis Expansion and the expansion of the Halifax Infirmary site's Emergency Department. The Cape Breton Regional Hospital Renal Dialysis Expansion is in progress.	In May 2004, the new Women's and Children's Health Centre opened in the South Shore DHA. The Centre brings together a full range of services for women and children including in-patient obstetrical and pediatric care, obstetric and pediatric clinics and educational programs. The Department of Health has been working with the Annapolis Valley DHA in their development of a DHA-wide Master Program. Responding to growing pressure on acute care services in the Valley area, government approved the opening of 21 acute care beds at the Valley Regional Hospital as well as emergency room renovations. Planning for this is underway. In February 2005, the site for the new Truro hospital was announced. The submitted Master Program outlines several options for the replacement of the Colchester Regional Hospital Site. Residents of Tatamagouche and the surrounding area will have improved access to community health care services as a result of a $2 million renovation project

Priority	Accomplishments
	at the Lillian Fraser Memorial Hospital. As part of the $2 million investment, Lillian Fraser will be upgraded to include additional space to deliver primary health care services. Renovations will also be made to the hospital's emergency room, inpatient area and space for laboratory services. The project will allow for better use of space and more appropriate service delivery. Residents of the Cumberland County area will receive enhanced health services and care closer to home, thanks to a new operating room being built at the Cumberland Regional Health Care Centre in Upper Nappan. The Cumberland Health Authority's success in recruiting health care staff has resulted in an increase in surgeries and other health services such as obstetrics and ear, nose, and throat services. The Health Authority is expected to have the services of four general surgeons by the end of this summer. This will have a significant impact on the use of operating room space. The St. Martha's Hospital Renewal project in Guysborough Antigonish Strait Health Authority has been approved with a completion date in 2008. In Capital DHA, the IWK Health Centre Redevelopment Project is underway with a four year time frame to completion.

Insured Health Programs

Priority	Accomplishments
National Common Drug Review (CDR) The CDR is an initiative undertaken by all Canadian, publicly funded F/P/T drug plans, with the exception of Quebec. The goals of the CDR are to reduce duplication, to maximize use of resources and expertise, and to enhance consistency and quality of drug reviews used to make provincial drug listing decisions. The Atlantic Common Drug Review will be phased out as the national process becomes fully operational.	The Common Drug Review (CDR) provides participating federal, provincial, and territorial drug benefit plans with: a systematic review of the available clinical evidence and a review of the pharmacoeconomic data for new drugs, and a formulary listing recommendations made by the Canadian Expert Drug Advisory Committee (CEDAC). The first CEDAC formulary listing recommendations were released May 27, 2004. During the fiscal year 2004-05, 22 recommendations were received by the province. Twenty (91%) of the recommendations were processed with the average length of time between receipt of the recommendation and implementing a decision being 5.4 weeks.
Prescription Monitoring Program (PMP) The Prescription Monitoring Program is a vital component of the province's approach to the prevention of abuse and misuse of narcotics and controlled drugs. Enhancements are planned to strengthen the program's ability to meet its mandate. **Note: This is a new priority and does not appear in the Business Plan for 2004-2005.*	Prescription Monitoring legislation was proclaimed and regulations were approved. The program privacy policy was approved. Members of the new Prescription Monitoring Program (PMP) Board were appointed. A computerized information system was developed to support the PMP.
Best Practices in Pharmaceutical Services Drug Evaluation Alliance of Nova Scotia (DEANS) The mission of DEANS is to contribute to the health of Nova Scotians by encouraging appropriate use of drugs. DEANS obtains and analyzes information related to critical drug care issues in the province, develops targeted interventions, and evaluates the results. Areas of focus for this year include Chronic Obstructive Lung Disease, osteoarthritis, chronic pain, and acid suppression therapy.	Drug Evaluation Alliance of Nova Scotia (DEANS) A needs assessment of pharmacists' learning preferences and knowledge gaps in the management of Chronic Obstructive Pulmonary Disease (COPPED) was completed. Results were used to develop targeted educational messages being delivered in several learning formats: live programs video conferences, live on-line sessions, and a print version for independent home study. Pharmacists who participate in these programs are given a unique opportunity to transfer new knowledge to their practice through a structured "reflection on practice" process.

Priority	Accomplishments
	DEANS brought together a group representing medicine, pharmacy, dentistry, and the Cape Breton Community Partnership on Prescription Drug Abuse. The group developed and secured funding from Health Canada's Drug Strategy Community Initiatives Fund for the project, "Appropriate Management of Non-Cancer Pain: an Interprofessional Continuing Education Approach". The project, which will develop, implement, and evaluate a needs-based and evidenced-based educational intervention on the management of chronic non-cancer pain for doctors, dentists, and pharmacists in the Cape Breton DHA, is currently underway. An unrestricted educational grant from Purdue Pharma will make it possible to implement and evaluate the educational intervention in all the other DHAs.
<u>Academic Detailing Service (ADS)</u> ADS is an initiative funded by the Department of Health and managed by Dalhousie Continuing Medical Education (CME). Nova Scotia is the first province in Canada to undertake a province-wide academic detailing program. In this form of CME, trained health care professionals visit physicians individually to provide objective, evidence-based CME on a particular topic in brief (15-20 minute) educational sessions. Research has shown this is one of the most effective forms of continuing medical education. Areas of focus for this year include osteoporosis, Alzheimer's disease and lipid lowering agents.	<u>Academic Detailing Service (ADS)</u> The ADS critically appraised the guidelines and source literature for the management of COPPED and presented their findings and areas of uncertainty to family physicians and respirologists. Approximately 53% of family physicians met with the academic detailers for this topic. The ADS completed a literature review of the uses of statins (lipid lowering agents) in cardiovascular disease. The academic detailers are in the process of presenting their findings to family physicians. Physicians who use ADS consistently rate it highly in evaluations. However, about 43% of family physicians have never used the ADS. Therefore, a research project to identify the barriers to using the ADS is underway. A questionnaire and telephone interviews are being used to explore why physicians do or do not use the ADS and to identify how it can better meet their continuing medical educational needs.
<u>Canadian Optimal Medication Prescribing and Utilization Service (COMPUS)</u> This is a F/P/T initiative to support best practices in prescribing and utilization. It supports provinces in their work to promote appropriate drug therapy and to ensure the health system is receiving value from	<u>Canadian Optimal Medication Prescribing and Utilization Service (COMPUS)</u> COMPUS, officially launched in 2004, will strengthen DEANS' ability to collaborate with other best practice groups across Canada and

Priority	Accomplishments
publicly funded prescription drugs. Nova Scotia has been actively involved in the development of this service.	internationally. DEANS was highlighted as an existing best practice initiative at many of the 2004 COMPUS stakeholder consultation sessions.
Expanded Access to Prescription Drugs The issue of access to prescription drugs for Canadians was highlighted in both the Kirby and Romanow Reports. An approach to "catastrophic drug coverage" was a major commitment of the First Ministers Accord of 2003. Twenty-one per cent of the population of Nova Scotia does not have prescription drug insurance. Work is underway to develop an income-based prescription drug insurance program.	In Fall 2004, the First Ministers identified the need for a National Pharmaceutical Strategy (NPS) that includes an analysis of access issues related to prescription drugs for Canadians. A Task Group under the NPS has been given the specific task of examining the issue of access, the implications and the cost. Nova Scotia is represented on this Task Group.

Continuing Care Services

Priority	Accomplishments
Framework for Continuing Care In order for the Department of Health to respond appropriately to changing care needs for Nova Scotians, work will begin on the development of a framework for continuing care. This will enable the Department to validate current services, examine alternatives for the effective delivery of services, and develop appropriate legislation to support service delivery.	The Department of Health has turned to Nova Scotians for input on continuing care solutions. A comprehensive consultation process began in February of this year involving families, health-care professionals and administrators from across the province. Families and communities were asked how they see continuing care services delivered today and in the years ahead. Their input about the type and mix of services will help form a provincial strategy for continuing care.
Health Care Costs for Residentially Based Services The Department of Health will continue the development of a multi-faceted approach to matching resources in nursing homes to the needs of residents. In January 2005, the Department of Health will begin coverage of the full health care costs of seniors in nursing homes, residential care facilities, and community-based options. Individuals who live in licensed residentially based services will pay accommodations and administration costs only.	The Department of Health invested an additional $9.2 million in health care services for seniors. As a result of this, changes were put into effect on January 1, 2005 whereby residents who live in long term care facilities under the Department of Health are no longer required to pay for the health care costs of long term care. Residents now pay towards their accommodation charge only. Also, those entering nursing homes as of January 1, 2005 are assessed for their ability to pay based on their income only and not on their assets. This change also simplifies the assessment process.
New Long Term Care Beds The Department of Health is responding to the need for expanded long term care bed capacity in some areas of the province. In addition to 30 new beds in 2003-2004, an additional 88 are planned for 2004-2005. These increases are a part of a broader planning process intended to match changing needs with existing resources.	The Department of Health expanded long term care capacity in 2004-05 by adding: • 30 nursing home beds in the Annapolis Valley District; and • 28 residential care facility beds and five nursing home beds in the Capital DHA. An additional 25 long term care beds have been approved for the Cape Breton District and will be available in 2005-06.

Priority	Accomplishments
Hospice Palliative Care Supported by a range of stakeholders and care providers, a project steering committee has completed service delivery guidelines for hospice palliative care services in Nova Scotia. Information and consultation sessions with the DHAs and the continuing care sector are planned for 2004-2005. Consultation results will inform ongoing service planning for end-of -life care.	The Department of Health is developing a provincial approach to hospice palliative care which will ensure that all Nova Scotians needing end-of-life care have access to appropriate and quality hospice palliative care services. Expanding access to end-of-life care was promised in the *2003 Blueprint for building a better Nova Scotia.* Information sessions were held in each DHA in Fall 2004 regarding the provincial approach. A final report with recommendations will be submitted to the Steering Committee and the guidelines will be implemented across the province through future business planning processes.

