

# Action for Health Key Performance Indicators

**JANUARY 2026**

REPORT OF THE AUDITOR GENERAL TO  
THE NOVA SCOTIA HOUSE OF ASSEMBLY

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January 27, 2026

Honourable Danielle Barkhouse  
Speaker  
House of Assembly  
Province of Nova Scotia

Dear Madam Speaker:

I have the honour to submit herewith my Report to the House of Assembly under Section 18(2) of the *Auditor General Act*, to be laid before the House in accordance with Section 18(4) of the *Auditor General Act*.

Respectfully,



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# Action for Health Key Performance Indicators

## Department of Health and Wellness

### Key Messages

- » *Action for Health* Key Performance Indicator (KPI) reporting is a positive initiative for transparency and accountability.
- » However, our audit reveals caution is needed to use and understand the 13 examined KPIs.
- » Identified reporting issues detract from accountability and full transparency.
- » Regional and local level KPIs are needed in addition to province-wide results.
- » The lack of comprehensive and cohesive health system reporting makes it challenging for Nova Scotians to understand health system performance.

### Why We Did This Audit

- » The 2025-26 budget included an estimated \$7.4 billion in healthcare spending, nearly half of the province's total spending budget.
- » Nova Scotians deserve to know what the \$1.3 billion invested under *Action for Health* is achieving.
- » Health system KPIs should promote full transparency and accountability, informing Nova Scotians about health system performance against targets and expectations, and the impact of substantial investments.

### Caution Required to Use *Action for Health* KPIs

- » Thirteen KPIs were examined, revealing a range of issues.
- » Caution is needed to use and understand the reported *Action for Health* KPIs.

### Reporting Issues Detract from Accountability and Full Transparency

- » Reporting of the *Percentage of Nova Scotians Seeking a Primary Care Provider* is not fully transparent following changes to the Need a Family Practice Registry in October 2024.
- » Ten KPIs, intended to measure the *Action for Health* plan, including for selected healthcare professionals such as family physicians, registered nurses, and continuing care assistants, have no target or an ineffective target.
- » Three KPIs found to have significant inconsistency between what is measured and what the KPI is intended to report on.
- » Two KPIs found to have significant data errors or incomplete data.
- » Two KPIs measuring patient wait times within benchmark exclude a significant portion of the wait.
- » Explanatory information required to fully understand the KPIs is not reported.
- » Each KPI reports only aggregated provincial results, masking health zone and facility performance.
- » Multiple websites reporting health measures, data, and statistics make it difficult for Nova Scotians to understand and make connections about health system performance.

## Recommendations and Responses

Recommendation	Department Response	
<p><b><u>Recommendation 1</u></b></p> <p>We recommend, to ensure full transparency, the Department of Health and Wellness (DHW):</p> <ul style="list-style-type: none"> <li>provide an explanation for the October 2024 changes in the methodology used to calculate the <i>Percentage of Nova Scotians Seeking a Primary Care Provider</i>; and,</li> <li>report as companion information, the number of individuals in the Need a Family Practice Registry comprising each status within the reported period (Cancelled, Registration Requested, Open, Pended, Placed).</li> </ul> <p style="text-align: right;">Paragraph 36</p>	<p>Action for Health continues to report the number of Nova Scotians that are still unattached.</p> <p>The process of using “status categories” within the Need a Family Practice Registry changed in October 2024. Status categories are now largely administrative designations to support navigating Nova Scotians to primary health care services based on their needs. The new registration and categorization process has improved the validation and identification of those being actively supported in the placement process.</p> <p>The reporting process on the Action for Health website has not been updated to reflect the changes in information collection and measurement and DHW agrees to publish additional information to explain how this KPI is calculated and any changes in methodology.</p>	 Department Disagrees
<p><b><u>Recommendation 2</u></b></p> <p>We recommend the Department of Health and Wellness set clear targets aligned to the planned investments and objectives of <i>Action for Health</i> for all reported KPIs and inform the public of those targets.</p> <p style="text-align: right;">Paragraph 52</p>	<p>Where available, Action for Health reporting has included targets using accepted national benchmarks (e.g. wait time standards) and/or to reflect the specific requirements of the Nova Scotia health system (e.g. number of family physicians per capita). In some situations, there are no national or provincial targets that can be used as a benchmark – for example Nova Scotia is one of the few provinces to have a registry for individuals seeking primary care or to publish unattached population numbers making benchmarking/target setting more complicated.</p> <p>DHW and its system partners have also established internal targets to support incremental achievement of performance, allowing for operational teams to focus on stepwise improvement targets. For example, the Action for Health target of 5% for the Need a Family Practice Registry was publicly shared as part of the Action for Health Plan. Internally, Nova Scotia Health (NSH) set a 9.5% target provincially by the end of December 2024, and 5% provincially by the end of January 2026. DHW agrees to continue to formalize and publish evidence-based targets and communicate those to the public. Where targets cannot be set, DHW will provide an explanation.</p>	 Department Agrees  <b>Target Date for Implementation:</b> November 2026

## Recommendations and Responses

Recommendation	Department Response	
<p><b><u>Recommendation 3</u></b></p> <p>We recommend the Department of Health and Wellness review the source of data for the <i>Family Physicians per 100,000</i> KPI and implement controls to align the data with the KPI's objective of reporting on family physicians responsible for a full panel of patients in the province.</p> <p>Paragraph 56</p>	<p>It is acknowledged that the source data for family physicians includes other primary care providers who may not have a full panel of patients; however, varying definitions of 'Family Physician' are valid for different purposes. In this reporting, locum physicians are considered to provide similar services to family doctors and are an important resource available to Nova Scotians. There are examples where, due to the duration of their locum practice, removing them from the count of family physicians would also result in inaccurate reporting of resources available to Nova Scotians.</p> <p>DHW agrees to review the source data and update the methodology behind this indicator to best capture the number of family physicians available in the province and provide clear descriptions of the data and the KPI's objective.</p>	 Department Agrees  <b>Target Date for Implementation:</b> November 2026
<p><b><u>Recommendation 4</u></b></p> <p>We recommend the Department of Health and Wellness expand its KPI reporting to include population-adjusted indicators that provide important context for primary care use and allow further comparisons over time and across regions.</p> <p>Paragraph 61</p>	<p>DHW believes that the current system-level indicators are appropriate and important for monitoring health transformation. These measures were deliberately selected to track how primary care investment is redirecting avoidable demand away from hospital settings. In addition to the currently used indicators, DHW agrees to further expand reporting on primary care access to include population based/adjusted indicators.</p>	 Department Agrees  <b>Target Date for Implementation:</b> November 2026
<p><b><u>Recommendation 5</u></b></p> <p>We recommend the Department of Health and Wellness work with NSH to identify and correct the causes of incomplete emergency department data.</p> <p>Paragraph 64</p>	<p>DHW and NSH have included a number of emergency department and emergency care metrics on the Action for Health website. These include emergency department availability and closure data, emergency visits, emergency patient triage levels, emergency department wait times and ambulance offloads and offload times.</p> <p>DHW and NSH are continuously working to improve data collection, and will explore potential data workflow improvements, which will be further enabled by the implementation of One Person One Record (OPOR).</p> <p>DHW agrees to work with NSH and IWK to address data gaps identified at the site level.</p>	 Department Agrees  <b>Target Date for Implementation:</b> November 2027

## Recommendations and Responses

Recommendation	Department Response
<p><b><u>Recommendation 6</u></b></p> <p>We recommend the Department of Health and Wellness report on patients who leave the emergency department without being seen as a companion KPI to the <i>Emergency Department Wait Times within Benchmark</i> KPI.</p> <p>Paragraph 66</p>	<p>Left Without Being Seen (LWBS) encounters are documented and monitored internally, however, there are inconsistencies and complications that preclude this from being an ideal Action for Health indicator.</p> <p>For example, Nova Scotia's LWBS data includes some patients whose care was initiated and/or completed in the emergency department or virtually. Our current clinical information systems cannot integrate with virtual care options and do not capture the time to care.</p> <p>Further, in rural emergency departments, LWBS rates include those who arrive at a closed emergency department, receive a triage assessment and are redirected to the most appropriate place for care, or are not appropriate (or decline an offer) for Virtual Urgent Care. Limitations such as these are planned to be addressed through OPOR implementation.</p> <p>As a result of these limitations DHW reserves the right to refrain from posting LWBS data as part of its Action for Health reporting until such time as data collection and systems integration allows for accurate public reporting.</p>
<p><b><u>Recommendation 7</u></b></p> <p>We recommend the Department of Health and Wellness work with NSH to identify and correct errors in physician departure data and correct all the results for the KPI on the <i>Action for Health</i> website.</p> <p>Paragraph 70</p>	<p>As noted in the report there are a small number of instances of departure data not being accurately recorded within the administrative systems used to populate this performance metric. DHW agrees to work with NSH and other partners to ensure any errors in the physician departure data are updated in the results on the Action for Health website.</p>
<p><b><u>Recommendation 8</u></b></p> <p>We recommend the Department of Health and Wellness identify, correct, and report the referral period in the reporting of <i>Wait Times within Benchmark</i> KPIs, for mental health and addictions and for completed surgeries.</p> <p>Paragraph 76</p>	<p>DHW is continuously working to improve data collection, and will explore data workflow improvements, which will be further enabled by OPOR implementation. DHW agrees to review available referral period data and identify gaps with provider organizations with an intent to include referral periods, where possible, in future public reporting</p>

## Recommendations and Responses

Recommendation	Department Response
<p><b><u>Recommendation 9</u></b></p> <p>We recommend the Department of Health and Wellness establish a requirement to publish complete methodology details for all publicly reported key performance indicators. Reported methodology documentation should include:</p> <ul style="list-style-type: none"> <li>» cautions where it is known incomplete data is substantial and could affect the KPI results;</li> <li>» data source(s);</li> <li>» definitions;</li> <li>» targets and benchmarks, including their source;</li> <li>» calculations used, including any inclusions or exclusions; and</li> <li>» any significant changes to calculations.</li> </ul> <p style="text-align: center;">Paragraph 81</p>	<p>DHW is committed to transparency and accountability, as Action for Health and KPI reporting demonstrates. To date, the Action for Health and KPI reporting has been simplified for the user experience with the data notes including information on reporting periods and notifying users of potential lags in reporting. It is acknowledged that publishing additional technical information (including methodology, data sources and formulas) is good practice. To that end, and to continue Nova Scotia's commitment to improve healthcare openly and accurately, DHW agrees to add methodology information for publicly reported indicators.</p>
<p><b><u>Recommendation 10</u></b></p> <p>We recommend the Department of Health and Wellness, where the data is available, report health system key performance indicators on a health zone basis and/or a facility basis, in addition to provincially aggregated results.</p> <p style="text-align: center;">Paragraph 86</p>	<p>Action for Health is a provincial plan and the published KPIs are intended to assess system-level transformation.</p> <p>Health zones are not a consistent administrative or reporting structure across all reporting entities and may not be an effective approach for all metrics. The Daily Dashboard reporting on the Action for Health website does include some performance measures that can be filtered to show zone and/or facility performance.</p> <p>For future reporting, DHW agrees to identify KPIs where additional regional context would add value without compromising accuracy or ease of interpretation.</p>
<p><b><u>Recommendation 11</u></b></p> <p>We recommend the Department of Health and Wellness establish and implement clear data quality control expectations for all publicly reported key performance indicators.</p> <p style="text-align: center;">Paragraph 91</p>	<p>As noted in the report there are a variety of data sources and data owners that contribute to Action for Health reporting, and although quality control procedures exist within these organizations, DHW has not published expectations for data quality for publicly reported indicators. DHW will review current indicators and develop quality control procedures as appropriate for publicly reported key performance indicators.</p>

## Recommendations and Responses

Recommendation	Department Response	
<p><b><u>Recommendation 12</u></b></p> <p>We recommend the Department of Health and Wellness implement cohesive and comprehensive health system reporting.</p> <p>Paragraph 101</p>	<p>Currently DHW provides public reporting on health and the health system through a number of different sites and locations. This includes Action for Health Progress Updates Dashboard, Public Reporting Daily Dashboard, Healthcare Wait Times, Patient Safety Indicators and Serious Reportable Events. DHW agrees to review all existing public reporting and work towards a complete and accessible set of monitoring resources, including a balance of system and population-based metrics.</p>	<p> Department Agrees</p> <p> <b>Target Date for Implementation:</b> November 2027</p>