Health Promotion, Public Health, Addiction and Emergency Health Services

Priority	Accomplishments
Emergency Preparedness and Response The Department of Health is developing plans for comprehensive emergency preparedness and response across the Nova Scotia health sector. Rather than focus planning on a single or anticipated group of potential hazards or threats, the intended "all hazards" approach will address the threats of Chemical, Biological, Radiological, Nuclear, Explosive, Terrorist (CBRNET) attacks, world economic uncertainty, weather-related disasters, and infectious diseases such as SARS (Severe Acute Respiratory Syndrome), BSE (Bovine Spongiform Encephalopathy, WNV (West Nile Virus), pandemic influenza, etc. This is consistent with the efforts of other provinces and the federal government. The Department of Health's emergency preparedness and response planning will span the health sector, integrate with analogous and connecting plans in health service delivery organizations (e.g. DHAs and long term care facilities), and involve the provincial Emergency Measures Organization (EMO), Health Canada, and other provincial government departments.	The *Health Protection Act* received Royal Assent on May 20, 2004 and is subject to proclamation. The new Act means public health officials will have more power when it comes to preventing, detecting and managing health threats in Nova Scotia. This will offer more protection from both familiar or new communicable diseases like SARS or health hazards, while continuing to respect individual civil rights. It will give the Minister of Health the authority to declare a public health emergency when warranted. Experts are concerned that the Avian influenza virus, H5N1, that is currently causing serious poultry and human health issues in Southeast Asia, is the most likely candidate to trigger a pandemic influenza. Work on the pandemic plan for Nova Scotia was led by the Office of the Chief Medical Officer of Health until December 2004 when Emergency Health Services assumed responsibility for emergency preparedness. The Nova Scotia plan, based on the framework of the Canadian plan, will be comprehensive, integrated and coordinated and will include the following components: surveillance, vaccines, antivirals, health services, emergency preparedness and response, public health measures and communications. All District Health Authorities currently have a Pandemic plan although not all are consistent in terms of quality and comprehensiveness. Plans are also being developed, and there is ongoing collaboration at various regional, provincial and federal levels to prepare for and deal with a range of public health threats – from pandemic influenza to West Nile Virus, to bio-terrorist events like Smallpox. To coordinate some of these efforts, the Department has established a planning initiative involving DHAs and other government departments to ensure the Nova Scotia health system is able to respond to threats such as smallpox. The EHS developed the Smallpox plan for Nova Scotia and submitted to the Center for Emergency Preparedness (CEPR) Health Canada at the end of February 2005.

Priority	Accomplishments
Communicable Disease Control and Prevention Priorities include: • Contributing to the implementation of the Nova Scotia HIV/AIDS Strategy by acting on its recommendations and supporting working groups, advisory committees, community activation and education • Providing resources for the expansion of anonymous testing and needle exchange program initiatives consistent with provincial standards • Developing protocol for management of individuals identified as unwilling or unable to prevent or manage the spread of HIV/AIDS • Developing protocol for needlestick post-exposure prophylaxis in the community to prevent the spread of blood borne pathogens • Supporting the re-evaluation of the provincial immunization schedule to ensure consistency with the national guidelines • Introducing staged implementation of new publicly funded vaccines	Nova Scotia has received funding from Health Canada through the National Immunization Strategy (NIS) for use in the introduction of new vaccines and/or expansion of the existing program. The National Advisory Committee on Immunization (NACI) has recommended the introduction of new vaccines in the last few years. In response to the recommendations of NACI and the NIS, Nova Scotia has introduced/ expanded the following programs: • Varicella Vaccine (Chicken Pox) - provided to all preschool children and adults at risk • Pneumococcal Vaccine - provided to all children born after January 1, 2005 and at risk children under 5 years of age. • Meningococcal Vaccine - provided to all children born after January 1, 2004, and all adolescents between 14 and 16. It is given together with Adacel in the school program. • Adacel (Whooping Cough) - provided to all 14-16 year olds in the school program.
Early Childhood Development Priorities include: • Planning for phased implementation of Health Beginnings-Enhanced Home Visiting for families and children need added supports. • Planning phased implementation of approved guidelines for postnatal support services in the postnatal period to infants, mothers and families. • Developing standards for prenatal education to ensure comprehensive, efficient and effective supports and services to mothers and families.	2004-05 saw continued support for programs that encourage healthy childhood development and parent education, enhanced home visiting programs for new parents and work with Family Resource Centres and other partners. Healthy Beginnings: Enhanced Home Visiting has introduced the role of community home visitor to this program. Provincial program standards have been developed to support this component and training of home visitors is underway. It is anticipated province-wide implementation will occur in 2005-06. The framework to guide evaluation of this program is complete and evaluation of enhanced home visiting will begin in the upcoming year.

Priority	Accomplishments
Public Health Infrastructure Following the recommendations of Learning from SARS: Renewal of Public Health in Canada (the Naylor Report), and the federal budget: • Assess and improve capacity to respond to new, emerging and ongoing public health issues in Nova Scotia. • Work with the federal government to begin development of a regional centre of excellence in public health.	Following the release of the Learning from SARS: Renewal of Public Health in Canada, Nova Scotia embarked on an assessment of the coordination, integration, and comprehensiveness of its public health system. Dr. Brent Moloughney, a public health physician, was contracted to complete the review. An external expert review team consisting of public health experts from Northwest Territories, Quebec and Newfoundland and Labrador are providing advice to the contractor. A Nova Scotia Advisory Committee has also been set up to provide advice throughout sentinel points of the review. The mandate is to: • Review the current public health system in Nova Scotia in the context of nationally recognized reports and recommendations; • Assess its strengths, limitations, and opportunities to ensure the system is responsive, integrated, coordinated, efficient, effective and prepared for new, existing, re-emerging public health threats, both acute and chronic in nature; • Identify recommendations to ensure Nova Scotia is optimally positioned for both federal and provincial investments.
Enhanced Public Health Capacity The Office of the Chief Medical Officer of Health will expand to include two additional Medical Officers of Health, an epidemiologist, a public health nurse specializing in communicable disease, a part-time position for disaster planning, and an environmental health specialist.	The expansion of the Office of the Chief Medical Officer of Health to include an epidemiologist, a public health nurse specializing in communicable disease, a part-time position for disaster planning, and an environmental health specialist took place in 2004-05. The recruitment of two additional Medical Officers of Health, will be effective October 3, 2005.
Labour Market Agreement for Persons with Disabilities The impact of addictions treatment on employability is well documented. The effectiveness of Addictions Services in addressing vocational crisis and client employability will be evaluated.	A review of the literature on the impact of addictions treatment on employability was completed in March 2005. The final evaluation report on the effectiveness of Addiction Services in addressing vocational crisis and client employability is expected in Fall 2005.

Priority	Accomplishments
	The objectives of the evaluation are to: 1. review the literature relative to work dysfunction and addiction, and determine the evidence related to employment as a key component of addiction treatment and rehabilitation; 2. develop an evaluation framework for measuring the impact of Addiction Services on clients' employability (including consistent measurement tools and indicators); 3. describe the strategies and activities undertaken by Addiction Services that enhance employability for clients (e.g., counseling, learning to work with others, setting goals, etc.); 4. demonstrate the impacts and outcomes of Addiction Services on clients' employability; and 5. make recommendations for improvements to Addictions Services programs related to employability and an ongoing system of monitoring and evaluation.
Enabling Framework for EHS Legislation A major priority for Emergency Health Services in 2004-2005 is the establishment of a legislative framework for all aspects of emergency health services delivery in Nova Scotia.	The *Emergency Health Services Act* was introduced and passed through Law Amendments in October 2004. The Act will ensure province-wide standards are met and that Nova Scotians will benefit from consistent high-quality ambulance services. The new legislation will also provide the flexibility to have the specified emergency health service providers enhance the primary health care services offered in any area of the province. This practice is already taking place on Long and Brier Islands, Digby County, where paramedics certified in community para-medicine work side by side with a nurse practitioner to provide basic medical services to residents. The legislation will also help ensure the River Hebert volunteer fire service adopts the practices of the Medical First Responder (MFR) agency quickly and effectively. Negotiations with Keefco regarding their status under the new Act are proceeding without any major issues.

Priority	Accomplishments
Hepatitis C In 2001, the Federal and Provincial governments, agreed that and envelope of federal transfers would be used for health care services indicated for the treatment of Hepatitis C infection and for medical conditions directly related to it. One of the commitments of signing the agreement was to provide reports to the public on the nature of initiatives benefitting from this federal funding. This is the first public written report outlining the utilization of the funding received through the Undertaking Agreement. *(*Note: This was not identified as a priority in the Department of Health 2004-2005 Business Plan)*	Nova Scotia has received $4.0 million since 2001. Initiatives that have been supported include: Standards Development of "Standards for Blood Borne Pathogen Prevention Services in Nova Scotia" involved a wide range of stakeholders including community based organizations (e.g., needle exchange programs, methadone programs, Nova Scotia AIDS Coalition), health care practitioners, academia, government and interested individuals. The purpose of the standards is to provide a framework to guide long term improvement in blood borne pathogens prevention services, as well as a foundation for the implementation of new services where necessary. The standards provide a point of reference for assessing gaps and provide direction for implementation of services to address those gaps. In addition, the standards promote consistency in service delivery across the province, while at the same time allowing the flexibility needed to reflect the varying capacities and needs of communities and organizations across the province. Standards also provide a framework for accountability reporting by DHAs as they work with community partners and the Department of Health to move toward meeting provincial standards. Services to prevent blood borne pathogen infections are intended to benefit all Nova Scotians, however, when planning services, special consideration must be given to populations at increased risk of infection when services are being designed. People who engage in one or more of the following risk behaviours are at increased risk for blood borne pathogen infections: • sharing needles, syringes and other drug using equipment • having unprotected anal, vaginal sexual intercourse or oral sex • sharing tattooing and piercing equipment Evidence also suggests that certain populations of people are more vulnerable to infection with blood

Priority	Accomplishments

	borne pathogens for a variety of reasons. These populations include:
	
	• Aboriginal people
	• Youth (children and youth, i.e., students, out-of-school or street/ homeless youth)
	• People who are involved with the criminal justice system
	• Men who have sex with men (gay and bisexual men)
	• Women
	• People experiencing mental health or addictions problems
	• People who are street-involved and/or homeless
	• Sex trade workers
	• People already infected with a blood borne pathogen such as hepatitis B, hepatitis C and HIV
	• People who use injection drugs
	
	Prevention services may need to be tailored to meet the needs of specific populations.
	
	The standards developed cover two areas:
	
	• General standards, which apply to all blood borne pathogens prevention services, and cover topics such as accessibility, planning, monitoring and evaluation, and health human resources; and
	• Component-specific standards, which include standards for effective services in the areas of:
	
	  • Health Education and Social Marketing
	  • Counseling, Testing and Referral
	  • Needle Exchange
	  • Methadone Maintenance Treatment.
	
	<u>Needle Exchange Programs</u>
	Needle exchange programs are based on the theory of harm reduction. The rationale behind harm reduction is that if it is not possible to prevent or cure an individual's activities; services should be put in place to minimize harm. One of the primary objectives of needle exchange programs is to prevent infections (HIV, Hepatitis C) by reducing needle sharing. Research has shown that needle sharing is directly related to the spread of HIV and Hepatitis C. The

Priority	Accomplishments
	effectiveness of needle exchange programs is dependent in part on its ability to provide accessible and comprehensive services. These services include, but are not limited to connection to support groups, street outreach, condom distribution, counseling, testing, primary health care services, addiction services and referrals. It is also crucial that needle exchange programs meet the needs of intravenous drug users in terms of location, time and place to increase accessibility. Nova Scotia has two needle exchange programs: Mainline Needle Exchange (Halifax) and Sharp Advice (Sydney). Both programs are experiencing growth and provide outreach services from their fixed sites. Increased funding to both community based organizations has assisted in the increased services as well as advanced efforts to meet the standards developed for needle exchange programs. <u>Immunization</u> Immunization, historically supported activity in public health, continues to take place. Hepatitis A and B vaccinations are publicly funded for all individuals infected with Hepatitis C. <u>Acute Care Services</u> The Queen Elizabeth II (QEII) Health Sciences Centre in Halifax operates a Liver Clinic for infected individuals, staffed by hepatologist and an expanded role nurse. This program/service provides viral load and genotype testing in addition to the provision of liver transplantation services. In 2003, additional funds were provided to the QEII to: • increase potential access to service; increase collaboration with regional Hepatitis C clinics; • improve liaison/collaboration with special interest groups; and, • establish a data management process. To date, the following have been the accomplishments of the enhanced programming: • an additional nurse practitioner has been hired;

Priority	Accomplishments
	• work is almost complete in the development of a data management system; • implemented monthly meetings with Direction 180 in Fall 2004; plan to implement a co-mentorship relationship between Capital Health and Direction 180 during the Winter 2005; • implemented formal linkages with Public Health Virology Lab; • a first draft of Integrated Treatment Guidelines for Hepatitis C patients are completed; a stakeholder review and approval process will provide a comprehensive approach to the implementation of these guidelines in clinical practice. <u>Community Supports</u> Community based organizations are a critical link in the provision of services and supports to persons infected with Hepatitis C as well as the general public. The Hepatitis Outreach Society has been funded to provide education, support and referral services. <u>Drug Therapy (Interferons and Ribavirin)</u> <u>Drug Therapy Coverage for Inpatients</u>: Under the *Canada Health Act*, inpatient drugs, including interferons and interferons in combination with Ribavirin are publicly funded. <u>Drug Therapy Coverage in the Community Setting</u>: The Nova Scotia Pharmacare Programs provide publicly funded drug coverage to Department of Community Services clients and residents of Nova Scotia who are 65 years of age or older and do not have drug coverage through Veterans Affairs Canada, First Nations and Inuit Health, or a private drug plan. The interferons and interferons in combination with ribavirin used in the management of Hepatitis C are covered under these Programs, regardless of the date or source of infection. The Pharmacare Programs do not provide coverage for patients waiting for federal compensation.

Health Information Management

The Health Information Management branch supports the strategic goals of the Department of Health by:

- Implementing information tools to facilitate the development of a portable, person-based electronic health record.
- Developing policies, procedures, and practices to protect health information privacy while ensuring appropriate and timely access to health information when it is required for health provision.
- Producing valid, timely information for reporting and decision-making purposes.
- Promoting optimal use of health information and investment in information technology.

Priority	Accomplishments
Health Information Management Strategy The Provincial Health Information Management Strategy provides a framework for the provision of sound, useful and user-friendly health information to support evidence-based decisions by citizens, managers and clinicians. The Strategy will continue to be refreshed in consultation with stakeholders.	Nova Scotia's Health Information Management Strategy is focused on implementing province-wide clinical and administrative systems to improve patient care, planning and accountability. The protection of the individual privacy and confidentiality within the context of a well managed health care system is the cornerstone of the Health Information Management Strategy. Nova Scotia has a provincial health Information Management Strategy with the goal of improving patient care, health outcomes and how the health system works. This strategy is focused on implementing secure systems that collect and transmit the necessary health information for the purposes of quality care.
Towards an Electronic Health Record The Nova Scotia Hospital Information System (NShIS) provides health care professionals with quick, accurate, and appropriate access to patient's medical history information, which is important to providing patient care. The system is a first step towards creating a provincial Electronic Health Record (EHR) for every Nova Scotian. The EHR will provide an integrated view of patient information and support sharing of pertinent information among attending care providers within and between provincial hospitals. The NShIS is being implemented in 34 hospitals beginning with the Guysborough-Antigonish-Strait DHA in February, 2003. Over 1,700 health care professionals in 13 hospitals in the Guysborough-Antigonish-Strait and Cape Breton DHAs are now	Nova Scotia's Health Information Management Strategy is focused on implementing province-wide clinical and administrative systems to improve patient care, planning and accountability. The goal is the establishment of a person-centric, longitudinal and portable electronic health record in order that authorized health care providers can have real time access to standardized and complete patient health information from across the spectrum of health and wellness services. The protection of individual privacy and confidentiality within the context of a well managed health care system is the cornerstone of the Health Information Management Strategy. A number of initiatives are currently underway to achieve an interoperable Electronic Health Record. The Nova Scotia Hospital Information System

Priority	Accomplishments
using the system. Clinical and administrative orders are now being entered electronically, and reports (e.g. lab results and x-ray results) are viewed by care providers through the hospital medical record. NShIS will begin implementation in the South Shore, Colchester-East Hants and Pictou DHAs this year. An expansion of the Province's Picture Archiving Capture and Storage (PACS) system is also planned. PACS captures diagnostic images in digital format and allows them to be viewed by radiologists anywhere is the province.	(NShIS) is a building block toward better care for Nova Scotians. This project is implementing a standard hospital information system in DHAs 1 to 8. Currently, 31 of 34 hospitals are using the system. They system addresses the following areas: • Patient Admitting, Discharge, Transfer and Registration • Community Wide Scheduling • Billing and Accounts Receivable • Laboratory • Diagnostic Imaging and Therapeutic Services • Hospital Pharmacy • Patient Care Services/ Nursing Documentation • Enterprise Medical Record • Data repository and reporting The hospital information system is a key foundational component to a person based, portable Electronic Record. The NShIS project is on time and on budget for completion by March 31, 2006. Upon completion, 34 hospitals in DHAs 1 through 8 will share relevant data within their district and across districts. Through an interoperability initiative with Capital District and the IWK Health Centre (which have different systems) and the NShIS, authorized health care providers will also be able to share pertinent patient information across all three hospital systems and all districts. As well, remote access will be available to physicians in their offices. NShIS will continue implementation in South West Nova DHA this fall. An expansion of the province's Picture Archiving and Communications System (PACS) system is also underway. PACS is a high-speed, graphical computer system that stores, retrieves and displays diagnostic images (such as MRI, CT scans, Ultrasounds, X-rays). Enabled by Nova Scotia's high-speed, provincial health data network, PACS can provide authorized health care providers with real-time access to diagnostic imaging reports and images across the province. The Department of Health, in cooperation with the DHAs, the IWK Health Centre, and with support from the Government of Canada is enhancing and

Priority	Accomplishments
	expanding the current provincial PACS environment including the capability to store images centrally in a provincial Diagnostic Image Archive. The planning phase is complete and implementation has begun. The planned implementation of the PACS project is September 2006. Canada Health Infoway will invest 75 % of the costs of improved components on Nova Scotia's PACS implementation plan. Currently, Annapolis Valley DHA, Guysborough Antigonish Strait Health Authority, South Shore DHA and Cape Breton DHA are implemented.
Nova Scotia Telehealth Network (NSTHN) The NSTHN connects DHAs with a sophisticated videoconferencing system that allows patients in rural areas to consult with specialists in large health centres. The service enhances access to health services and supports clinical education efforts for rural and remote health care personnel. In 2004/05, the NSTHN will continue the expansion of patient-related services.	Nova Scotia was the first province in Canada to establish a province-wide Telehealth network. Province wide access was established in 1999. The Nova Scotia Telehealth Network (NSTN) is one of the most comprehensive and active Telehealth networks in Canada. 71 video-conferencing systems provide for educational and medical consultations into 46 healthcare facilities across the province. The NSTHN assists in delivering a wide range of clinical services and educational programs to patients and health care providers. Administrative meetings are also held via the network. The NSTHN works in collaboration with a number of partners including the DHAs and the IWK Health Centre. In partnership with the South Shore DHA and the North Queens Health Centre, the NSTHN added video -conferencing capability to: • North Queens Health Centre (NQHC) • This expansion provides the ability for patients to receive clinical care and patient education sessions without leaving their home community. The expansion also provides the NQHC with the ability to use the NSTHN for the provision of education sessions for health care providers and administrative meetings. In partnership with the Capital DHA, the NSTHN added video-conferencing capability to:

Priority	Accomplishments
	Cobequid Community Health Centre (CCHC) • This expansion will initially provide the CCHC with the ability to use the NSTHN for the provision of education sessions for patients/ health care providers and administrative meetings. Expansion related to clinical care will be addressed when the CCHC moves to their new facility in 2005-06. Nova Scotia Rehabilitation Centre (NSRC) • This expansion provides the ability for patients from across Nova Scotia to receive clinical care and patient education sessions from the NSRC without leaving their home community. The expansion also provides the NSRC with the ability to use the NSTHN for the provision of education sessions for health care providers and administrative meetings. Registered Nurse Professional Development Centre (RN-PDC) • This expansion provides the ability for the RN-PDC to support delivery of program initiatives using the NSTHN. This includes using videoconferencing to support the delivery of the Critical Care Nursing Program (CCNP) and the Emergency Nursing Program (ENP). The RN-PDC also provides a number of continuing education opportunities via the NSTHN. Other accomplishments were: • The existing NSTHN Teleradiology Network was integrated with the new provincial PACS network to allow existing users to immediately utilize the PACS network with existing equipment. • The NSTHN workstations were integrated to the Provincial Health Network enabling enhanced clinical capabilities and network support. • The network to current technology videoconferencing and telecommunication standards was upgraded to realize enhanced performance. • The technology used in existing clinical applications was reviewed and reconfigured to further integrate Telehealth into these settings.

Priority	Accomplishments
Privacy and Access The implementation of federal privacy legislation in January 2004 for components of the health care sector has reinforced the need for a comprehensive privacy framework for health information in Nova Scotia. Priorities in 2004-2005 include: • Developing and implementing privacy standards for Nova Scotia Hospital Information System and other health information systems. • Working with other jurisdictions on a harmonized set of privacy rules for health information. • Working with the District Health Authorities on privacy best-practice guidelines.	Nova Scotia legislation provides a legal framework for regulating personal health information. *The Freedom of Information and Protection of Privacy Act* (1993) governs access to and privacy of information, including personal health information, held by public bodies. The *Hospitals Act* protects personal health information in hospitals. Under the *Pharmacy Act*, a patient's records are confidential and may not be disclosed to any person other than the patient, except with the patient's consent or as required by law. The Department of Health is assessing the benefits of developing legislation for the protection of personal health information. The Department of Health has formulated a privacy standards regime for use in the Nova Scotia Hospital Information System (NShIS), a province-wide electronic hospital record. This project included standards for appropriate access to patient information on a "need to know" basis, monitoring and access to information on the system, and mandatory privacy training for all users. All users are subject to the NShIS Privacy and Security Policy. The Department of Health has worked with the DHAs and the Provincial Health Programs to develop consistent privacy policies for the protection of personal health information. Priorities for 2005-06 include: • Developing and implementing privacy standards for Nova Scotia Hospital Information System and other health information systems. • Working with the DHAs on privacy best-practice guidelines for the Provincial Health Programs • Developing and implementing a Privacy Impact Assessment Policy for the Department of Health.