## Reference Guide – Key Findings and Observations

Paragraph or Page	Key Findings and Observations
<b><i>Caution Required to Use Action for Health Key Performance Indicators (KPIs)</i></b>	
Paragraph 15	Thirteen KPIs examined were assessed for reliability and full transparency
Paragraph 16	Unique KPIs examined show a range of results
Page 17	<i>Family Physicians per 100,000 Nova Scotians</i>
Page 17	<i>Surgical Waitlist Growth Rate Ratio</i>
Page 18	<i>Registered Nurses Annual Net Increase</i>
Page 18	<i>Total Registered Continuing Care Assistants</i>
Page 19	<i>Number of Admissions to Long-term Care (from Hospital and Community)</i>
Page 19	<i>Volume of the Home Care Waitlist</i>
Page 20	<i>Percentage of Hospital Admissions for People Whose Complex Needs Could Have Been Addressed with Primary Health Care</i>
Page 20	<i>Percentage of Emergency Department Visits by Patients without Access to a Primary Healthcare Provider</i>
Page 21	<i>Percentage of Urgent Addictions and Mental Health First Treatment Wait Times within Benchmark</i>
Page 21	<i>Percentage of Non-Endoscopic Surgical Services Completed or Wait Times within Benchmark</i>
Page 22	<i>Family Physicians Annual Net Increase</i>
Page 22	<i>Emergency Department Wait Times within Benchmark</i>
Page 23	<i>Percentage of Nova Scotians Seeking a Primary Care Provider (as tracked by the Need a Family Practice Registry)</i>
<b><i>The Reporting of the Percentage of Nova Scotians Seeking a Primary Care Provider KPI is Not Fully Transparent Following 2024 Changes to the Need a Family Practice Registry</i></b>	
Paragraph 17	Need a Family Practice Registry established to connect Nova Scotians to primary care providers
Paragraph 19	High number of cancellations reflect validation work being done
Paragraph 23	Placement activity steady during <i>Action for Health</i> period
Paragraph 24	Significant changes to Need a Family Practice Registry in October 2024
Paragraph 27	Introducing <i>Registration Requested</i> status reduces the number counted for the KPI
Paragraph 30	Changing treatment of <i>Pended</i> status reduces the number counted for the KPI
Paragraph 35	Reduced counts impact the <i>Percentage of Nova Scotians Seeking a Primary Care Provider</i>
Paragraph 36	Reporting of <i>Percentage of Nova Scotians Seeking a Primary Care Provider</i> on <i>Action for Health</i> website is open to misinterpretation
<b><i>Ten KPIs Intended to Measure Action for Health have No Target or an Ineffective Target</i></b>	
Paragraph 37	\$241 million dedicated to improve surgical access between 2022-2026
Paragraph 38	Operating room capacity affects surgery wait times
Paragraph 39	<i>Action for Health</i> objective is to expand operating room capacity to reduce waitlists
Paragraph 40	<i>Surgical Waitlist Growth Rate Ratio</i> target not effective for <i>Action for Health</i> accountability

Paragraph 43	Health workforce strategy is a major component of <i>Action for Health</i> , investing \$196 million between 2022-2026
Paragraph 44	No targets set to measure recruitment and retention of healthcare professionals
Paragraph 46	The Department says health transformation makes it difficult to set targets
Paragraph 47	Expansions of long-term care and home care planned under <i>Action for Health</i>
Paragraph 49	Results show long-term care admissions and home care waitlist targets met
Paragraph 50	Targets based on pre-pandemic levels of service not aligned to <i>Action for Health</i> goals
Paragraph 52	Public targets different than internal targets used by management

**Three KPIs Found to Have Significant Inconsistency between What is Measured and What the KPI is Intended to Report On**

Paragraph 53	Inclusion of locum physicians artificially boosts family physicians per 100,000 results
Paragraph 57	<i>Action for Health</i> primary care expenditures \$211 million between 2022-2026
Paragraph 58	Definition issue affecting two primary care KPIs
Paragraph 59	Difficult to determine if changes in the results show improvement or deterioration in primary care
Paragraph 60	CIHI reports a similar KPI, calculated per 100,000 population

**Two KPIs Found to Have Significant Data Errors or Incomplete Data**

Paragraph 63	<i>Emergency Department Wait Times within Benchmark</i> data is incomplete
Paragraph 65	Patients who leave the emergency department without being seen are not reported
Paragraph 67	<i>Family Physicians Annual Net Increase</i> data errors detected, resulting in some departing physicians not reported in physician count

**Two KPIs Measuring Patient Wait Times within Benchmark Exclude a Significant Portion of the Wait**

Paragraph 71	<i>Mental Health and Addictions Wait Times within Benchmark</i> KPI is tracked by portions of the total wait time
Paragraph 73	Mental health and addictions KPI hides variation in performance across the wait portions
Paragraph 74	Exclusion of Wait 0 (referral and triage period) significantly impacts the reported results
Paragraph 75	<i>Completed Surgeries Wait Times within Benchmark</i> KPI also excludes referral period

**KPI Explanatory Information, Required to Fully Understand the KPIs, is Not Reported**

Paragraph 77	Best practice is to report complete explanation and methodology
Paragraph 79	<i>Action for Health</i> website reports only brief "Data Notes" to explain the KPIs
Paragraph 82	KPI results published only as provincial aggregates mask local variation in performance
Paragraph 84	Significant investments of \$1.3 billion over four years on <i>Action for Health</i>
Paragraph 85	Large scale investments should have complete reporting

**Lack of Comprehensive and Cohesive Health System Reporting Makes it Challenging for Nova Scotians to Understand Health System Performance**

Paragraph 87	Complex systems and processes, many partners involved in producing KPIs
Paragraph 90	New governance committee has a mandate for healthcare data quality and auditing
Paragraph 92	Other available performance indicators could enhance reporting on <i>Action for Health</i> and health system performance
Paragraph 96	<i>Action for Health</i> reporting adds to the complicated health data landscape
Paragraph 99	Models of cohesive health system reporting are available in other provinces

## »» Background

1. The Nova Scotia government launched its *Action for Health* strategic plan in 2022 to transform the provincial healthcare system.
2. One of the plan's six core goals is to "build accountability at every level" by setting "clear and transparent metrics and standards for the planning and delivery of health services."
3. The Department of Health and Wellness ("the Department") leads health system transformation and it has ultimate responsibility for *Action for Health*. The Department works closely with partners that deliver health care services, such as Nova Scotia Health (NSH) and others, to capture relevant health system data for reporting.
4. Key actions in the strategic plan include assessing and clearly communicating results, achieved through the development of health system indicators designed "to measure and report publicly on progress and performance of the health system." According to the Department, this action item was completed when it identified and published 27 Key Performance Indicators (KPIs) on the *Action for Health* Progress Updates Dashboard ("the website")<sup>1</sup>.



Source: *Action for Health Strategic Plan*

5. A complete list of the indicators is set out in Appendix II, including new ones added in June 2025. These indicators cover a wide range of health system topics, including:
  - » tracking the numbers of selected healthcare professionals;
  - » measuring admissions to long-term care and homecare waitlists; and,
  - » assessing healthcare operational performance in a variety of areas.
6. Key Performance Indicators (KPIs) are important to understand an organization's progress in achieving its strategic and operational goals. The *Action for Health* KPIs should keep Nova Scotians informed of the government's progress in achieving its intended outcomes with the significant investments being made through the *Action for Health* strategic plan.
7. Spending under the banner of *Action for Health* in its first four years is anticipated to be nearly \$1.3 billion.

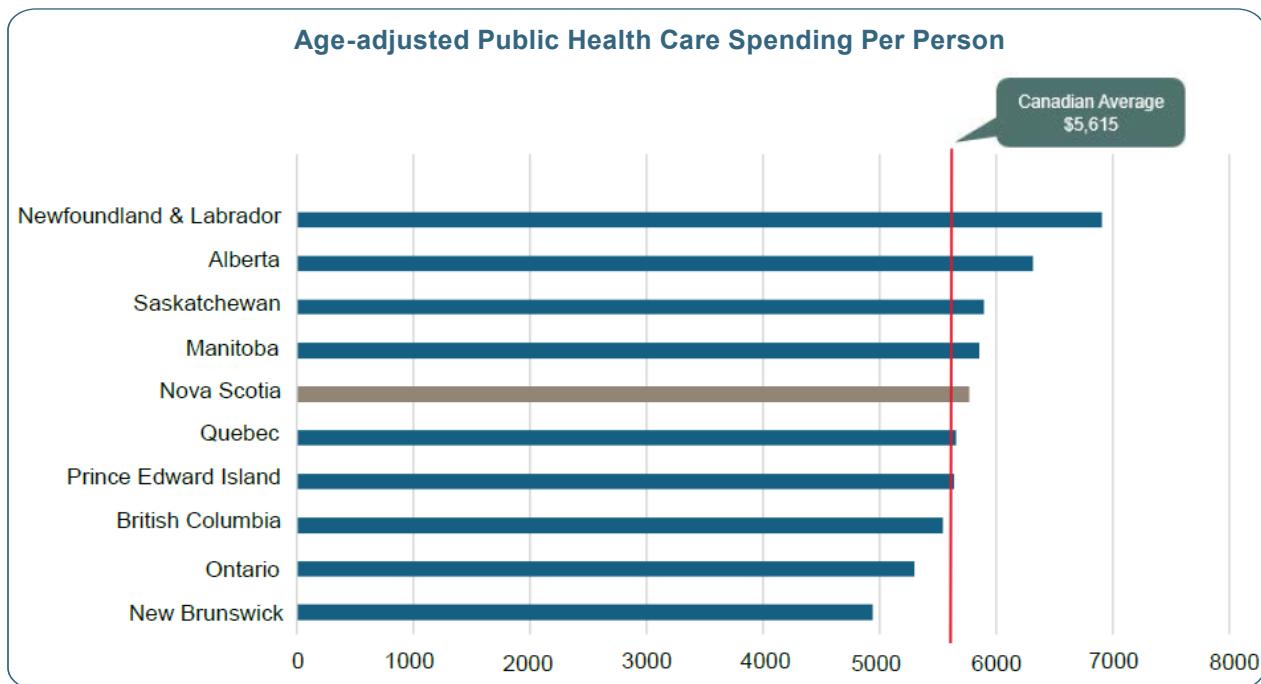
Action for Health Spending					Total
Fiscal Year	2022-23 (actual)	2023-24 (actual)	2024-25 (actual)	2025-26 (budget)	2022-2026
Amount	\$64,743,000	\$298,253,000	\$520,197,575	\$374,060,000	\$1,257,253,575

Source: Department of Health and Wellness (unaudited) - includes operational and capital expenditures

<sup>1</sup> The *Action for Health* Progress Updates Dashboard is a standalone webpage navigated to from the *Action for Health* website: <https://experience.arcgis.com/experience/803e058d4ab747629a5c14419d7e5c4a>

## Canadian Institute for Health Information (CIHI) reports nationally

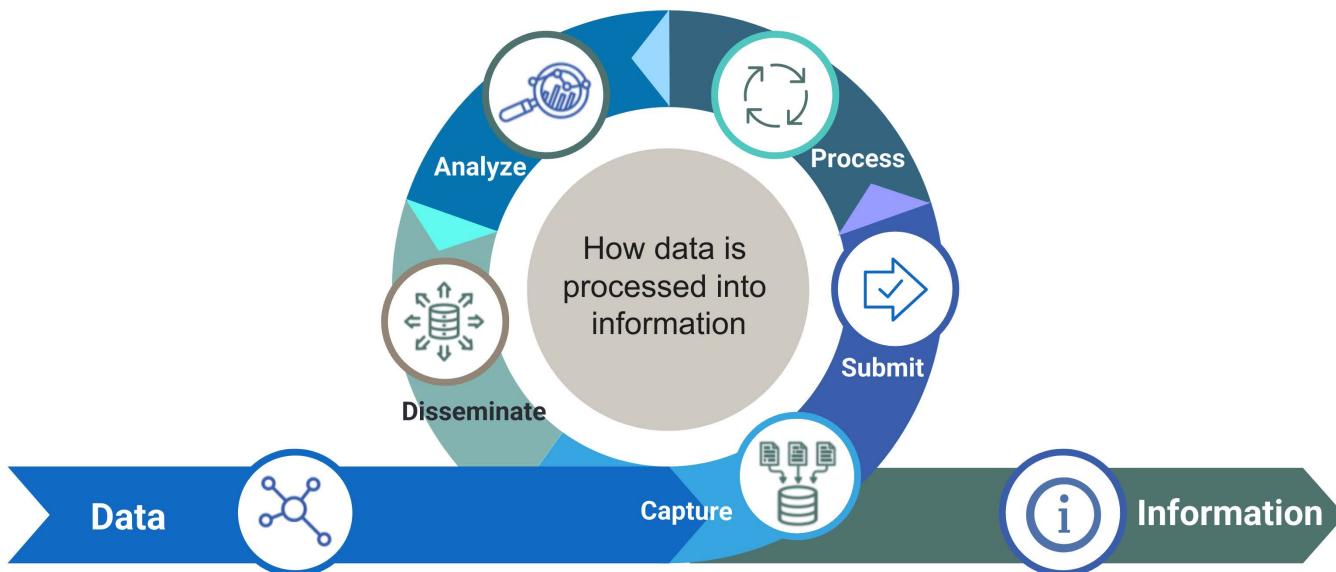
8. The Canadian Institute for Health Information (CIHI) collects and publishes data on its website about health system performance across the country (<https://www.cihi.ca/en>). Nova Scotia participates in this reporting and sends data to be included in CIHI's jurisdictional comparisons.
9. For example, CIHI reports comparisons on provincial healthcare expenditures per person. Based on 2022 data, this comparison shows Nova Scotia is in the middle with expenditures of \$5,766 per person. This is slightly higher than the Canadian average of \$5,615 per person.



Source: Office of the Auditor General of Nova Scotia, based on unaudited CIHI reported data

10. Many provinces and territories publish health care statistics and information in addition to CIHI. The information published varies from province to province.
11. CIHI provides guidance to provinces for assessing and assuring data quality and information quality. Data quality refers to the accuracy and completeness of the data used to calculate a performance indicator. Information quality refers to the meaningfulness and relevance of the information communicated by a performance indicator. CIHI emphasizes that communicating relevant information backed by quality data is beneficial because it promotes increased knowledge and trust. The following graphic shows data transformed into information. It highlights that raw data is the foundation, followed by processing and analysis used to produce reported information. All components of the cycle are critical to producing reliable outcomes that promote knowledge, trust, and full transparency.