Priority	Accomplishments
Health Data The Department of Health is committed to improving the quality of our data and producing useful indicators and reports to support citizens, clinicians and managers in making evidence-based decisions about health care. This year the Department will produce Nova Scotia's report on the health of our citizens and the performance of the health system as part of the Province's commitment in the First Ministers' Accord.	Measuring health and health system indicators improves Nova Scotia's ability to assess the health of Nova Scotians and the performance of its health system. The Nova Scotia government believes that health decisions must be based on good evidence. Analytic and statistical reports produced during 2004-05 by the Information Management Branch provided an evidence base for health decisions in Nova Scotia. Nova Scotia is investing in information management and information technology initiatives, not only because they play a vital role in the management of our health care system, but also because the information gathered will help government make the right decisions to deliver better health care to Nova Scotians across the province.

Health Human Resources

The Department of Health is developing health human resource strategies involving collaborative and comprehensive research, consultation with partners, training, recruitment and retention.

Priority	Accomplishments
Chief Health Human Resources Officer The Department of Health has created the position of Chief Health Human Resource Officer to coordinate the Province's approach to the recruitment, retention and retraining of health care professionals. This is particularly urgent as the health care work force ages and retires over the next few years.	In April of 2004, the position of Chief Health Human Resource Officer was created to coordinate Health Human Resource (HHR) planning. Dr. Peter Vaughan assumed this role and will build on the work already underway through Nova Scotia's Nursing Strategy, ongoing physician recruitment efforts, other training and recruitment initiatives for other health professionals. An Atlantic study will be conducted to assess future regional demands for health and training education programs. The Atlantic study is to be completed by September 2005.
Nursing Strategy Launched in 2001, Nova Scotia's Nursing Strategy continues to make a positive contribution to nursing recruitment, retention and renewal throughout the province. It addresses nursing's major challenges 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. Beginning in 2003, government began investing $7.1 million to train an additional 240 nurses over the next four years. In 2004-05, the department will work with nursing stakeholders to explore the feasibility of further expansion of nursing seats in the province, including the possibility of new education sites. Also in 2003-04, the Nursing Strategy awarded $200,000 in Nursing Grants to help nurses undertake 22 short-term projects to enhance nursing practice, improve quality of work life, and promote innovation and creativity. In 2004-05, these projects will be implemented and evaluated. Also in 2003-04, a provincial working group was established to develop recommendations to enhance the sustainability of the rural nursing	The Nursing Sector Study (NSS) is the first national nursing study that is both endorsed and led by the three nursing stakeholder groups in Canada: registered nurses, registered psychiatric nurses and licensed practical nurses. The overall goal of this study is to produce an integrated labour market strategy for these three regulated nursing occupational groups in Canada. Phase I of the study has been completed. In Phase I, research about the nursing labour market in Canada was conducted in 13 different steps by a large team of researchers. The Nursing Sector Study Report is drawn from the largest research initiative in nursing in Canada. It represents the current state of affairs for nursing. It will be a valuable resource to Nova Scotia as it moves forward on the provincial Health Human Resource plan and will inform future activities of the Provincial Nursing Network and the Nursing Strategy for Nova Scotia. In 2004, St. Francis Xavier University graduated 25 nurses from the 20 month new accelerated option program and ten nurses from the bridging program for LPN to become registered nurses. This was part of the 60 seat expansion provided by the Nursing Strategy.

Priority	Accomplishments
workforce. In 2004-05, the department will receive their report and recommendations and identify priorities for implementation.	In 2004, a total of 297 nurses graduated from Dalhousie University, St. Francis Xavier University, and the University of Cape Breton and 80 nurses graduated from the LPN program at Nova Scotia Community College. The feasibility of further expansion of nursing seats, including the possibility of new education sites will be explored in fiscal 2005-06. The evaluation of the nursing grants was completed with final reports received for all of the projects undertaken. The initiative was well received by practicing nurses across diverse settings. In May 2004, the Provincial Nursing Network approved the following priorities aimed at sustaining the rural nursing workforce: • to develop and implement a marketing strategy through partnerships between health providers, educational institutions, and communities; • to support employer initiatives that enhance quality of work life; • to support leadership education for rural managers and nursing staff; and • to monitor and evaluate indicators to support planning for recruitment and retention of nurses in rural areas. The recommendations are being implemented in consultation with stakeholder groups and will continue into the fiscal year 2005-06.
Medical Laboratory Technologists In 2004-05, Nova Scotia will continue to fund a joint initiative between the New Brunswick Community College and Nova Scotia Community College to train 25 Medical Laboratory Technologists. Nova Scotia will offer students bursaries of $4,000 in each year of the 2-year program of studies and in exchange, these students will commit to working in the Nova Scotia health care system for a 2-year period. Other options for meeting the need to train Medical Laboratory Technologists will be identified and explored during 2004-2005.	In response to the challenges with staffing medical lab technologist positions in some areas of Nova Scotia, an investment has been made in this area to ensure that Nova Scotians receive the medical services they need, when they need them, within Nova Scotia. In March 2005 the Department of Health purchased a 25 seat program to train Medical Laboratory Technologists at the New Brunswick Community College in conjunction with the Nova Scotia Community College. Students are eligible to receive a $4,000 bursary for each year of the two year program. In exchange, they sign a return-in-service agreement to work in Nova Scotia for two years after graduation. Training includes a 16 week clinical placement at a hospital in Nova Scotia. Departments of Health and Education

Priority	Accomplishments
	are studying the feasibility of implementing an entry level training program for Medical Laboratory Technologists in Nova Scotia.
Physician Alternative Funding Plans (AFP) Physician Alternative Funding Plans (AFP) provide an alternative to the traditional fee-for-service approach to paying physicians. Rather than simply rewarding patient volumes, AFP arrangements recognize teaching, research, and broader health care objectives. The Department of Health is committed to improving the accountability provisions of alternative payment arrangements.	In Spring 2004, the Department of Health retained North South Group Inc. to conduct an audit of the province's largest and most complex Alternative Funding Plan (AFP), which is the current funding contract with the Dalhousie/ Capital Health Department of Medicine group of doctors. The audit focused on financial aspects, value for money, and contract management. The audit report provided 42 recommendations to improve how alternative funding plans are negotiated, written, and monitored. Nova Scotia is a national leader in offering AFPs to doctors. There is, however, a learning curve associated with being on the leading edge. The Department of Health anticipated many of the recommendations provided in the audit report is now in the process of prioritizing them. The Department of Health is developing a framework that will guide our pathway for future alternative funding plans. A multi-stakeholder group will be facilitating this initiative with an expected completion date in 2005-06.
Enhancing Physician Training Capacity The Department of Health is committed to enhancing undergraduate and postgraduate training opportunities for physicians in the province. Eight new first-year seats were added to the Dalhousie Faculty of Medicine in 2003-04. An additional eight seats will be added to the first-year class in 2004-05.	Nova Scotia is building a solid plan for Health Human Resources (HHR) that will support our health care system today and in the future. The province is on track for submitting a comprehensive HHR strategy by December 31, 2005. The goal of the Atlantic Health Education Training Planning Study (AHETPS) is to assist Nova Scotia and our sister provinces in Atlantic Canada to become more efficient in the production of Health Human Resources through enhanced health and education planning. This study will produce a framework that will assist in developing plans from March to June 2005. The study will contribute to the development of a strategy to meet the First Ministers Meeting Commitments of

Priority	Accomplishments
	2004, which include: providing targets for training, recruitment and retention, and having plans made public by December 2005. Responding to local, national and international trends toward a reduced supply of newly trained physicians and a pending retiring cohort of practicing physicians, the Department of Health supported an increase in the number of medical school seats at Dalhousie University.
Physician Resource Plan Implementation Strategy Nova Scotia's Physician Resource Planning Steering Committee has completed the development of a methodology robust and flexible approach to physician service planning across the province. Consultations are ongoing and will continue in 2004-05, as implementation plans are developed.	The Department of Health's recruitment coordination efforts support the nine DHAs, the IWK Health Centre, communities and groups of physicians throughout the province. In addition, the Department of Health is engaged in province-wide physician resource planning aimed at matching recruitment strategies to identified gaps and problem areas in the province. The specialties of greatest concern in the rural areas are Anaesthesia, Psychiatry and General Internal Medicine. There are also some academic vacancies (e.g. Anaesthesia in Capital Health).
Reducing Barriers to Practice for International Medical Graduates (IMGs) Recruitment of physicians from other countries is one of several strategies to meet ongoing physician resource requirements for Nova Scotia and Canada as a whole. About 25% of all practicing physicians in Nova Scotia are IMGs. All IMGs seeking license in Nova Scotia are screened and assessed by the College of Physicians and Surgeons of Nova Scotia (CPSNS) to ensure that their credentials (training, experience, and qualifications) are at the standard of Canadian medical graduates. This initiative will focus on identifying credential-based barriers, enhancing evaluation and educational opportunities, and easing entry into medical practice.	The international pool of physicians provides an opportunity for increased capacity to meet ongoing physician resource requirements for Nova Scotia. The college of Physicians and Surgeons of Nova Scotia developed a Credential Assessment program and centre (referred to as CAPP) for internationally-trained physicians with the stated goals of increasing the number of physicians practicing in Nova Scotia, maximizing human/ intellectual capital of immigrants, and assisting in attracting and retaining highly skilled immigrants to Nova Scotia. The Halifax Immigrant Learning Centre (HILC) has partnered with the Registered Nurses Professional Development Centre in the development of two programs. The first program is English as a Second Language for Internationally Educated Health Professionals and the second is an Orientation to the Canadian Health Care System and Professional

Priority	Accomplishments
	Practice in Nova Scotia. The Halifax Immigrant Learning Centre delivered the first program starting January 31, 2005 with graduation planned for April 2005. The partnership has also included the College of Registered Nurses of Nova Scotia. These programs have been informed through wide stakeholder consultation with regulatory bodies, employers, educational institutions, and health professionals who have been educated outside of Canada.