**Canadian Institute for Health Information (CIHI) Information Quality Framework**



Source: Office of the Auditor General of Nova Scotia, based on Information Quality Framework, Canadian Institute for Health Information

12. We undertook this audit to determine if the KPIs selected by the Department of Health and Wellness promote knowledge, trust, and full transparency. We assessed a sample of reported KPIs, selected from those reported on the *Action for Health* website. Our sample was selected to provide a cross-section of indicators representative of different aspects of the healthcare system, including those tracking the numbers of doctors, nurses, and continuing care assistants, and measuring access to primary, long-term, and home care.
13. The Department of Health and Wellness told us that the *Action for Health* KPIs it selected for public reporting were designed to report on the *Action for Health* strategic plan initiatives, providing representation across the plan. It also selected indicators that would be likely to show impacts from the *Action for Health* initiatives within the anticipated horizon of one to three years, and would be easy to understand by the public.
14. Nova Scotia should be commended for initiating a program to report health system key performance indicators, with performance targets. The decision to report key performance indicators as a part of a plan to build accountability at every level of the health system is a positive initiative for transparency and accountability. The results of this audit reveal this program could be more effective with identified improvements. The recommendations of this report are intended for consideration in relation to the specific KPIs examined and should also inform the construction of health system reporting in the future.

## »» Caution Required to Use *Action for Health* Key Performance Indicators (KPIs)

### Thirteen KPIs examined were assessed for reliability and full transparency

15. Each of the 13 KPIs we examined is unique. Our detailed examinations were designed to assess the reliability of each selected KPI in terms of its reporting and contributions to promoting knowledge about the *Action for Health* strategic plan initiatives. We considered what would be needed to provide Nova Scotians with reliable information they can use to assess accountability and transparency of health system performance.

### Unique KPIs examined show a range of results

16. Our assessments of the examined KPIs reflect the circumstances and objectives of each. A conclusion is given about the degree of caution needed for Nova Scotians looking to use these KPIs to understand health system performance and outcomes of the *Action for Health* strategic plan. The categories below present a summary of our results to convey areas of caution about the examined KPIs.

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**Summary Results of Examined KPIs and Related Degree of Caution Required**

Action for Health Key Performance Indicator	Data	Targets	Consistency and Transparency	Reporting	Quality Controls	Results Summary for each KPI
Family Physicians per 100,000 Nova Scotians	✓	✓	⚠	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 17
Surgical Waitlist Growth Rate Ratio	✓	⚠	✓	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 17
Registered Nurses Annual Net Increase	✓	⚠	✓	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 18
Total Registered Continuing Care Assistants	✓	⚠	✓	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 18
Number of Admissions to Long-term Care (from Hospital and Community)	✓	⚠	✓	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 19
Volume of the Home Care Waitlist	✓	⚠	✓	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 19
Percentage of Hospital Admissions for People Whose Complex Needs Could Have Been Addressed with Primary Health Care	✓	✓	⚠	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 20
Percentage of Emergency Department Visits by Patients without Access to a Primary Healthcare Provider	✓	✓	⚠	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 20
Percentage of Urgent Addictions and Mental Health First Treatment Wait Times within Benchmark	✓	⚠	⚠	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 21
Percentage of Non-Endoscopic Surgical Services Completed or Wait Times within Benchmark	✓	⚠	⚠	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 21
Family Physicians Annual Net Increase	⚠	⚠	✓	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 22
Emergency Department Wait Times within Benchmark	⚠	⚠	✓	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 22
Percentage of Nova Scotians Seeking a Primary Care Provider (as tracked by the Need a Family Practice Registry)	✓	⚠	⚠	⚠ <sup>1</sup>	⚠ <sup>2</sup>	Page 23

Source: Office of the Auditor General of Nova Scotia

<sup>1</sup> Results include two common cautions applicable to all 13 examined KPIs. Some KPIs examined received an additional caution, as per the individual KPI results summary.

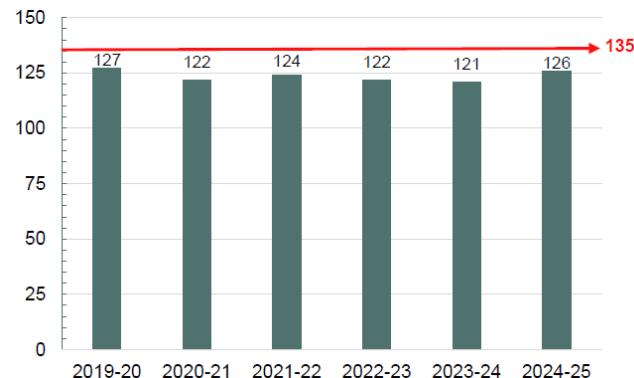
<sup>2</sup> Results include one common caution applicable to all 13 examined KPIs. Some KPIs examined received an additional caution, as per the individual KPI results summary.

**A summary of the results for each examined KPI follows (p. 17-23)**

## Family Physicians per 100,000 Nova Scotians

**About:** This KPI intends to show the number of family physicians available to the Nova Scotia population. It measures the total number of physicians actively billing the province as a General Practitioner in a fiscal year.

Chart Source: *Office of the Auditor General*, based on data from *Action for Health* website



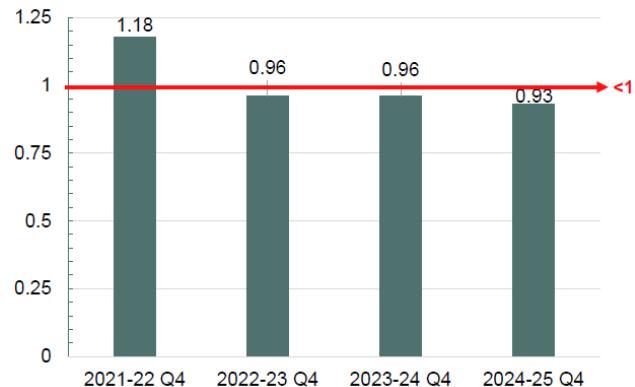
### OAG Results Summary

Data	✓	No significant data errors or incomplete data detected.
Targets	✓	A target of 135 family physicians is set based on the typical number of people a family physician can serve.
Consistency & Transparency	⚠	Data for this KPI includes more than Nova Scotia family physicians. It includes hospitalist and emergency physicians, and temporary replacement physicians (called locum physicians). Discussion at para. 53-56.
Reporting	⚠	Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
Quality Controls	⚠	Indicator data quality controls are not written and there is no sign-off when completed. Discussion at para. 87-89.

## Surgical Waitlist Growth Rate Ratio

**About:** This KPI intends to show the health system's capacity to service the demand for surgery. It measures the supply and demand for surgery based on estimates of hours required for surgeries in queue (demand) and on actual time spent on completed surgeries (supply). The ratio is calculated by demand divided by supply.

Chart Source: *Office of the Auditor General*, based on data from *Action for Health* website, Q4 only



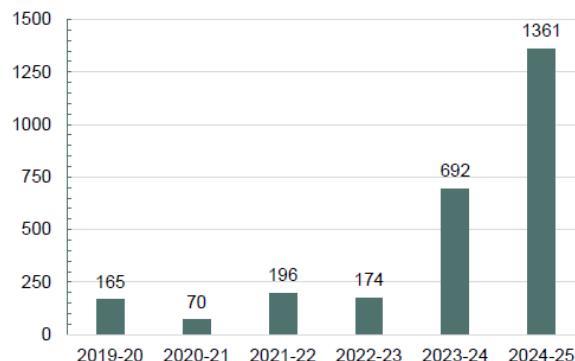
### OAG Results Summary

Data	✓	No significant data errors or incomplete data detected.
Targets	⚠	The set target is not effective to measure <i>Action for Health</i> 's planned expansion in operating room capacity. Discussion at para. 37-42.
Consistency & Transparency	✓	This KPI is consistent with the intended <i>Action for Health</i> reporting on surgical capacity.
Reporting	⚠	Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
Quality Controls	⚠	Indicator data quality controls are not documented as a clear checklist and there is no sign-off when completed. Discussion at para. 87-89.

### Registered Nurses Annual Net Increase

**About:** This KPI intends to show the annual increase or decrease in registered nurses working in Nova Scotia. It measures new registered nurses employed, minus those who left the workforce in a registration year, as tracked by the College of Nursing.

Chart Source: Office of the Auditor General, based on data from Action for Health website



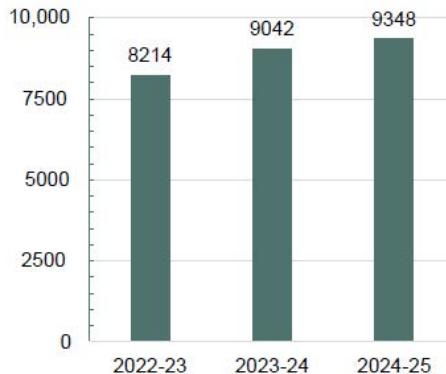
#### OAG Results Summary

<b>Data</b>		No significant data errors or incomplete data detected.
<b>Targets</b>		No public target is set. An internal target to hire 1,000 internationally trained nurses per year is set. Discussion at para. 43-46.
<b>Consistency &amp; Transparency</b>		This KPI is consistent with the intended <i>Action for Health</i> reporting on recruitment and retention of nurses.
<b>Reporting</b>		Results on the website are mislabeled showing nurse entries and departures for the previous registration year (e.g. results labelled 2023-24 are entries and departures for November 1, 2022 to October 31, 2023). Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
<b>Quality Controls</b>		Indicator data quality controls are not written and there is no sign-off when completed. Discussion at para. 87-89.

### Total Registered Continuing Care Assistants

**About:** This KPI intends to show the total number of registered continuing care assistants in Nova Scotia. It measures active registrants in the Continuing Care Assistant's Registry, managed by the Health Association of Nova Scotia.

Chart Source: Office of the Auditor General, based on data from Action for Health website



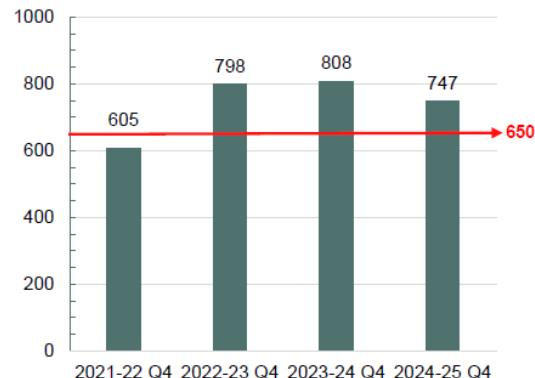
#### OAG Results Summary

<b>Data</b>		No significant data errors or incomplete data detected.
<b>Targets</b>		No public target is set. Discussion at para. 43-46.
<b>Consistency &amp; Transparency</b>		This KPI is consistent with the intended <i>Action for Health</i> reporting on availability of Continuing Care Assistants.
<b>Reporting</b>		Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
<b>Quality Controls</b>		Indicator data quality controls are not written and there is no sign-off when completed. Discussion at para. 87-89.

## Number of Admissions to Long-term Care (From Hospital and Community)

**About:** This KPI intends to show Nova Scotians' access to long-term care. It measures the total number of people admitted to long-term care in Nova Scotia.

Chart Source: Office of the Auditor General, based on data from *Action for Health* website, Q4 only



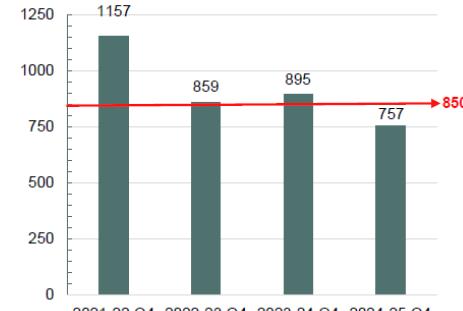
### OAG Results Summary

Data	✓	No significant data errors or incomplete data detected.
Targets	⚠	The target set of 650 admissions is based on the pre-pandemic average; it is ineffective to measure the long-term care expansion planned under <i>Action for Health</i> . Discussion at para. 47-51.
Consistency & Transparency	✓	This KPI is consistent with the intended <i>Action for Health</i> reporting on access to long-term care.
Reporting	⚠	Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
Quality Controls	⚠	Indicator data quality controls are not written and there is no sign-off when completed. Minor data quality control errors identified during testing. Discussion at para. 87-89.

## Volume of the Home Care Waitlist

**About:** This KPI intends to show Nova Scotians' access to homecare services. It measures the total number of people approved for homecare services who are not yet receiving the approved services.

Chart Source: Office of the Auditor General, based on data from *Action for Health* website, Q4 only



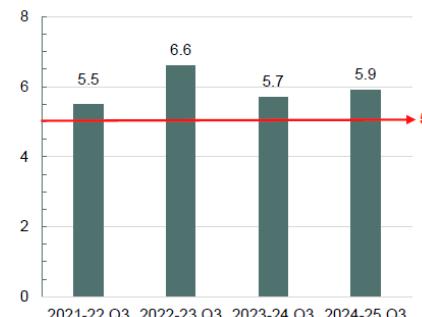
### OAG Results Summary

Data	✓	No significant data errors or incomplete data detected.
Targets	⚠	The target set of 850 people waiting for home care is based on the pre-pandemic average; it is ineffective to measure the home care expansion planned under <i>Action for Health</i> . Discussion at para. 47-51.
Consistency & Transparency	✓	This KPI is consistent with the intended <i>Action for Health</i> reporting on access to home care services.
Reporting	⚠	Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
Quality Controls	⚠	Indicator data quality controls are not written and there is no sign-off when completed. Minor data quality control errors identified during testing. Discussion at para. 87-89.