Health System-Wide Priorities

Priority	Accomplishments
Healthcare Safety Nova Scotians can be proud of the competent and dedicated personnel who work in the health system and of the comprehensive programs that are provided. Even with our many assets, however, undesirable outcomes can occur occasionally. Healthcare or "patient" safety is not a new issue. Significant measures have been introduced over the years in various health care delivery settings. Although much has been done, more can be accomplished through targeted actions and collaboration across the health care continuum of services. Nova Scotia is represented on the newly established Canadian Patient Safety Institute and is coordinating a provincial counterpart working group to identify and address safety issues. DHAs and other health organizations will continue to collect information on adverse events and improve processing to ensure safety.	In September 2003, the Department of Health established a Healthcare Safety Working Group (HSWG) to recommend a multi-year plan of action aimed at improving safety through the adoption of safety practices and fostering a safety culture. The HSWG was led by the Department of Health and included representation from across health care. The HSWG submitted its report in November 2004. It identified priority areas and contained 20 recommendations for action, which could be undertaken over three years. Moving forward on the working group's recommendations, a Healthcare Safety Advisory Committee will be established to provide advice to the department and health care agencies on safety practices, and to coordinate collective action to improve safety. Over the past year the HSWG has developed Safety Tips for Nova Scotians, produced a resource guide for reference by health care agencies, held a workshop to engage the healthcare system's leaders in discussion on strategies to improve safety, and initiated work on a provincial policy on the disclosure of adverse events. Other safeguards have been built into the system as barriers to mishaps and monitors of safety within the past year: • National surveillance guidelines on severe respiratory infections in hospital patients are being implemented; • Provided sponsorship to enable satellite broadcast of an important quality conference; • Piloting e-therapeutics website for pharmacists and physicians; • Funded several tools for use by all Nova Scotia hospitals in their ongoing efforts to review safe medication practice; • Created a provincial Infection Control Consultant position; • Established a provincial blood coordination

Priority	Accomplishments
	program to ensure that national standards on the use of blood products are in place; • Established a working group to develop quality review guidelines for use by DHAs in improving care. • Developed *Protection of Persons in Care Act*.
Provincial Wait Times Monitoring Project Valid and reliable information on the performance of the health care system is critical for the effective management of the system. It provides the evidence required to make good decisions about the best allocation of resources. A steering committee was formed consisting of 18 members who represent the clinical community and health care administration from various health districts in the province and the Nova Scotia Department of Health. The steering committee selected the following key areas for development: • Surgical Services (beginning with Orthopedics) • Diagnostics (beginning with MRI/ CT and Genetic Screening) • Referrals from General Practitioner to Specialist (beginning with Gastroenterology, Medical Oncology and Plastic Surgery). A standing Wait Time Monitoring Advisory Committee will be formed to: • Oversee the development of a province-wide way of collecting standard wait time information for a range of health care services. • Publish wait time information so that Nova Scotians can make informed choices about whether to seek care from another physician if wait times are shorter. • Work to address the bottlenecks so that wait times are shortened.	In January 2004, the government committed funding to begin the collection of standardized wait time information across the province and the establishment of the Nova Scotia Wait Time Advisory Committee. The Wait Time Advisory Committee advises the Minister on the province-wide collection and reporting of standardized wait time information and ways to address bottlenecks so that wait times are shortened. The Committee includes physicians and administrators from the DHAs, the Department of Health, and three members of the public. The first meeting was held in March 2005. In Summer 2004, the collection of province-wide standardized Diagnostics Services wait time data began. Preliminary data to assess prospective wait times are now available for a variety of diagnostic services including MRI and CT. The data are being reviewed for accuracy prior to public release. In Fall 2004, a sample of specialist consultation wait time data for Plastic Surgery and Gastroenterology was collected as a pilot test. Physicians participated on a voluntary basis. A second round of collection began in late winter and early spring. Preliminary data are now available for these two areas. In March 2005, data collection expanded to include dermatology and neurology consultations. Data will be reviewed for accuracy prior to public release.

Priority	Accomplishments
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.	New processes have been put in place to recruit and retain young Nova Scotians studying in a health discipline in a Francophone university by creating opportunities for them to return to their home province for their clinical placements. Though the Consortium National de Formation en Santé (CNFS) is leading this, close collaboration with the Department of Health and Dalhousie University is essential. The Réseau Sante, Nova Scotia's French Language Health Network, continues to make progress in fulfilling its mandate. There is an increasing awareness that removing linguistic barriers to health is not only a wise business decision but one truly grounded in quality patient-centred care. The Cape Breton DHA has implemented a new policy which stipulates that all direct patient care positions posted for the facility in Cheticamp will include a French language requirement. Nova Scotia's health system has been infused with close to 50 new paramedics trained in French at Universite Sainte-Anne. Having these health professionals with the ability to work in both official languages is a positive development.

Priority	Accomplishments
Chronic Disease Management The management of chronic disease and the burden of illness of our aging population is a growing challenge for the Nova Scotia health system. Complementing the efforts of the Office of Health Promotion, the Department of Health will work with service providers in primary care, acute care and other settings to improve self-care and promote effective multidisciplinary patient management practices. Efforts will focus on improving care coordination and service integration.	Many chronic diseases such as asthma, hypertension, and diabetes can be managed effectively through outpatient care. Measuring the number of people who end up in hospital for treatment of these chronic conditions can help us to assess how well we are providing access to outpatient care for these conditions. In 200-02, 355 Nova Scotians per 100,000 were treated in hospital for conditions that could have been managed through outpatient care. This rate is about one-third less than it was in 1995 -96 when the rate was 596 Nova Scotians per 100,000. The expansion of primary health care services is helping to ensure that more Nova Scotians can effectively manage chronic diseases before they require hospitalization.
Patient Navigation for Cancer Patients and their Families Many of the province's DHAs have chosen to adopt an approach to cancer patient navigation. Begun by Cancer Care Nova Scotia, patient navigation ensures patients and their families have the information, knowledge and support they need to navigate the complexities of the cancer care system.	The Cancer Patient Navigators role was initiated through Cancer Care Nova Scotia (CCNS) and select DHAs. Patient navigators assist diagnosed patients and their families with cancer in all aspects of the treatment process. CCNS initially funded patient navigation and piloted it in three DHAs: Yarmouth, New Glasgow, and Antigonish. In 2004-05, funding responsibility transferred to the DHAs. Bridgewater and Kentville have since implemented the role in their respective DHAs. DHAs are free to fund and provide this role/service from within their approved budgets. Department of Health funding for any new positions/ programs must be approved through the New and Expanded Program and business planning processes. Patient Navigation personnel clearly enhance cancer care treatment programs.

Priority	Accomplishments
Multi-Year Funding for Front-Line Health Care Beginning in 2003-2004, the Department of Health committed to increasing funding for hospitals and other services provided by the DHAs by at least seven per cent per year. This will continue in 2004-2005, adding significant support to front-line health care. This funding is in addition to funding already provided for salaries and negotiated salary increases.	In December 2004, the ministers of Health and Health Promotion announced $62 million in federal funding commitments to support reduced wait times, more health professionals and healthy choices along with $15 million in medical equipment money. Funding allocations include four capital projects totaling $19 million, $19.5 million allocated throughout the province to address key pressure areas affecting wait times, $2 million for addiction prevention and treatment, and $6.3 million for one time operating costs such as long term care deferred maintenance and start up funds for the Early Intensive Behavioural Intervention Treatment for children with autism.

Financial Results 2004 - 2005

(in thousands)

2004-2005 Estimate	Cost Centres	2004-2005 Actual	Est./Act.Variance
31,320,600	Total-Administration	29,640,465	1,680,135
511,334,000	Medical Payments	500,456,841	10,877,159
102,954,000	Pharmacare Program	106,272,772	(3,318,772)
36,851,000	Other Insured Programs	33,967,907	2,883,093
(24,557,000)	Revenue and Recovery	(26,203,854)	1,646,854
74,091,000	Emergency Health Services	72,571,734	1,519,266
81,609,000	Other Health Care Initiatives	75,307,048	6,301,952
8,256,000	Other Programs	11,085,440	(2,829,440)
1,108,392,000	Total - District Health Authorities	1,129,143,232	(20,751,232)
	Care Coordination		
28,676,600	Home Care Services	27,510,698	1,165,902
98,117,800	Long Term Care	98,813,579	(695,779)
246,645,000	Capital Grants - Health	253,706,886	(7,061,886)
38,000,000		57,134,884	(19,134,884)
2,341,690,000	********Department of Health*******	**2,369,407,633**	**(27,717,633)**

Department of Health
Financial Results 2004 - 2005 Estimate vs. Actual

Estimate:	**$2,341,690,000**
Actual:	**$2,369,407,633**
Total Variance:	**$ (27,717,633)**

Variance Explanations:

Administration: Decrease due to vacancies and Medavie actual administration costs less than budgeted..

Medical Payments/Physician Services: Decrease due to Alternative Funding for physicians vacancies.

Pharmacare Program: Increase in Pharmacare Program due to savings not achievable for restricting payment for only cheapest drug in a class.

Other Insured Programs: Decrease in utilization.

Revenue and Recovery: An overall net decrease is due to increase in revenue of inpatient rates in NRIP non resident inpatients and OPIP out-of-province hospital payments from Nova Scotia to other provinces and decrease in third party liability claims, Levy claims lower than anticipated.

Emergency Health Services: Decrease due to retired ambulance sales, increase in ambulance service fees in non-resident trips and higher collection rate and HST recovery anticipated to be higher than planned.

Other Healthcare Initiatives and Other Programs: Net decrease is due to Canadian Blood Services - utilization and US Exchange rate , savings achieved in the Budget Management Plan, and increase due to re-instatement of Clinical Academic Budget.

DHA/PHDCC's: Additional funding to meet Wait Time Pressures and operational pressures, and increase due to VAC adjustments.

Care Coordination/Home Care Services: Additional savings in care coordination/home care services as a result of delays in hiring staff, underutilisation of overflow agencies in Home Support Agencies and increase in VON nursing volume.

Long Term Care Program: Increase in public pay residents in the system and one time maintenance costs.

Capital Grants: Increase due to one time spending for DHA capital pressures.

2004-2005 Department of Health Outcomes Report

The following measures provide an overview of important information about health services in Nova Scotia and the health of Nova Scotians. In this report, you will note that the years in which data is available vary by measure. Some federal agencies collect data based on deadlines that differ from Nova Scotia's deadlines. In addition, the data contained in this report comes from nine different sources. These data sources have different reporting time periods and capacity to report on data in a timely fashion and are constantly undergoing improvement. For these reasons, primarily, the availability of data will vary by measure.

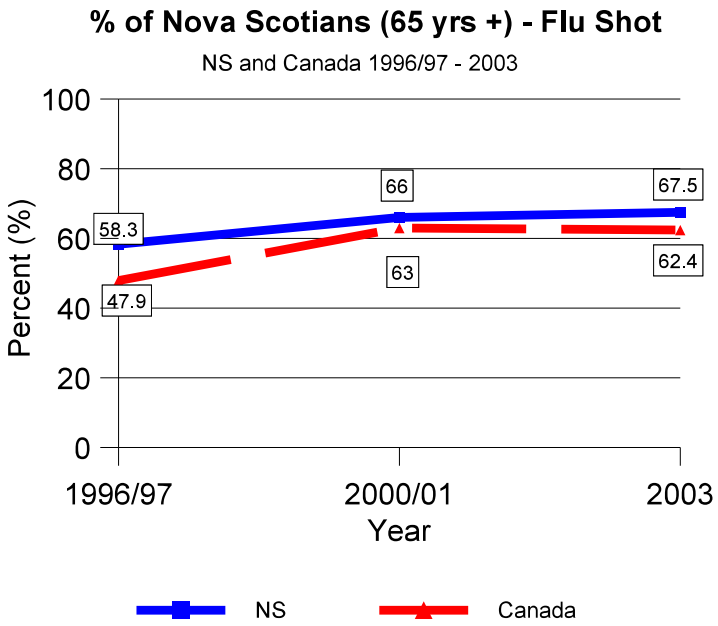
Outcome Measures - New, Revised and Discontinued

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
Average Number of Community-based Visits for Clients with Serious Mental Illness	Due to recent improvements to the Mental Health Outcomes Information System (MHOIS) the numbers that are being reported in these measures are not comparable to previous reports.
Psychiatric Inpatient Units Days Accounted for by Patients with Serious Mental Illness	
Number of Clients with Serious Mental Health Problems Treated Outside of Inpatient Hospital Settings	
Ambulatory Care Sensitive Conditions (ACSC)	In 2003 there was an adjustment to the range of conditions that were included as part of the ACSC grouping. As a result, the rates reported herein are not comparable to previous reports. Generally, the new calculations will report higher rates of ACSC in all provinces including Nova Scotia.

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.



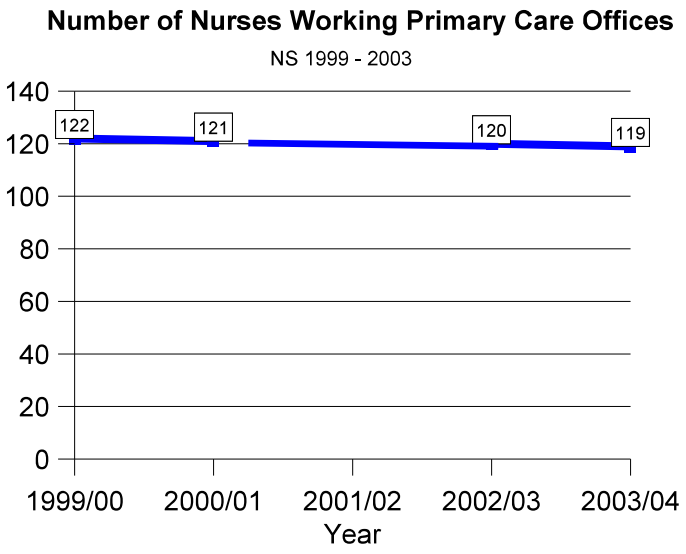
What Does the Measure Tell Us?
Vaccination coverage is measured by calculating the percentage of people (age 65 years and older) who reported having their last flu shot during the past year. By increasing the number of people who receive flu shots, we can decrease the burden of illness on vulnerable 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 2000-01 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 2004-05, 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 in 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. A limitation of this measure, however, is its inability to discern whether nurses reporting working in primary care practices are providing direct patient care or not.

Where Are We Now?

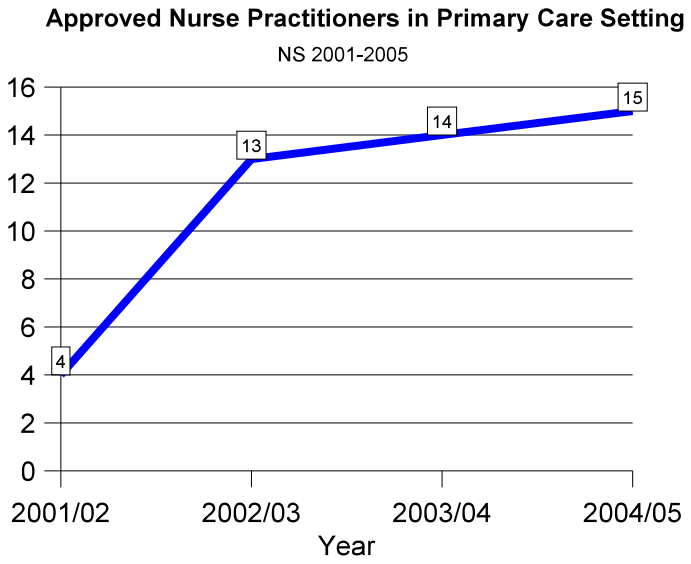
In 2003-04, there were 119 nurses working in primary care offices. This is a slight decline from previous years.

Where Do We Want to Be in the Future?

Specific targets have not been set, however 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 procedures, health promotion or specialty care.

Number of Nurse Practitioners Working in Primary Health Care Settings

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 nurse practitioners working in primary health care settings.



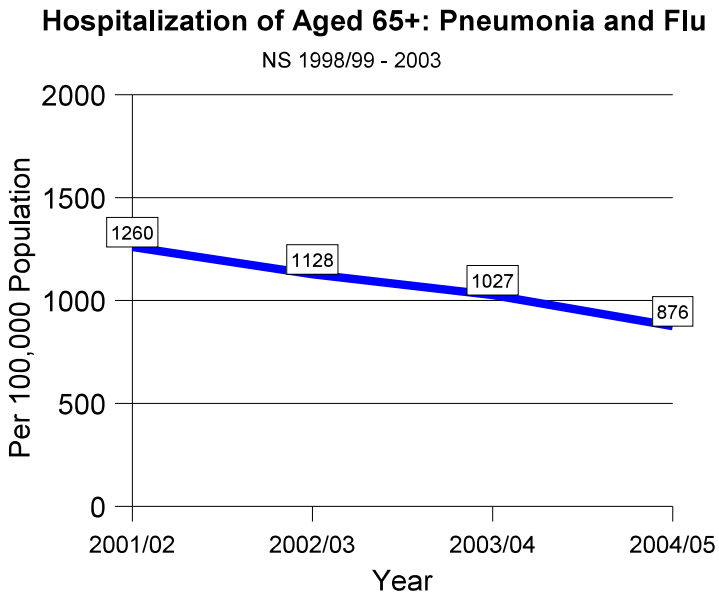
What Does the Measure Tell Us?
This measure is one way of showing what type of, and how much access to health professionals the public has at primary care sites.

Where Are We Now?
In 2004-05, there were 15 nurse practitioners working in primary care settings. There has been a steady increase in the number of nurse practitioners in primary care settings since 2001-02.

Where Do We Want to Be in the Future?
Specific targets have not been set. Strategies to promote the number of nurse practitioners working in primary care settings 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.

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 acute care and other health resources . 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.



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.

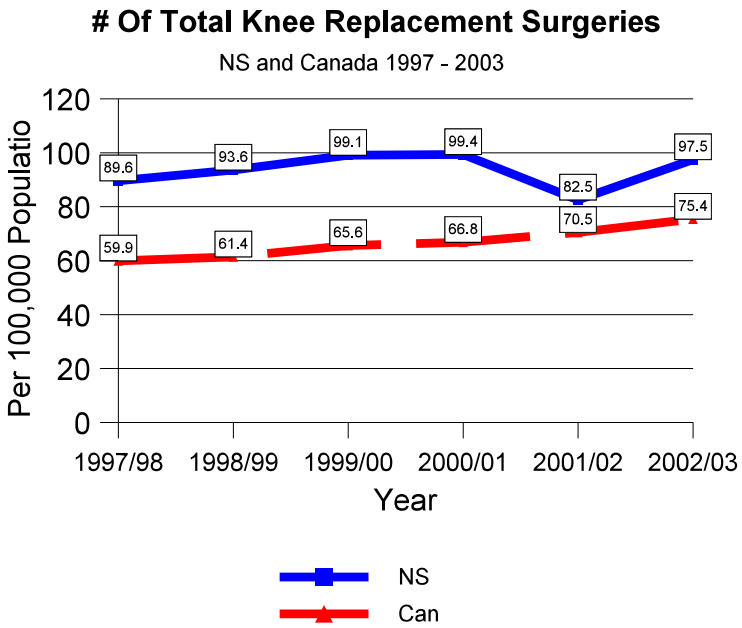
Where Are We Now?
During the year 2004-05, 876 people per 100,000 population aged 65 years or older were hospitalized for pneumonia and influenza. This shows a significant decrease since 2001-02 when 1,260 people were hospitalized.

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. Canadian data is not reported here because hospitals across the country began to collect clinical information using a different classification system in 2001-02 and 2003-04. As a result, comparability between provinces has been compromised. New valid Canadian data will be available from the Canadian Institute for Health Information for 2004-05 in March 2006.

The Department of Health will, however, continue to 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 Care. A desired outcome in this area is ensuring access to quality hospital services. This may be measured indirectly by assessing the rate at which various procedures requiring hospital stay are performed. One of these procedures is Total Knee Replacement Surgery.



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.

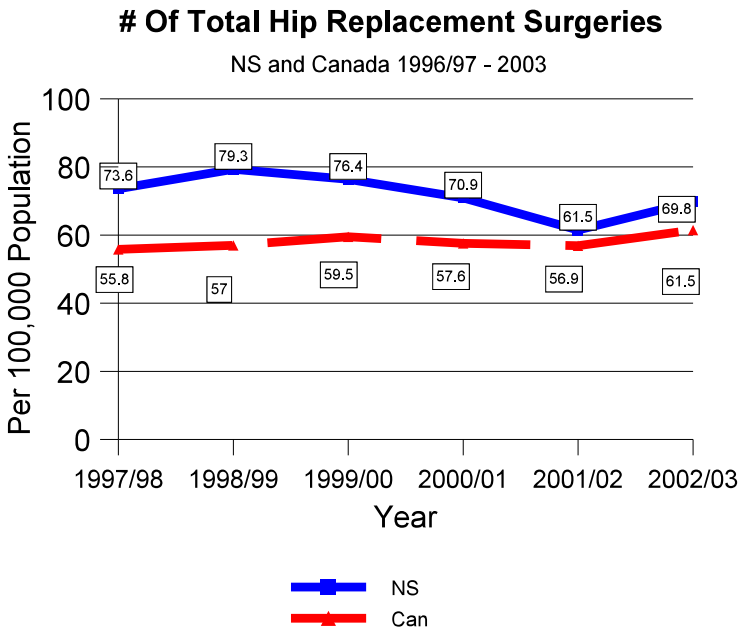
Where Are We Now?

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 1997-98 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. In 2002-03 the Nova Scotia rate rose to 97.5 per 100,000. While the gap between the Nova Scotian and Canadian knee replacement rate was narrowed in 2001-02, Nova Scotia continues to have a higher age standardized rate (97.5 per 100,000) than the Canadian average (75.4 per 100,000) in 2002-03.

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 (75.4 per 100,000 in 2002-03).

Number of Total Hip Replacement Surgeries

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



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?