## Percentage of Hospital Admissions for People Whose Complex Needs Could Have Been Addressed with Primary Health Care

**About:** This KPI intends to show Nova Scotians' access to primary care. It aims to measure hospitalizations that could be avoided with access to effective primary care, by counting the number of hospital admissions for a specific set of chronic conditions and then calculating it as a percentage of total hospital admissions (see para. 57).

Chart Source: Office of the Auditor General, based on data from Action for Health website, Q3 only



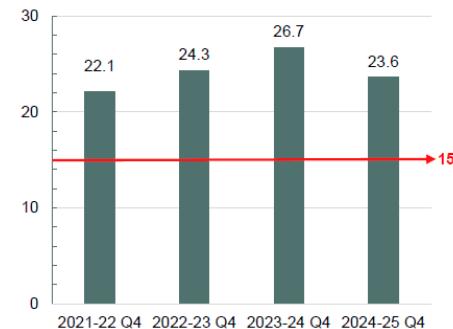
### OAG Results Summary

Data	✓	No significant data errors or incomplete data detected.
Targets	✓	A public target of 5% is reported.
Consistency & Transparency	⚠	As this KPI is calculated as a percentage of total hospital admissions, the results are not fully transparent with respect to primary care. Discussion at para. 57-61.
Reporting	⚠	Inadequate methodology and explanation, discussion at para. 77-81. For example, the public title given by the Department for this KPI may be open to misinterpretation of what is being measured. Nova Scotians should know this KPI only counts patients under age 75 and excludes any hospitalizations that ended in death. Reporting only provincial aggregated results, discussion at para. 82-86.
Quality Controls	⚠	Indicator data quality controls are not documented as a clear checklist and there is no sign-off when completed. Discussion at para. 87-89.

## Percentage of Emergency Department Visits by Patients without Access to a Primary Healthcare Provider

**About:** This KPI intends to show Nova Scotians' use of emergency departments instead of primary care. It measures certain visits to the emergency department, calculated as a percentage of total emergency visits.

Chart Source: Office of the Auditor General, based on data from Action for Health website, Q4 only



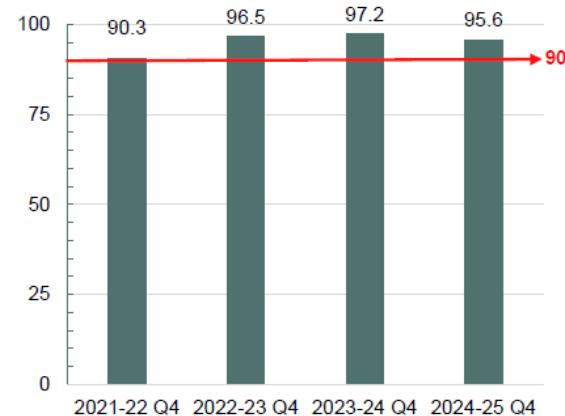
### OAG Results Summary

Data	✓	No significant data errors or incomplete data detected.
Targets	✓	A public target of 15% is reported.
Consistency & Transparency	⚠	As this KPI is calculated as a percentage of total emergency room visits, the results are not fully transparent with respect to primary care, discussion at para. 57-61. Additional issues identified that detract from transparency, discussed at para. 94-95. For example, the KPI definition includes "urgent" visits, but should not. Further, the KPI excludes people who went to emergency for minor issues who are listed as having a family doctor, but who may not have had timely access.
Reporting	⚠	Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
Quality Controls	⚠	Indicator data quality controls are not documented as a clear checklist and there is no sign-off when completed. The KPI misses up to 2% of people without a family doctor who visited emergency for a minor issue, because not all variations on 'no family doctor' used in the data are captured by the data filtering process. Discussion at para. 87-89.

## Percentage of Urgent Addictions and Mental Health First Treatment Wait Times within Benchmark

**About:** This KPI intends to show how often Nova Scotians' access to addictions and mental health treatment is within the established expected wait time. It measures the actual wait times against the set benchmark for each portion of the wait and then calculates an aggregate result.

Chart Source: *Office of the Auditor General, based on data from Action for Health webpage, Q4 only*



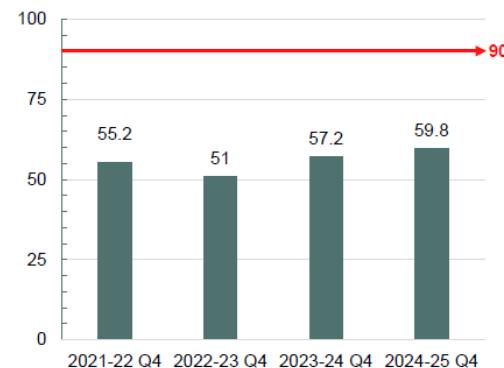
### OAG Results Summary

<b>Data</b>		No significant data errors or incomplete data detected.
<b>Targets</b>		Performance expectation is unclear; target used by management internally (100%) does not match public target (90%). Discussion at para. 52.
<b>Consistency &amp; Transparency</b>		This KPI is inconsistent with the intended <i>Action for Health</i> reporting on access to mental health and addictions treatments. The definition omits the referral and triage portion of the wait time (Wait 0) from the calculation. Discussion at para. 71-76.
<b>Reporting</b>		Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
<b>Quality Controls</b>		Indicator data quality controls are not documented as a clear checklist and there is no sign-off when completed. Discussion at para. 87-89.

## Percentage of Non-Endoscopic Surgical Services Completed or Wait Times within Benchmark

**About:** This KPI intends to show how often Nova Scotians access surgeries within the established expected wait time. It measures the actual wait times against the set benchmark.

Chart Source: *Office of the Auditor General, based on data from Action for Health website, Q4 only*



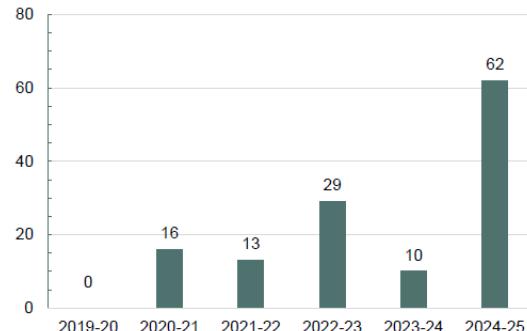
### OAG Results Summary

<b>Data</b>		No significant data errors or incomplete data detected.
<b>Targets</b>		Performance expectation is unclear; the target used by management internally (65%) does not match the public target (90%). Discussion at para. 52.
<b>Consistency &amp; Transparency</b>		This KPI is inconsistent with the intended <i>Action for Health</i> reporting on access to surgery. The definition omits the referral portion of the wait time (consultation wait) from the calculation. Discussion at para. 71-76.
<b>Reporting</b>		Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
<b>Quality Controls</b>		Indicator data quality controls are not documented as a clear checklist and there is no sign-off when completed. Discussion at para. 87-89.

## Family Physicians Annual Net Increase

**About:** This KPI intends to show the annual increase or decrease in family physicians practicing in Nova Scotia. It measures new family physicians minus the number of family physicians who stopped practicing in a fiscal year, as tracked by Nova Scotia Health.

Chart Source: Office of the Auditor General, based on data from Action for Health website



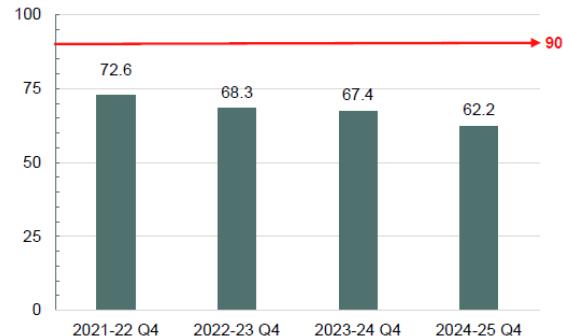
### OAG Results Summary

<b>Data</b>	⚠	Testing revealed significant errors in the data. Errors and delays in recording physician departure dates resulted in physician departures not being counted in 2023-24 and 2024-25. Discussion at para. 67-70.
<b>Targets</b>	⚠	No public target is set for this KPI. Discussion at para. 44-46.
<b>Consistency &amp; Transparency</b>	✓	This KPI definition is consistent with the intended <i>Action for Health</i> reporting.
<b>Reporting</b>	⚠	Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregate results, discussion at para. 82-86.
<b>Quality Controls</b>	⚠	Indicator data quality controls are not written and there is no sign-off when completed. Discussion at para. 87-89.

## Emergency Department Wait Times within Benchmark

**About:** This KPI intends to show how often Nova Scotians access emergency department treatment within the expected wait time set by the Canadian Association of Emergency Physicians. It measures the actual wait times against the set benchmark of three hours.

Chart Source: Office of the Auditor General, based on data from Action for Health website, Q4 only



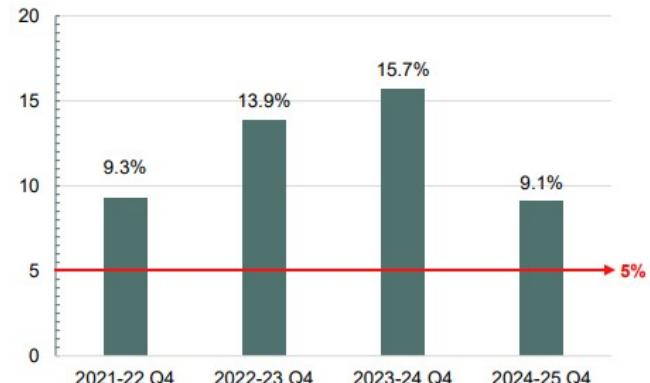
### OAG Results Summary

<b>Data</b>	⚠	Testing revealed significant incomplete data by facility, 8%-65% of wait time data needed to calculate the KPI were not recorded. Visits to the emergency department without the relevant wait time data are excluded from the reported results. Discussion at para. 62-66.
<b>Targets</b>	⚠	Performance expectation is unclear; the target used by management internally (70%) does not match the public target (90%). Discussion at para. 52.
<b>Consistency &amp; Transparency</b>	✓	This KPI definition is consistent with the intended <i>Action for Health</i> reporting.
<b>Reporting</b>	⚠	Inadequate methodology and explanation, discussion at para. 77-81. For example, complete methodology would advise these reported results include only level 1 and level 2 emergency departments. Level 3 emergency departments and urgent treatment centres are not included. Reporting only provincial aggregated results, discussion at para. 82-86.
<b>Quality Controls</b>	⚠	Indicator data quality controls are not documented as a clear checklist and there is no sign-off when completed. Discussion at para. 87-89.

### Percentage of Nova Scotians Seeking a Primary Care Provider (as tracked by the Need a Family Practice Registry)

**About:** This KPI intends to show Nova Scotians' access to primary care by counting the individuals who self-register for help finding a family doctor as tracked in the Need a Family Practice Registry. The number is counted within the Registry and then the KPI is calculated as a percentage of Nova Scotia's population.

Chart Source: Office of the Auditor General of Nova Scotia,  
 based on *Action for Health* website, Q4 only



### OAG Results Summary

Data	✓	No significant data errors or incomplete data detected.
Targets	⚠	Performance expectation is unclear; target used by management internally ranged from 9.5%-10%, and does not match the public target (5%). Discussion at para. 52.
Consistency & Transparency	⚠	Changes made in 2024 removed some unattached individuals from the KPI count, affecting the reported results from Q3 2024 onward. As of March 31, 2025, the number of affected records was 36,753 (approximately 3% of Nova Scotia's population). Had they been included, the Q4 2024-25 result would be 12.6% rather than the reported 9.1%. Discussion at para. 17-36.
Reporting	⚠	Inadequate methodology and explanation, discussion at para. 77-81. Reporting only provincial aggregated results, discussion at para. 82-86.
Quality Controls	⚠	Indicator data quality controls are not documented as a clear checklist and there is no sign-off when completed. Minor data quality control errors identified during testing. Discussion at para. 20; 87-89.