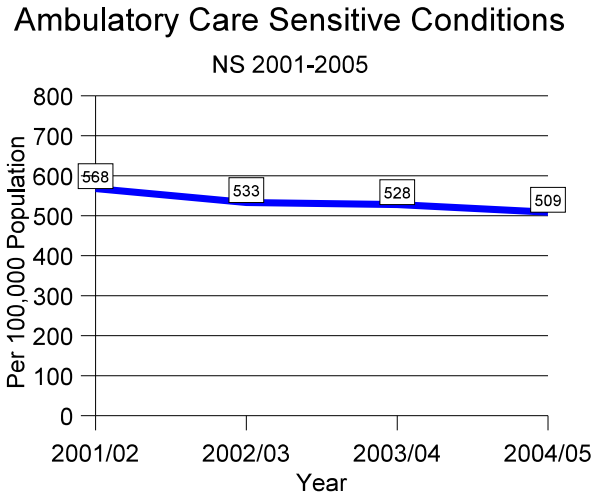
Total Hip Replacement Surgery is known to result in considerable improvement in functional status, pain relief, and other gains in health-related quality of life. Over the past six years, the age standardized rate of hip replacement surgeries in Nova Scotia decreased from 73.6 per 100,000 population in 1997-98 to 69.8 per 100,000 population in 2002-03. During the same period, age standardized total hip replacement rates have increased across Canada from 55.8 per 100,000 population in 1997-98 to 61.5 per 100,000 population in 2002-03. 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 (61.5 in 2002-03).

Proportion of People Admitted to Hospital for Conditions Where Appropriate Outpatient Care May Prevent the Need for Hospitalization (Ambulatory Care Sensitive Conditions)[2]

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



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 is typically less expensive than hospitalization. Tracking hospitalization rates for these conditions over time can provide an indicator of the impact of community and home-based services. ACSCs include conditions such as hypertension, asthma and angina.

Where Are We Now?

During 2004-05, 509 hospitalizations per 100,000 occurred in Nova Scotia for conditions where appropriate outpatient care may have prevented the need for hospitalization. Provincially and nationally, ambulatory care sensitive condition rates have steadily decreased over the last six years reflecting a consistent positive trend towards the more efficient use of health services.

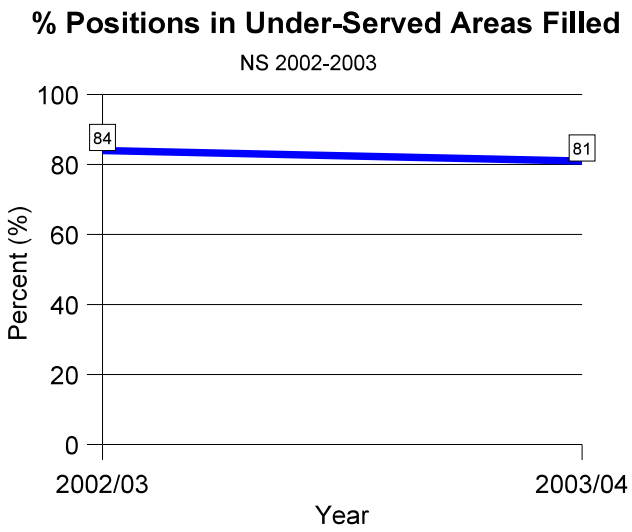
Where Do We Want to Be in the Future?

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 (current Canadian average not available due to change in methodology). Toward this end, the Department of Health will continue to monitor the effective utilization of hospital beds and review opportunities to use outpatient services most effectively.

[2] Please note the changes to this measure at the top of this section.

Percentage of Family Physician Positions 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 family physician positions filled in under-served areas. Under-served areas are defined as those that have a history of recruitment and retention difficulties, where recruiting by local committees has been unsuccessful for more than six months, and where the medical needs of the community are not being otherwise served. Those areas that are designated as "under-served" have incentive programs to support physician recruitment. The total number of under-served areas can change over time.

Where Are We Now?

In 2003-04, there were fewer positions identified as being in under-served areas: 42 as compared to 44 identified the previous year in 2003. Thirty-four of these 42 physician positions were filled (81 per cent). This percentage is down slightly from the 84% in 2002-03.

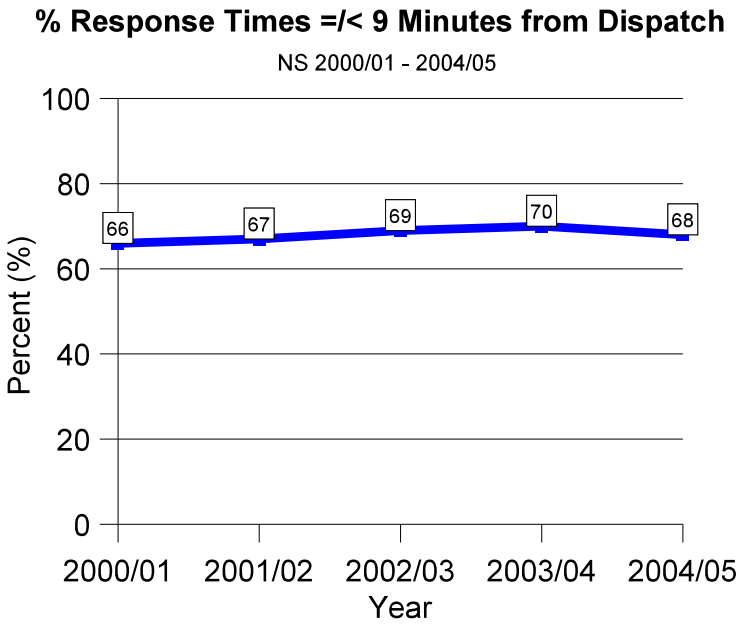
The total number of family physicians in under-served areas changes rapidly because of natural fluctuations (deaths, retirements, and the voluntary relocation of providers within the province) and successful recruitment. Ongoing recruitment efforts are required to maintain or exceed the provincial target (80 percent). Nova Scotia is focussing on building multi-professional care teams. Four pilot Strengthening Primary (Health) Care Initiative (SPCI) sites were transitioned to the District Health Authorities and received sustainable funding and eight new Primary Health Care Nurse Practitioner positions 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 its Physician Recruiter and via website 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 timely access to quality emergency health services. One of the ways in which this outcome may be assessed is by calculating response times from the time an emergency call is answered to arrival at the emergency scene.



What Does the Measure Tell Us?

In urban areas, the industry standard for response time is under 9 minutes, 90% of the time. 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. There are no standards for suburban or rural areas, however, making it difficult to compare Nova Scotia results (which are urban, suburban and rural) with EMS systems in other jurisdictions that are often urban only systems. Geography would naturally dictate that response times would be higher in suburban and rural areas than they would be in urban areas.

Where Are We Now?

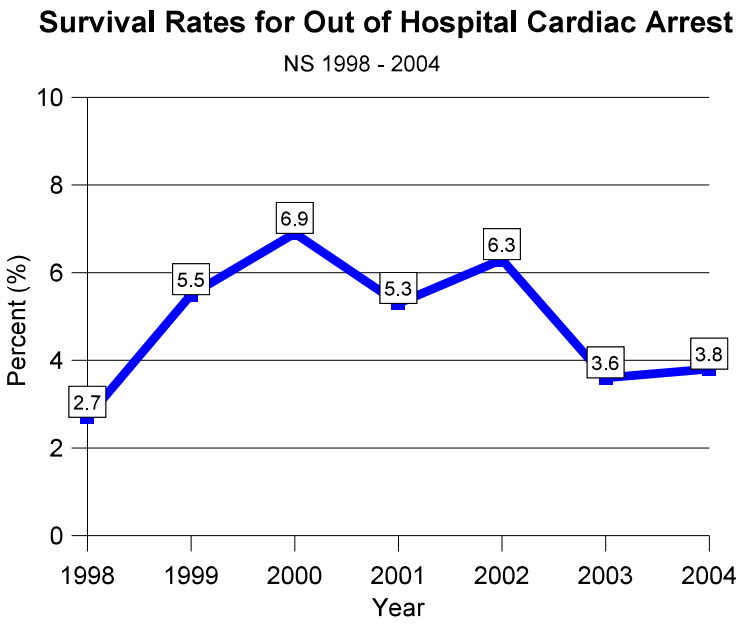
In 2004-05, response times from the time a call is answered to arrival at the emergency scene was 9 minutes or less 68% of the time. This shows an improvement since 2000-01 when response times of 9 minutes or less occurred 66% of the time.

Where Do We Want to Be in the Future?

The Department of Health is dedicated to continually improving response times by using methods and technology that will result in the most efficient use of ambulances.

Survival Rates for Out-of-Hospital Cardiac Arrests

One of the Department of Health's core business areas is Emergency Health Services. A desired outcome in this area is ensuring the effectiveness of Emergency Health Services in the management of out of hospital cardiac arrests.



What Does the Measure Tell Us?

A measure of the effectiveness of emergency health services is survival from out of hospital cardiac arrest. Many factors affect out-of-hospital cardiac arrest survival such as whether the arrest occurs in public, whether the victim is witnessed and receives bystander CPR and the timing of defibrillation.

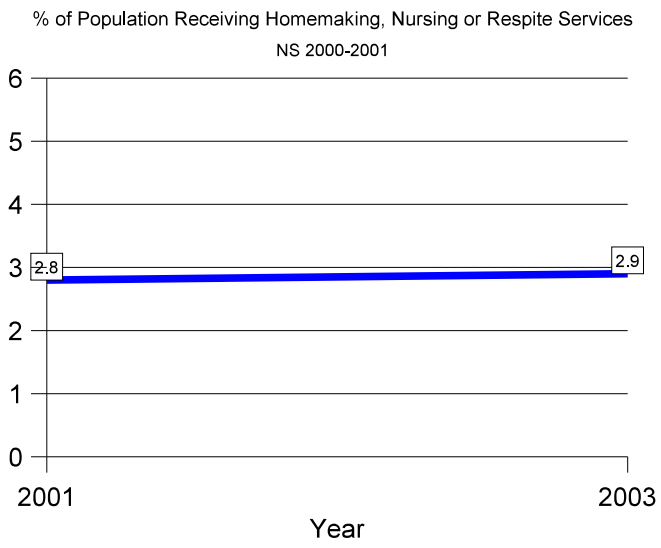
Where Are We Now?

In 2004, the provincial survival rate for out-of-hospital cardiac arrests (OOHCA) was 3.8%. It is difficult to compare Nova Scotia's system with other systems because of the different mixes of urban, suburban and rural areas. Most systems reporting survival rates are urban only systems. However, it is possible to compare Nova Scotia's out-of-hospital cardiac arrest survival rates over multiple years. The variation in this measure from year to year is considered to be within the normal range.

Where Do We Want to Be in the Future?

Nova Scotia's goal is to continue to improve survival rates for out-of-hospital cardiac arrests over time. With the involvement of stakeholders, strategies to achieve this target include ongoing training, procedural review and development, the development of a bystander care initiative, and the continuing encouragement of organizations, businesses and public buildings to stock automatic external defibrillators.

Percentage of the Population (Age 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; and lower costs are often associated with home care, compared to care in institutions.

What Does the Measure Tell Us?

As more home care programs are implemented, it is expected that these services will be provided to increasing numbers of people. Estimating the percentage of the population (age 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 2001, 2.8% of individuals, age 15 or older, received homemaking, nursing or respite services. In 2003, Nova Scotians reported that 2.9% of individuals, age 15 or older, received homemaking, nursing or respite services.

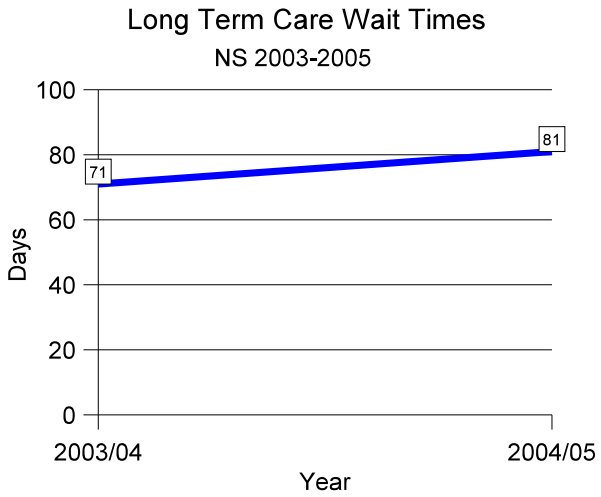
Where Do We Want to Be in the Future?

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 implemented Single Entry Access processes so that entry into Home Care and Long Term Care services is via a single, more efficient and less complex, process.

Continuing Care Wait Times

One of the Department of Health's core business areas is Continuing Care Services. A desired outcome in this area is ensuring access to quality Home Care and Long Term Care Services. One way in which access to long term care and home care services can be measured is by assessing the time that clients wait for services.

The Department is developing systems to allow for accurate and timely measurement of wait times. Currently Long Term Care wait times are available, while Home Care wait times are still under development.



What Does the Measure Tell Us?

Wait times are seen as an important measure of system accessibility and efficiency. Where available, it is important to report on data that measures the wait time for a particular service. This reporting allows service providers to assess and manage wait times better while also allowing clients and potential clients to understand the timing of their care. While an efficient health care system has some level of "wait" inherent, reduced wait times are generally interpreted as reflecting improved service delivery.

The Long Term Care wait time is defined as the period, in days, from client assessment until initial admission to a long term care facility.

Where Are We Now?

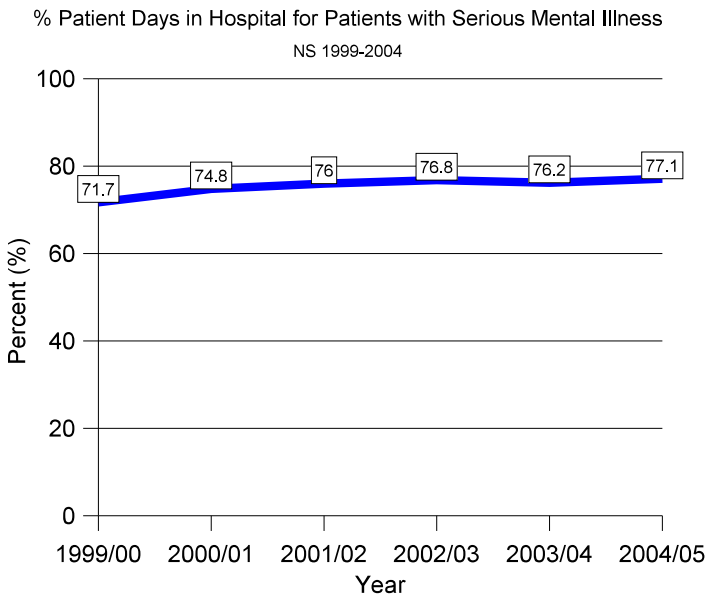
In 2003-04 the average wait time for Long Term Care admission was 71 days. In 2004-05 the average wait time was 81 days. As a result of changes in long term care funding policy implemented January 1, 2005, more Nova Scotians are seeking long term care placement, resulting in longer wait times in 2005.

Where Do We Want to Be in the Future?

It is our goal to ensure that Nova Scotians have appropriate access to Home Care and Long Term Care services. More data are required before a formal target can be set. We have implemented Single Entry Access processes so that entry into Home Care and Long Term Care services is via a single, more efficient and less complex, process.

Psychiatric Inpatient Units Days 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 by patients with serious mental illness suggests success in shifting service options from inpatient to alternate settings for appropriate clients and achieving more appropriate use of inpatient hospital care.



What Does the Measure Tell Us?

Persons with serious and persistent mental health problems are those who benefit most from hospital admissions. Other individuals, however, for whom outcomes are not enhanced by hospital care, may also be admitted to hospital because alternative community-based services or supports are not available. With limited inpatient capacity, this may reduce the availability of hospital care for those who need it most. The percentage of all patient days spent in 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. Severe and persistent mental illness is defined as one of several diseases affecting the brain (e.g., schizophrenia, bipolar disorder), in which sufferers are significantly functionally impaired by the illness for an indefinite period of time.

Where Are We Now?

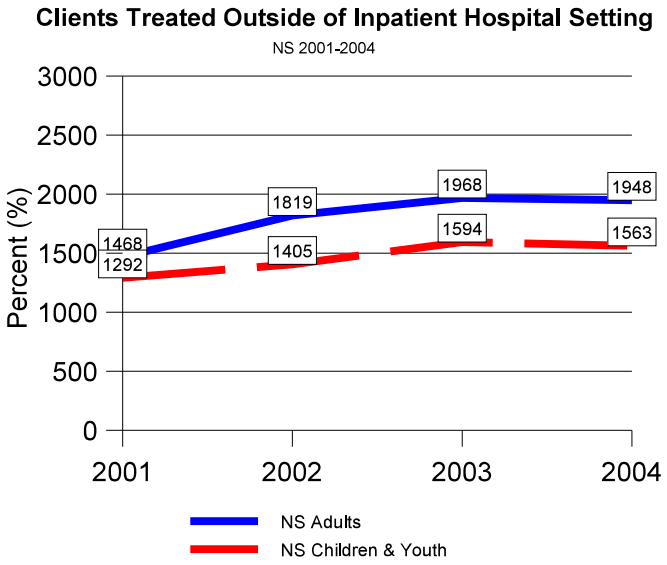
In 2004-05, 77.1 percent of patient days spent in psychiatric inpatient units were accounted for by patients with serious mental illness. This represents a moderate improvement in the utilization of inpatient services in Nova Scotia.

Where Do We Want to Be in the Future?

The Department of Health had set a target of 75% by 2004-05. This target remains unchanged. The strategy to reach this goal is to continue to support shifting service options from inpatient hospital care to alternate settings where appropriate.

Number of Clients with Serious Mental Health Problems Treated Outside of Inpatient Hospital Settings (Community-Based Visits)

One of the Department of Health's core business areas is Mental Health Services. A higher overall proportion of clients with serious mental health problems being treated outside of inpatient hospital settings is an indicator of increased use of community-based care alternatives for people who suffer from mental illness.



What does this measure tell us?

In most jurisdictions, there is a move from acute hospital-based treatment to community-based care for people who suffer from mental illness. Increasingly, persons with severe and persistent mental illness are being successfully supported in achieving the highest level of functioning possible in the least restrictive setting. This requires an array of treatment alternatives to inpatient hospitalization and the necessary supports to keep people well and living in their communities. This measure indicates progress being made in identifying individuals with mental illness who can appropriately reside in the community and the level of progress made in providing community-based services and supports that suit their needs. Severe and persistent mental illness is defined as one of several diseases affecting the brain (e.g., schizophrenia, bipolar disorder), in which sufferers are significantly functionally impaired by the illness for an indefinite period of time.

Where Are We Now?

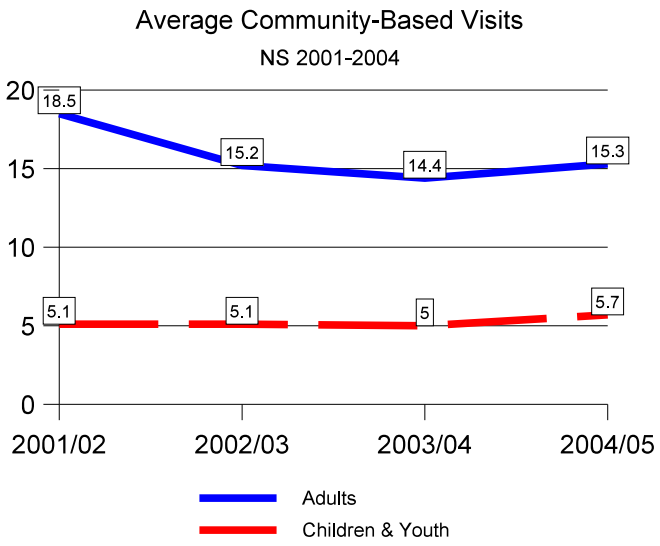
There has been a 33% increase in the number of adult clients with serious mental illness being treated outside of inpatient hospital settings between 2001 and 2004. In the same period there has been a 20% increase in the number of youth clients with serious mental illness being treated outside of inpatient hospital settings.

Where Do We Want to Be in the Future?

The Department of Health has a target for 2005 of 1906 adults and 1550 children and youth with serious mental illness to be treated outside of inpatient hospital settings.

Average number of Community-Based Visits for Clients with Serious Mental Illness

One of the Department of Health's core business areas is Mental Health Services. A higher average number of visits by clients with serious mental health problems is an indicator of increased use and availability of community-based care alternatives for people who suffer from mental illness.



What does this measure tell us?

In most jurisdictions, there is a move from acute to community-based care for people who suffer from mental illness. Increasingly, persons with severe and persistent mental illness are being successfully supported in achieving the highest level of functioning possible in the least restrictive setting. This requires an array of treatment alternatives to inpatient hospitalization and the necessary supports to keep people well and living in their communities. Those with severe and persistent mental illness are expected to require more intense and frequent support. Therefore, as more services become available, this population should be able to avail themselves of more frequent mental health service contacts. Severe and persistent mental illness is defined as one of several diseases affecting the brain (e.g., schizophrenia, bipolar disorder), in which sufferers are significantly functionally impaired by the illness for an indefinite period of time.

Where Are We Now?

The average number of visits for adults with serious mental illness has declined over the period between 2001-02 and 2004-05. This reduction is at least partially a result of a recent significant increase (33%) in the absolute number of adult clients that are being treated (the denominator).

During the same period, the average number of visits for children and youth has increased. Despite the apparent small increase in visits to children and youth over this period, the increase represents, on a relative scale, a substantial increase in overall visits.

Where Do We Want to Be in the Future?

In 2001, the Department of Health set a target for 2004-05 of 15 visits on average for adults and six visits on average for children and youth. This target remains unchanged.