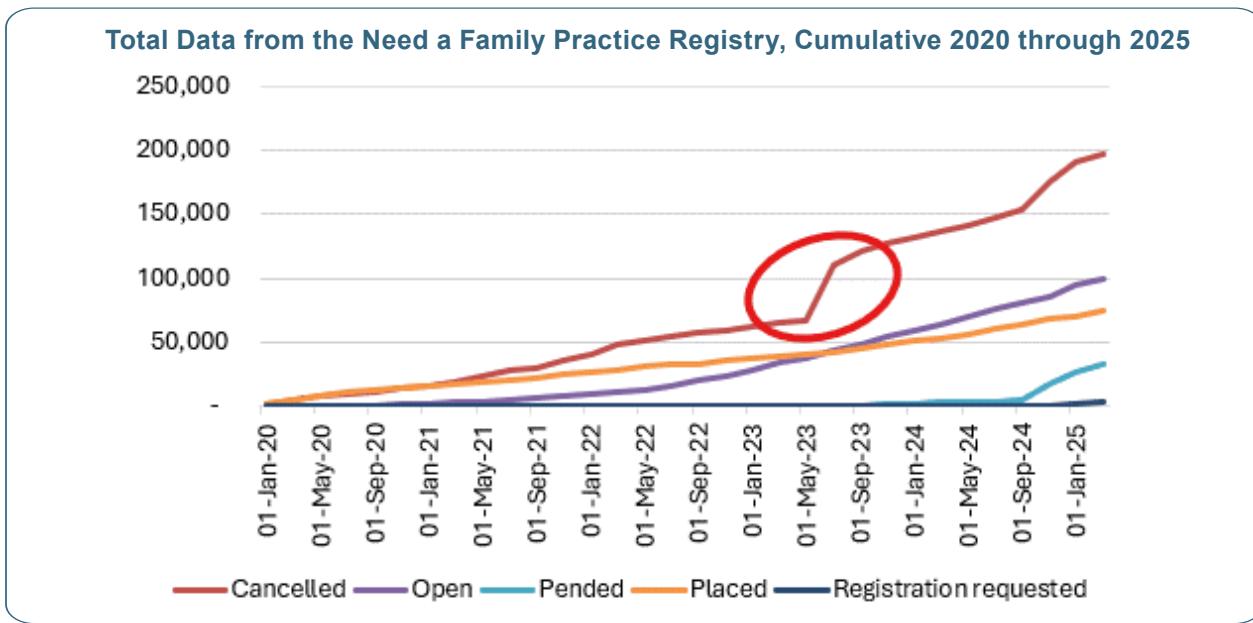
### »» The Reporting of the Percentage of Nova Scotians Seeking a Primary Care Provider KPI is Not Fully Transparent Following 2024 Changes to the Need a Family Practice Registry

#### Need a Family Practice Registry established to connect Nova Scotians to primary care providers

17. The Need a Family Practice Registry is a database of self-registered people looking for a primary care provider. NSH uses the registry to connect registered individuals with a primary care provider who is accepting new patients. Nova Scotians have been encouraged to join the registry if they are looking for a primary care provider, resulting in several hundred thousand Nova Scotians signing up. Nova Scotia news media reports regularly on the registry.
18. The registry is also the source of data behind the KPI *Percentage of Nova Scotians Seeking a Primary Care Provider*, reported quarterly on the *Action for Health* website. Changes to primary health care delivery now mean that an attachment to a primary care provider from the registry can be to a nurse practitioner, a primary care clinic, or to a family physician.

## High number of cancellations reflect validation work being done

19. Individual Nova Scotians supply their own information when they register. The system does not limit the number of registrations an individual can open and the system accepts invalid and duplicate health card numbers. These issues can result in duplications in the system and difficulties differentiating individuals. Registrants' situations may also change during the time spent waiting, including individuals finding a primary care provider on their own, moving to a new community or out of province, or passing away.
20. We observed work done to validate the data in the registry during our examination. A few errors among cancelled records were detected that, once discovered, resulted in records being reinstated. Overall, our sample testing showed that validation work appropriately resulted in the cancellation of records within the registry.
21. NSH told us they hired students to perform intensive validation work during 2023 and 2024. The impact is visible in the cumulative data graph below, where the red line shows the number of cancelled records at points in time. We can see increased rates of cancellations corresponding to steeper slopes beginning in May 2023.



Source: The Office of the Auditor General, based on data supplied by NSH

22. The intensive validation work since 2023 significantly impacted the size of the registry by removing over 100,000 individual records that were previously counted as seeking a primary care provider. Those reductions should not be interpreted as the placement of individuals with primary care providers.

## Placement activity steady during *Action for Health* period

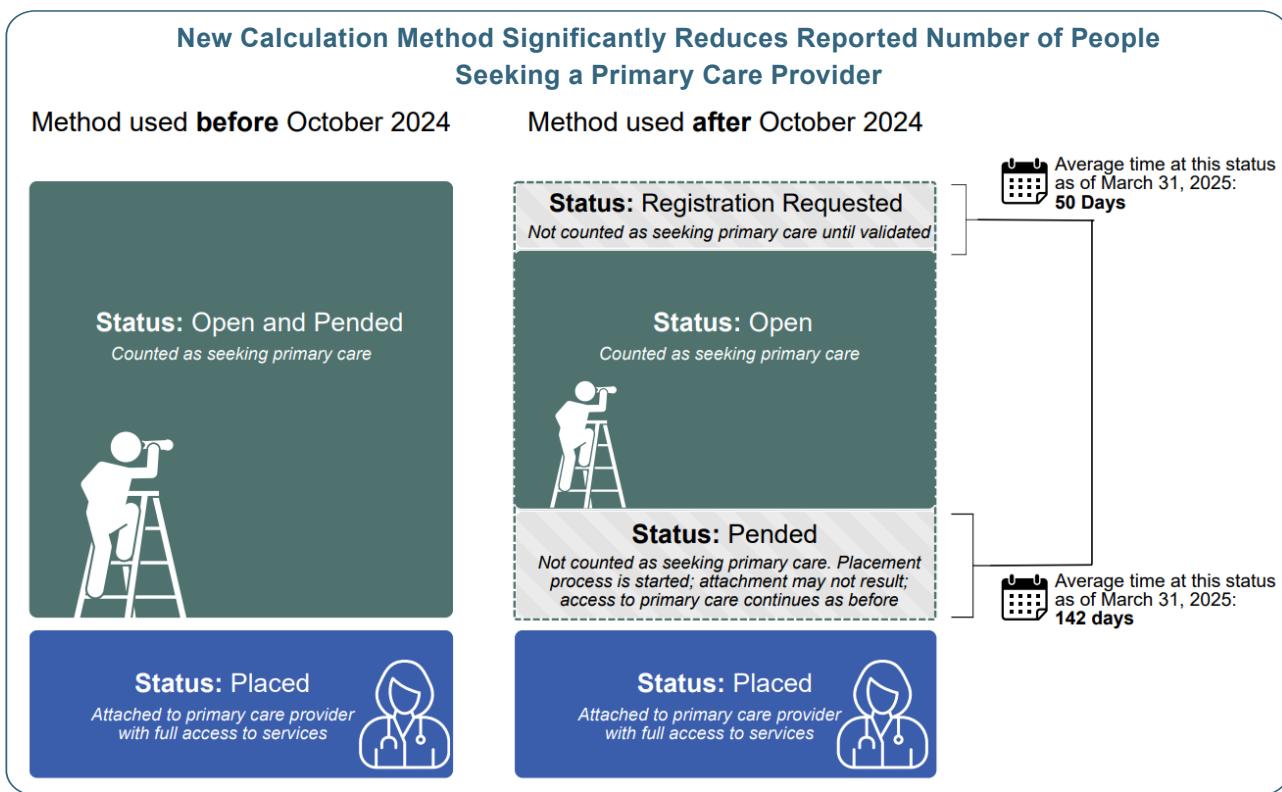
23. In the cumulative data chart, the orange line shows a steady rate of placing individuals with primary care providers over time. The audit did not assess the effectiveness of facilitating access to primary care, but our testing confirmed that a sample of individuals listed in the registry as 'Placed' with a primary care provider was verified using billing records.

## Significant changes to Need a Family Practice Registry in October 2024

24. The KPI is prepared by counting the number of individuals in the registry who are seeking a primary care provider and then calculating the number as a percentage of Nova Scotia's population.

25. Individuals seeking a primary care provider are categorized in the registry by their status. Prior to October 2024, as soon as a person registered, they were given a status of *Open*. The individual's status stayed *Open* until they were *Pended*, *Placed*, or *Cancelled*. A status of *Pended* was given when a placement was in progress but not completed. A status of *Placed* was given when an individual was attached to a primary care provider.

26. Prior to October 2024, the KPI count included all those with an *Open* and *Pended* status (see left column in graphic below). After October 2024, the count includes only those with an *Open* status (see right column in graphic below).



Source: Office of the Auditor General of Nova Scotia

### Introducing *Registration Requested* status reduces the number counted for the KPI

27. Beginning in October 2024, a new status of *Registration Requested* was created and automatically assigned when an individual registers. The status is changed to *Open* by staff after completing validation of the following: verifying contact information is complete; ensuring health questionnaires identifying health care needs are filled out; and verifying health card numbers. Beginning in October 2024, the system also automatically changes an individual's *Open* status to *Registration Requested* if the individual goes on the website to update some types of information, such as their contact information or their health questionnaire. Individuals with a *Registration Requested* status remain at that status until it is manually changed to *Open* by NSH staff.

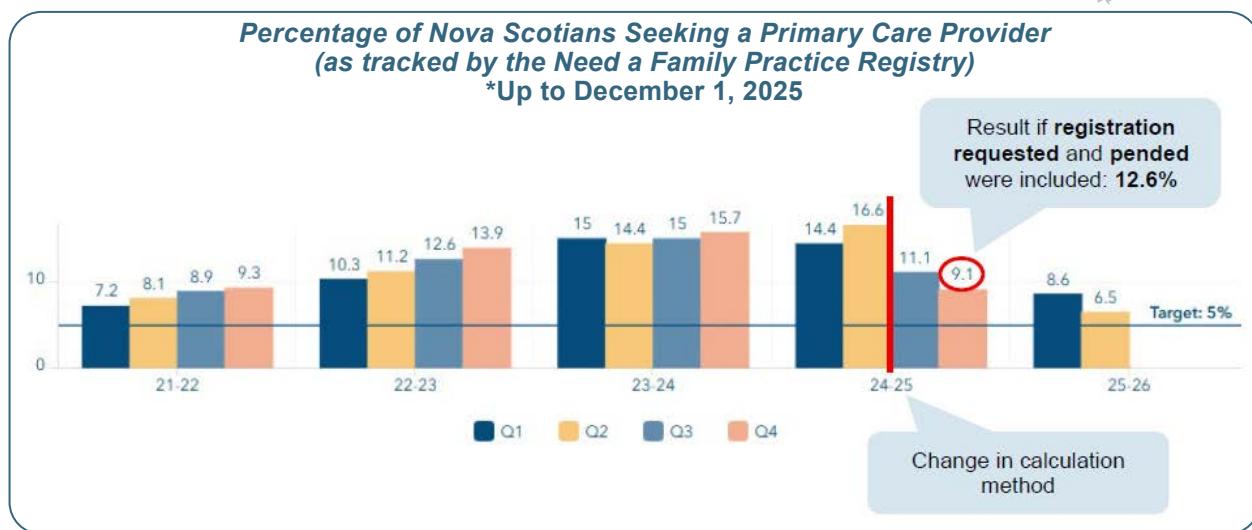
28. Our analysis showed that as of March 31, 2025, there were 3,789 individuals with a status of *Registration Requested* with an average duration of 50 days. NSH told us this new status supports validation work, acknowledging there is a wait which they continue to focus on improving.
29. Although the introduction of the *Registration Requested* status assists with validation work to manage the Need a Family Practice Registry, it removes individuals from the count of Nova Scotians seeking a primary care provider for the KPI. Prior to October 2024, those individuals would have been counted because they would have been assigned an *Open* status at the time of the KPI counting.

### **Changing treatment of *Pended* status reduces the number counted for the KPI**

30. The other significant October 2024 change was no longer counting individuals with a *Pended* status for the KPI. As described above, *Pended* status is used within the registry to indicate placement with a primary care provider is in progress, but not yet complete. While our assessment did not test the accuracy of *Pended* status, it did show as of March 31, 2025, there were 32,964 individuals with a status of *Pended* with an average duration of 142 days.
31. The written definition of the KPI says it counts Nova Scotians on the Need a Family Practice Registry who are not attached to a primary care provider.
32. Individuals are given a *Pended* status in the registry at the beginning of their attachment process indicating it is in progress, but not yet complete. However, an individual with a *Pended* status is not yet attached to the proposed primary care provider. At that point in the process, the individual's access to primary care continues as before, until the attachment is complete. The new method of counting for the KPI removes pended individuals from the count. The individual's status in the registry will be changed to *Placed* once the process is completed and the patient is successfully attached to a primary care provider from whom they can receive primary care.
33. According to NSH, the rationale provided for the change is its increased confidence that the placement process will be successfully completed, because the province's new agreement with doctors in 2023 means doctors accept patients more often. The Department's view is individuals with a *Pended* status no longer need support finding a primary care provider and therefore are not counted.
34. In our view, excluding the reporting of individuals with a *Pended* status prevents Nova Scotians from understanding the complete picture of individuals not yet attached to a primary care provider.

### **Reduced counts impact the *Percentage of Nova Scotians Seeking a Primary Care Provider***

35. As of March 31, 2025, *Registration Requested* and *Pended* status accounted for 36,753 registered individuals. Using the KPI's calculation, this represents 3.47% of Nova Scotia's population. Had these individuals been included in Q4 2024-25, the reported result would have been 12.6% rather than the reported 9.1%.



Source: Office of the Auditor General of Nova Scotia, based on *Action for Health* website; OAG recalculation based on most recently available KPI population data

### Reporting of Percentage of Nova Scotians Seeking a Primary Care Provider on *Action for Health* website is open to misinterpretation

36. The reported explanation for this KPI does not outline the October 2024 changes, nor their impact on the KPI results. Without identifying the significant changes to the KPI, the reported results on the *Action for Health* website are open to misinterpretation.

#### Recommendation 1

We recommend, to ensure full transparency, the Department of Health and Wellness:

- provide an explanation for the October 2024 changes in the methodology used to calculate the *Percentage of Nova Scotians Seeking a Primary Care Provider*; and,
- report as companion information, the number of individuals in the Need a Family Practice Registry comprising each status within the reported period (Cancelled, Registration Requested, Open, Pended, Placed).

#### Department of Health and Wellness Response

Action for Health continues to report the number of Nova Scotians that are still unattached.

The process of using “status categories” within the Need a Family Practice Registry changed in October 2024. Status categories are now largely administrative designations to support navigating Nova Scotians to primary health care services based on their needs. The new registration and categorization process has improved the validation and identification of those being actively supported in the placement process.

The reporting process on the *Action for Health* website has not been updated to reflect the changes in information collection and measurement and DHW agrees to publish additional information to explain how this KPI is calculated and any changes in methodology.

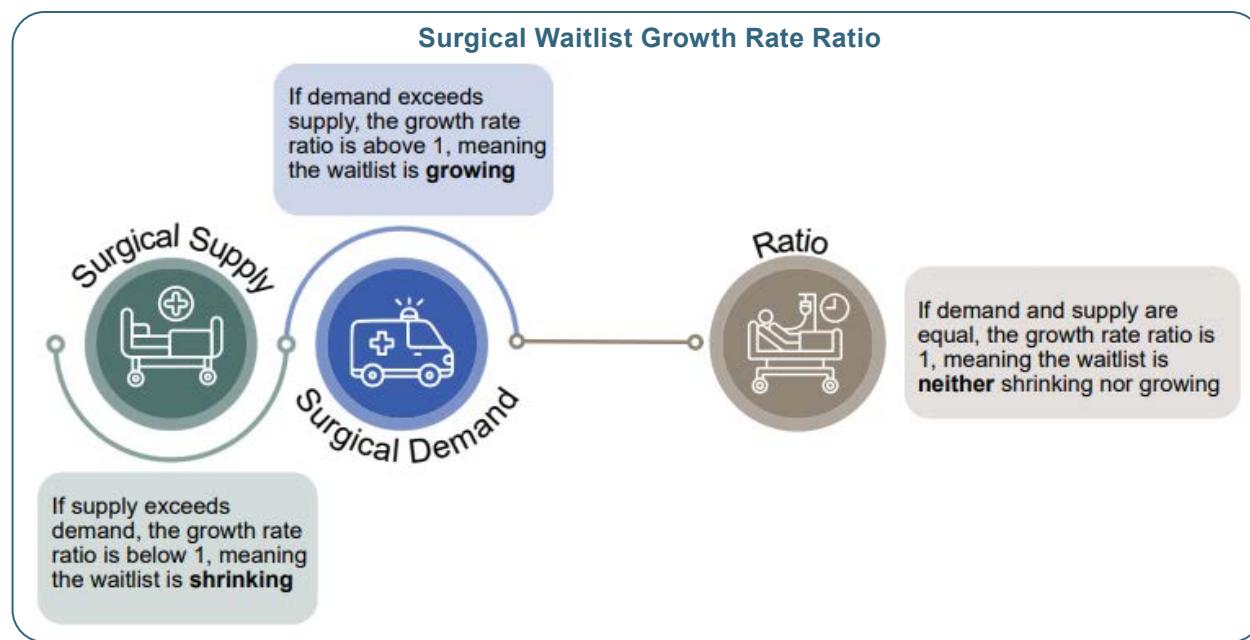
## »» Ten KPIs Intended to Measure *Action for Health* have No Target or an Ineffective Target

### \$241 million dedicated to improve surgical access between 2022-2026

37. *Action for Health* sets out \$241 million dedicated to surgical access spending between 2022-2026, making it the largest expenditure under *Action for Health*. *Action for Health* sets goals of expanding surgical capacity to reduce surgical waitlists.

### Operating room capacity affects surgery wait times

38. Operating room capacity can affect surgery wait times. For example, assuming demand for surgery remains stable, if operating room capacity increases and more surgeries are performed, it should result in people waiting a shorter time for surgery and a corresponding reduction to the waitlist. *Action for Health* sets out plans to reduce surgical waitlists and expand operating room capacity under its action area titled "Implement Innovative Solutions to Reduce Surgical Wait Times, provide safe, quality care, and achieve benchmarks." The Department reports the *Surgical Waitlist Growth Rate Ratio* as an indicator of surgical capacity.



Source: Office of the Auditor General of Nova Scotia

### *Action for Health* objective is to expand operating room capacity to reduce waitlists

39. One action item under *Action for Health* is focused on dedicating resources to expand operating room hours and capacity. Another action item plans to reduce waitlists by completing 2,500 additional surgeries in the first twelve months of *Action for Health*. The goal to expand operating room capacity to reduce surgical waitlists requires the capacity to exceed demand enough to make a difference, and sufficient to overcome any other increases in demand (such as from population increase).

### **Surgical Waitlist Growth Rate Ratio target not effective for *Action for Health* accountability**

40. The target set for this KPI is a range of "1 or less than 1." The internal management information we examined says the objective of this set target is to *prevent* the surgical waitlist from growing, not to *reduce* the surgical waitlist. With a target of 1:1, the supply and demand for surgical services are equal. There is no excess capacity and therefore reaching that target of 1, or almost 1, is not likely to result in reduced wait times.
41. The target reported to the public on the *Action for Health* website is at the upper end of the range, reported as a target of "<1." The reported results seem to be at or just below 1, indicating that supply is equal to or slightly above demand. The reporting indicates the target is already being met.
42. However, *Action for Health* sets clear goals of increasing surgical capacity to reduce surgical wait times. The set target ratio of <1, is vague with respect to the extra surgical capacity needed to achieve the goal of reducing surgical waits. Therefore, the set target is not effective for evaluating if *Action for Health* is delivering on its plans to expand surgical capacity enough to reduce surgical waits.

### **Health workforce strategy a major component of *Action for Health*, investing \$196 million between 2022-2026**

43. *Action for Health* outlines the objective for Nova Scotia to become a magnet for health providers, setting out actions aimed at both the recruitment and retention of health care professionals. Expenditures under the Health Workforce Strategy between 2022-2026 are \$196 million, making it the third largest component of the strategic plan. Developing a health workforce strategy was a major component of this work, listed as complete on the *Action for Health* website since Winter 2025.

### **No targets set to measure recruitment and retention of healthcare professionals**

44. The KPIs reporting on workforce recruitment and retention activities are those counting the numbers of healthcare professionals who join and leave the workforce. Seven KPIs track the coming and going of healthcare professionals in Nova Scotia:
  - » Family Physicians: new inflow; and, annual net increase,
  - » Nurse Practitioners: new inflow; and, annual net increase,
  - » Registered Nurses: new inflow; and, annual net increase,
  - » Total registered Continuing Care Assistants.
45. All of these KPIs are directly impacted by efforts to recruit new healthcare professionals to the province and by efforts to retain existing healthcare professionals. Although we did not audit all seven of these KPIs, the *Action for Health* website lists their targets as "under development." As a result, the targeted objective of recruitment and retention efforts is not reported and therefore it is difficult to assess progress.

### **The Department says health transformation makes it difficult to set targets**

46. The Department told us there have been discussions on establishing targets for the physician, nurse, and continuing care assistant KPIs, but that it is difficult to establish a specific target for numbers of health professionals to be added or retained with all the changes underway. Their aim is "growth" with KPIs measuring recruitment and retention of healthcare professionals.

## **Expansions of long-term care and home care planned under *Action for Health***

47. Homecare services provide patients with the option to return home from hospital sooner and/or maintain independent living in the community with a range of supports. Long-term care facilities provide ongoing personal care and nursing care for patients to the level that is needed.
48. *Action for Health* sets out plans related to access to long-term care and home care services, outlining how access will be expanded with investments in people, technology and infrastructure. Planned long-term care expansion includes renovating and building more than 2,500 single-bed rooms over three years and seeking federal government funding for an additional 1,000 new private rooms for a total of 3,500 new single-bed rooms, as well as increasing staffing levels at long-term care homes. Planned home care expansion activities include refocusing efforts on Home First strategies to help more patients return home with increased levels of support rather than wait in hospital for admission to long-term care.

## **Results show long-term care admissions and home care waitlist targets met**

49. According to the June 2025 update on the *Action for Health* website, the indicator for long-term care and for home care both report positive results that are better than target. *Admissions to Long-term Care* did better than the target, with almost 100 more individuals placed in long-term care facilities than targeted. *Volume of the Home Care Waitlist* did better than the target, with about 100 fewer people waiting for home care services than targeted.

## **Targets based on pre-pandemic levels of service not aligned with *Action for Health* goals**

50. The Department of Seniors and Long-term Care told us that the targets for *Admissions to Long-term Care* and *Volume of the Home Care Waitlist* were set based on pre-pandemic average performance. The *Action for Health* objective in both of these areas is to substantially expand services. Based on the strategic plan's goals, we would expect the target to be aligned with the planned expansions supporting increased admissions to long-term care and fewer people waiting for home care services. In both cases, it may be possible to achieve pre-pandemic levels of performance without expanding services.
51. To demonstrate, we can refer to the findings in our audit of Planning and Acquiring Nursing Home Beds released in September 2025 revealing that increases in long-term care beds as of April 2025 were modest (408) in relation to the *Action for Health* targeted bed expansion and the target dates are still in the future (2027 and 2032). The expansion of long-term care planned under *Action for Health* has not yet materialized, but the reported results show performance that was better than target. If results can be met without realizing the planned investments, it is an indication of a target set too low to effectively hold government accountable for the planned investments.

## **Public targets different than internal targets used by management**

52. Our audit uncovered instances where the KPI target reported publicly on the *Action for Health* website differed from the targets for the same KPI and time frame being used internally by management. Reporting a different target publicly than the one used by management results in inconsistent objectives, where management is working toward a different goal than that reported to the public. As a result, the intended goals are not clear and it is difficult to assess if goals are being achieved. Full transparency as to government's plans and goals is not achieved when different targets are communicated to the public.

### Target Reported to the Public versus Internal Target Used by Management

Title	Public Target	Management's Internal Target
<i>Percentage of Non-Endoscopic Surgical Services Completed or Wait Times Completed within Benchmark</i>	90%	65%
<i>Emergency Department Wait Times within Benchmark</i>	90%	70%
<i>Percentage of Nova Scotians Seeking a Primary Care Provider (as tracked by the Need a Family Practice Registry)</i>	5%	10%
<i>Percentage of Urgent Addictions and Mental Health First Treatment Wait Times within Benchmark</i>	90%	100%

Source: Office of the Auditor General of Nova Scotia

#### Recommendation 2

We recommend the Department of Health and Wellness set clear targets aligned to the planned investments and objectives of *Action for Health* for all reported KPIs and inform the public of those targets.

#### Department of Health and Wellness Response

Where available, Action for Health reporting has included targets using accepted national benchmarks (e.g. wait time standards) and/or to reflect the specific requirements of the Nova Scotia health system (e.g. number of family physicians per capita). In some situations, there are no national or provincial targets that can be used as a benchmark – for example Nova Scotia is one of the few provinces to have a registry for individuals seeking primary care or to publish unattached population numbers making benchmarking/target setting more complicated.

DHW and its system partners have also established internal targets to support incremental achievement of performance, allowing for operational teams to focus on stepwise improvement targets. For example, the Action for Health target of 5% for the Need a Family Practice Registry was publicly shared as part of the Action for Health Plan. Internally, NSH set a 9.5% target provincially by the end of December 2024, and 5% provincially by the end of January 2026. DHW agrees to continue to formalize and publish evidence-based targets and communicate those to the public. Where targets cannot be set, DHW will provide an explanation.

#### » Three KPIs Found to Have Significant Inconsistency Between What is Measured and What the KPI is Intended to Report On

##### Inclusion of locum physicians artificially boosts family physicians per 100,000 results

53. Our examination of the KPI *Family Physicians per 100,000 Nova Scotians* revealed that the source of data used to calculate this KPI is family physicians billing for services through Medavie Blue Cross, the major administrator of government-sponsored health programs in Nova Scotia. The performance target set for this KPI is based on the typical number of patients an ongoing family physician can serve, called a full panel of patients. It estimates how many ongoing family physicians serving a full panel of patients are needed to serve the whole Nova Scotia population.

54. Our testing showed that there is a significant difference in the total number of physicians contained in the Medavie Blue Cross billing data and those being tracked as ongoing family physicians by NSH in its Physician Tracker. In our examination, the Medavie Blue Cross billing data included an additional 533 physicians that were not tracked by NSH as family physicians. Our audit revealed the general practitioners billing through Medavie Blue Cross includes more than the ongoing family physicians; it also includes emergency department physicians, hospitalist physicians, and short-term or locum physicians who may not be individually tracked by NSH.
55. For example, locum physicians are often used to temporarily replace family physicians who are on a leave of absence or vacation. Including locum physicians in a KPI intended to report on the number of practicing family physicians in Nova Scotia, at the same time as including the original physician being replaced, is double counting. This would occur any time a physician and their out-of-province replacement submit billings in the same year, such as when a leave of absence or vacation is for less than a year.
56. Medavie Blue Cross told us they could only identify locum physicians in the data if they are set up under the locum program they administer. Based on this, our examination identified 218 confirmed locum physicians included within the 2023-24 KPI data. Our calculation then showed that excluding the confirmed locum physicians from the KPI would reduce the results from 121 to 101 family physicians per 100,000 Nova Scotians for that year.

### **Recommendation 3**

We recommend the Department of Health and Wellness review the source of data for the *Family Physicians per 100,000* KPI and implement controls to align the data with the KPI's objective of reporting on family physicians responsible for a full panel of patients in the province.

### **Department of Health and Wellness Response**

It is acknowledged that the source data for family physicians includes other primary care providers who may not have a full panel of patients; however, varying definitions of 'Family Physician' are valid for different purposes. In this reporting, locum physicians are considered to provide similar services to family doctors and are an important resource available to Nova Scotians. There are examples where, due to the duration of their locum practice, removing them from the count of family physicians would also result in inaccurate reporting of resources available to Nova Scotians.

DHW agrees to review the source data and update the methodology behind this indicator to best capture the number of family physicians available in the province and provide clear descriptions of the data and the KPI's objective.

### **Action for Health primary care expenditures \$211 million between 2022-2026**

57. Primary healthcare services and actions to reduce the number of Nova Scotians looking for a family doctor are a high priority focus of *Action for Health*. At \$211 million from 2022-2026, primary care is the second largest *Action for Health* expenditure category.

## Definition issue affecting two primary care KPIs

### **Percentage of Hospital Admissions for People whose Complex Needs Could Have Been Addressed with Primary Care**

Counts the number of hospital admissions for a specific set of chronic conditions, calculated as a per cent of total hospital admissions.

Chronic conditions tracked include: diabetes, angina, and epilepsy; also known as Ambulatory Care Sensitive Conditions, as per the Canadian Institute of Health Information (CIHI).



### **Percentage of Emergency Department Visits by Patients without Access to a Primary Care Provider**

Counts emergency department visits by patients listed as not having a family doctor in the records system, calculated as a per cent of total emergency department visits.



Source: Office of the Auditor General of Nova Scotia

58. In the case of both KPIs, primary care performance is being measured indirectly based on specific kinds of patients' use of hospitals and emergency rooms. The results are presented as a percentage of total hospitalizations and total emergency room visits. Results reported in this way tell us about the amount of hospital and emergency department resources taken up by the identified patient type, but they do not directly tell Nova Scotians about the availability of primary care or about patients' ability to access it. Due to this construction of the KPIs, the results could be misinterpreted.

## Difficult to determine if changes in the results show improvement or deterioration in primary care

59. It is difficult to separate the source and the nature of changes in the results for these KPIs because the percentage is of a total that is not directly related to primary care. For example, changes to the total emergency department visits and the total hospitalizations could produce changes to the overall reported results that are unrelated to changes in primary care access. As a result, it is difficult to determine if fluctuations in the results reflect an improvement or a deterioration in primary care services, the KPI's intended measure.

## CIHI reports a similar KPI, calculated per 100,000 population

60. CIHI reports a measure of hospitalizations for tracked chronic conditions similar to Nova Scotia's, but the calculation is the number of hospitalizations per 100,000 population. CIHI's method reports the actual number of occurrences calculated using a stable reference point (per 100,000 population) that isolates changes in what is reported. This is a more direct method that can support conclusions about changes in access to primary care for the cohort being measured. With a stable reference point, users can easily compare and interpret results over time and across different regions, urban versus rural for example, all in a way that is consistent and meaningful.

61. For these reasons, in our view, the current construction of the performance indicators is not effective to clearly and transparently report on access to primary care or on primary care initiatives under the *Action for Health* strategic plan.

#### **Recommendation 4**

We recommend the Department of Health and Wellness expand its KPI reporting to include population-adjusted indicators that provide important context for primary care use and allow further comparisons over time and across regions.

#### **Department of Health and Wellness Response**

DHW believes that the current system-level indicators are appropriate and important for monitoring health transformation. These measures were deliberately selected to track how primary care investment is redirecting avoidable demand away from hospital settings.

In addition to the currently used indicators, DHW agrees to further expand reporting on primary care access to include population based/adjusted indicators.

### **»» Two KPIs Found to Have Significant Data Errors or Incomplete Data**

62. The accuracy of a KPI depends on the quality and reliability of the data used to calculate it. Significant data errors were identified within two KPIs. In each case the source and cause of the issue is different, but the impact is significant enough to impact the accuracy of the reported results. Here, we are highlighting KPIs where the definition of the KPI is sound, but problems in the underlying data make the reported results inaccurate.

#### ***Emergency Department Wait Times within Benchmark* data is incomplete**

63. In our assessment of the KPI for *Emergency Department Wait Times within Benchmark*, we detected significant incomplete data, with a wide variation from site to site. The reasons for incomplete data include providers failing to log the time the patient was seen; records on paper charts not completely transferred to the electronic record used for the KPI; and patients who registered but left the department before they were seen.

64. Within the emergency department data we examined (Q3 2024-25) the average volume of incomplete data across all sites was almost 20%, but some sites were missing significantly more. For example, Yarmouth Regional Hospital had 65% and Cape Breton Regional Hospital had 37% incomplete data that could not be used. In both cases, these emergency departments rely on paper records to log the time the patient was seen, which is later transcribed to the electronic records used to calculate the KPI. Transcription to the electronic system may not always be complete or may be delayed. Other causes of incomplete emergency department data may not be fully known. NSH is aware of the problem.

#### **Recommendation 5**

We recommend the Department of Health and Wellness work with NSH to identify and correct the causes of incomplete emergency department data.

#### **Department of Health and Wellness Response**

DHW and NSH have included a number of emergency department and emergency care metrics on the Action for Health website. These include emergency department availability and closure data, emergency visits, emergency patient triage levels, emergency department wait times and ambulance offloads and offload times.

DHW and NSH are continuously working to improve data collection, and will explore potential data workflow improvements, which will be further enabled by the implementation of One Person One Record (OPOR).

DHW agrees to work with NSH and IWK to address data gaps identified at the site level.

## **Patients who leave the emergency department without being seen are not reported**

65. Some of the incomplete data described above is due to patients who registered but left the emergency department before they were seen. Those emergency visit records are removed from the data because the duration of their wait time is not known. In that circumstance, the patient did not see a provider and therefore the “time to provider” measure used in the KPI cannot be calculated. According to CIHI, patients who leave the emergency room without being seen are more likely to have lower urgency and more likely to have a condition that could be managed in primary care. However, reporting on this constituency of emergency room patients is an important component of assessing emergency department efficiency, representing an important qualifier for emergency department wait times data. Our examination of samples of emergency department records identified 12% and 15% of visits were patients who left without being seen.

66. Rates of people who go to the emergency department but leave before they are seen are tracked and reported internally for use by management, adding important context to the *Emergency Department Wait Times within Benchmark* KPI. The rates of people leaving the emergency department without being seen should be reported alongside the emergency department wait times. Beginning in 2021, this information was reported in the Annual Accountability Report on Emergency Departments, reported under the *Emergency Department Accountability Act*, until it was repealed in February 2025. The *Action for Health* progress updates website does not report on people who left the emergency department without being seen.

### **Recommendation 6**

We recommend the Department of Health and Wellness report on patients who leave the emergency department without being seen as a companion KPI to the *Emergency Department Wait Times within Benchmark* KPI.

### **Department of Health and Wellness Response**

Left Without Being Seen (LWBS) encounters are documented and monitored internally, however, there are inconsistencies and complications that preclude this from being an ideal Action for Health indicator.

For example, Nova Scotia’s LWBS data includes some patients whose care was initiated and/or completed in the emergency department or virtually. Our current clinical information systems cannot integrate with virtual care options and do not capture the time to care.

Further, in rural emergency departments, LWBS rates include those who arrive at a closed emergency department, receive a triage assessment and are redirected to the most appropriate place for care, or are not appropriate (or decline an offer) for Virtual Urgent Care. Limitations such as these are planned to be addressed through OPOR implementation.

As a result of these limitations DHW reserves the right to refrain from posting LWBS data as part of its Action for Health reporting until such time as data collection and systems integration allows for accurate public reporting.

## **Family Physicians Annual Net Increase data errors detected, resulting in some departing physicians not reported in physician count**

67. Nova Scotia Health (NSH) uses a Recruitment Tracker and a Physician Tracker to calculate *Family Physicians Annual Net Increase*. Both are managed by NSH as spreadsheets using manual data entry processes. The Recruitment Tracker is maintained by recruiters who track offers made to family physicians to start practicing in Nova Scotia. The Physician Tracker is maintained using information from a committee that tracks physician departures.

68. NSH told us these trackers were not designed to be used as source data for KPIs, but that each is the best source of information for the purpose of supplying the 'start date' to count new physician arrivals and the 'end date' to count physician departures. Our examination found significant errors in departure dates recorded in the Physician Tracker related to the physician departures in 2023-24 and 2024-25.
69. We found that four family physician departures were in 2023-24, but they were not factored into the KPI because entry of information in the Physician Tracker was delayed. NSH told us sometimes there is delay in receiving confirmation of physician departures from the committee tasked with tracking physician resources, because sometimes the physician does not notify of their departure. Had these physicians been counted in the year of their departure, 2023-24, the result for that year would be six net new family physicians, rather than the 10 reported on the *Action for Health* website. The departures are not reported in the following year because that is not the year of departure.
70. We found another four family physicians who left in 2024-25, but they were also not factored into the KPI because their departure dates were entered in the tracker incorrectly. Three were entered in the Physician Tracker with a departure date of October 1, 2023 and one with a departure date of September 14, 2023. The entries were too late for the 2023-24 calculation, so they were not included in that year, but due to the errors in the departure dates, they were not included in 2024-25 either. Had these departures been counted in 2024-25, the actual year of departure, the result for that year would be 58 net new family physicians, rather than 62.

#### **Recommendation 7**

We recommend the Department of Health and Wellness work with NSH to identify and correct errors in physician departure data and correct all the results for the KPI on the *Action for Health* website.

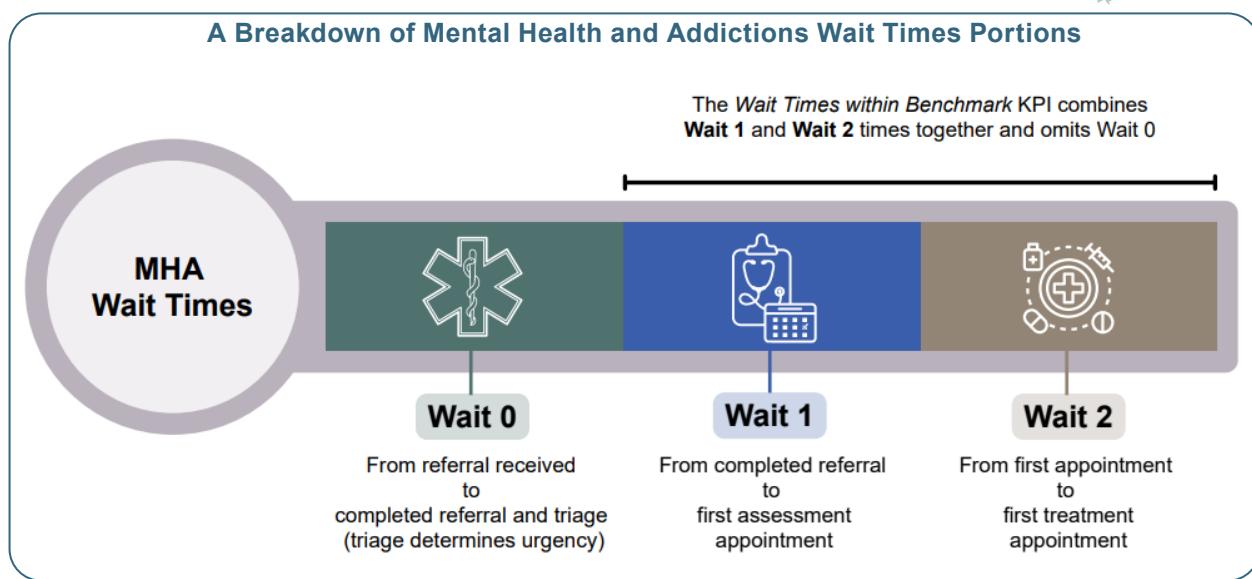
#### **Department of Health and Wellness Response**

As noted in the report there are a small number of instances of departure data not being accurately recorded within the administrative systems used to populate this performance metric. DHW agrees to work with NSH and other partners to ensure any errors in the physician departure data are updated in the results on the Action for Health website.

### **»» Two KPIs Measuring Patient Wait Times within Benchmark Exclude a Significant Portion of the Wait**

#### ***Mental Health and Addictions Wait Times within Benchmark KPI is tracked by portions of the total wait time***

71. The waiting period for mental health and addictions appointments is broken down into functional portions called Wait 0, Wait 1, and Wait 2. Each portion corresponds to a stage in the process used to service the need for mental health and addictions treatments with a corresponding benchmark for the wait time.



Source: Office of the Auditor General of Nova Scotia

72. The Wait 0 component of the calculation corresponds to the period immediately following the referral. It is during this portion of the wait that the patient's referral is received and a triage assessment is made. Wait 1 is from the time the triage is completed to the first appointment with a mental health professional (introduction and assessment) and Wait 2 is from the time of the first appointment with a mental health professional to the first treatment appointment with a mental health professional. Sometimes the first appointment and the first treatment appointment happen on the same day.

#### **Mental health and addictions KPI hides variation in performance across the wait portions**

73. The *Mental Health and Addictions Wait Times within Benchmark* KPI is calculated by aggregating the percentage of waits that were within benchmark for Wait 1 and Wait 2 and excluding the results for Wait 0. Because of this method of calculation, the reported results hide the variation in performance at each stage of the process. As we can see in the table below comparing the breakdown of wait portion results, there is significant variation in the results for each of the different wait portions (and health zones) which are not evident in the provincially reported results. The performance details for each of the wait portions indicate different kinds of issues or causes of long waits that may require different responses to address, and should be reported to Nova Scotians.

#### **Mental Health and Addictions Appointments Wait Times within Benchmark Breakdown of NSH Results by Process and Health Zone - Q2 2024-25**

	Urgent Priority	Regular Priority
<b>Wait 0 - Referral and Triage Portion</b>		
NSH Central Zone	89%	21%
NSH Eastern Zone	73%	54%
NSH Western Zone	76%	46%
NSH Northern Zone	100%	45%

		Urgent Priority	Regular Priority
<b>Wait 1 - Completed Triage to Provider First Assessment Appointment</b>			
NSH Central Zone		98%	37%
NSH Eastern Zone		97%	21%
NSH Western Zone		88%	75%
NSH Northern Zone		100%	87%
<b>Wait 2 - Completed First Appointment to First Treatment Appointment</b>			
NSH Central Zone		75%	87%
NSH Eastern Zone		94%	73%
NSH Western Zone		n/a	87%
NSH Northern Zone		97%	45%
<b>NSH Provincial Reported Results (Aggregate of Wait 1 and Wait 2)</b>			
<b>Nova Scotia</b>		<b>95.3%</b>	<b>61%</b>

Source: Office of the Auditor General of Nova Scotia, based on unaudited data provided by NSH

Note: NSH results were isolated for the purpose of this analysis, provincial results reported on the Action for Health website also include IWK results

### Exclusion of Wait 0 (referral and triage period) significantly impacts the reported results

74. Furthermore, when we re-calculated the results to include Wait 0, it shows a significant impact to the KPI. Our re-calculation shows that including Wait 0 in Q2 2024-25 would reduce the performance results by 4.3% and 7.9% for urgent and regular appointments respectively.

#### **NSH Mental Health and Addictions Appointments Wait Times within Benchmark OAG Recalculated Q2 2024-25 to Include Wait 0**

	Urgent Priority Appointments	Regular Priority Appointments
<b>Reported Q2 2024-25 Results (NSH provincially aggregated Wait 1 and Wait 2) [A]</b>	95.3%	61%
<b>OAG Recalculated KPI to Include Wait 0 Results [B]</b>	91%	53.1%
<b>Difference in OAG Recalculated Results [A minus B]</b>	-4.3%	-7.9%

Source: Office of the Auditor General of Nova Scotia, based on unaudited data provided by NSH

Note: NSH results were isolated for the purpose of this analysis, provincial results reported on the Action for Health website also include IWK results

### Completed Surgeries Wait Times within Benchmark KPI also excludes referral period

75. Similarly, our examination revealed that the referral period for *Percentage of Non-Endoscopic Surgical Services Completed or Wait Times within Benchmark* is also excluded from its KPI calculation. Called the consultation wait time on the Nova Scotia Wait Times' website, this portion of the wait is from the time a referral for surgery is made until the consultation with a surgeon. The wait times within benchmark data for the KPI are calculated from the time the patient meets with a surgeon and the decision for surgery is made to the completed surgery. The complete impact of this omission is not known, and management indicated the surgery referral date information may not be consistently available for reporting.

76. The omission of the referral period from the wait times within benchmark KPIs for mental health and addictions and scheduled completed surgeries means that results do not reflect the whole patient wait

time. Patients experience their wait for services from the moment a referral is made. Intake, triage and other aspects of the referral period are part of the health system servicing those needs and therefore performance at those stages of the process should be included in the reporting.

#### **Recommendation 8**

We recommend the Department of Health and Wellness identify, correct, and report the referral period in the reporting of *Wait Times within Benchmark* KPIs, for mental health and addictions and for completed surgeries.

#### **Department of Health and Wellness Response**

DHW is continuously working to improve data collection, and will explore data workflow improvements, which will be further enabled by OPOR implementation. DHW agrees to review available referral period data and identify gaps with provider organizations with an intent to include referral periods, where possible, in future public reporting

### **»» KPI Explanatory Information, Required to Fully Understand the KPIs, is Not Reported**

#### **Best practice is to report complete explanation and methodology**

77. CIHI's Information Quality Framework, discussed earlier at para. 11, highlights the importance of users being able to understand the information being reported. When CIHI publishes health data and health information about Canadians, it uses an organized template with explanatory notes detailing the purpose, the source of the data, the definitions used, and an explanation of how the indicator is calculated. This collection of information is often referred to as 'methodology,' detailing the methods used to produce the result. Where necessary, CIHI's information also includes notes of caution when there are known reliability concerns with the data or known exclusions that could affect the interpretation of the results.
78. We observed other Canadian jurisdictions, such as New Brunswick, Ontario, and Alberta, also have standard practices to include explanations specific to each indicator they report, including the source of the information, the calculation methods, and key definitions used.

#### **Action for Health website reports only brief "Data Notes" to explain the KPIs**

79. Explanations for the *Action for Health* Key Performance Indicators reported by the Department are included in a document called "Data Notes" published on the website.
80. The Data Notes indicate the KPIs were selected to represent the six solutions in the *Action for Health* plan. There is one general caution note that there can be a lag in available data, and that published results for previous quarters may be updated. There is a very brief comment about each published KPI stating how often it is updated (annually or quarterly) and when the next publication is expected. There is one comment about a significant change in how nurses are counted, effective May 2024.
81. The definitions and calculation of many of the KPIs are complex and require complete explanation to understand the meaning of the KPI, what is being measured and how, and what the KPI represents.

### **Recommendation 9**

We recommend the Department of Health and Wellness establish a requirement to publish complete methodology details for all publicly reported key performance indicators. Reported methodology documentation should include:

- » cautions where it is known if incomplete data is substantial and could affect the KPI results;
- » data source(s);
- » definitions;
- » targets and benchmarks, including their source;
- » calculations used, including any inclusions and exclusions; and,
- » any significant changes to calculations.

### **Department of Health and Wellness Response**

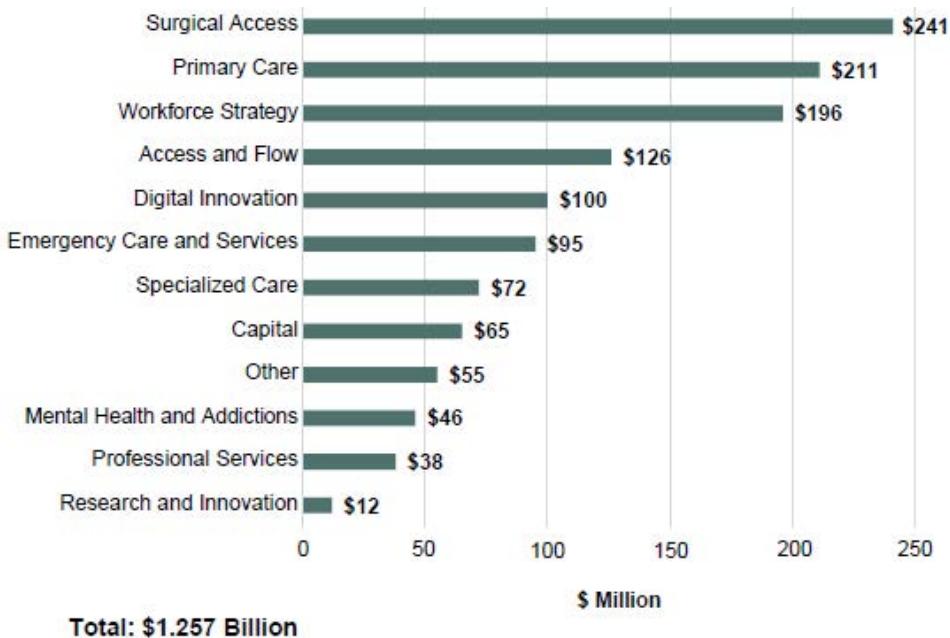
DHW is committed to transparency and accountability, as Action for Health and KPI reporting demonstrates. To date, the Action for Health and KPI reporting has been simplified for the user experience with the data notes including information on reporting periods and notifying users of potential lags in reporting. It is acknowledged that publishing additional technical information (including methodology, data sources and formulas) is good practice. To that end, and to continue Nova Scotia's commitment to improve healthcare openly and accurately, DHW agrees to add methodology information for publicly reported indicators.

### **KPI results published only as provincial aggregates mask local variation in performance**

82. The *Action for Health* key performance indicators are reported only as an aggregated provincial result. When aggregated results are reported for performance indicators, it can mask variation in performance at the health zone level and at the facility or local community level.
83. The Department told us the KPIs are tied to the *Action for Health* plan. As a provincial strategic plan, the Department decided to only report province-wide results. Our examination of KPIs shows that many of the KPIs are available to report regionally by health zone and some more locally by facility. Our examination showed that results can vary across the health zones and facilities.

### **Significant investments of \$1.3 billion over four years on *Action for Health***

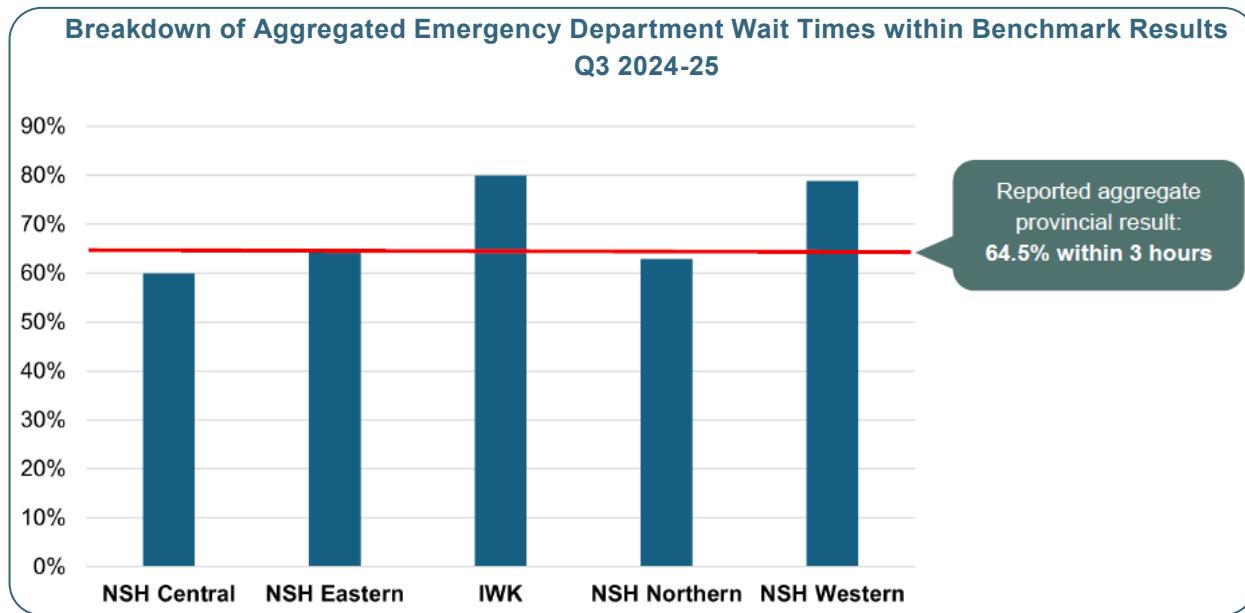
84. The province plans to spend nearly \$1.3 billion on *Action for Health* in its first four years, with \$883.2 million already spent in the first three years. Nova Scotia's total 2025-26 budgeted health expenditures under the Departments of Health and Wellness and Seniors and Long-term Care are \$7.4 billion.

**Action for Health Breakdown of Expenditures 2022-2026 (\$ Millions)**


Source: Office of the Auditor General of Nova Scotia, based on unaudited financial information supplied by the Department

**Large scale investments should have complete reporting**

85. Given the level of investment in *Action for Health* and the intended efforts to transform health care, reporting on performance should include all levels of the health system. In order to inform Nova Scotians in all parts of the province about their health system, it is important to include local variation in performance, allowing more specific accountability and full transparency. Reporting by health zone or by local facility allows for comparisons across geographical regions and for Nova Scotians to broadly understand health system performance and the impact of *Action for Health* investments.
86. The below example of the provincially aggregated KPI performance results broken down into their component parts demonstrates how reporting health zone and facility results better informs Nova Scotians about health system performance. Disaggregated results can highlight where challenges may exist and can help Nova Scotians better understand the decisions being made and the impact of investments.



Source: Office of the Auditor General of Nova Scotia, based on reported Q3 2024-25 data supplied by NSH

Caution Note: This audit found that the data is incomplete

### **Recommendation 10**

We recommend the Department of Health and Wellness, where the data is available, report health system key performance indicators on a health zone basis and/or a facility basis, in addition to provincially aggregated results.

### **Department of Health and Wellness Response**

Action for Health is a provincial plan and the published KPIs are intended to assess system-level transformation.

Health zones are not a consistent administrative or reporting structure across all reporting entities and may not be an effective approach for all metrics. The Daily Dashboard reporting on the Action for Health website does include some performance measures that can be filtered to show zone and/or facility performance.

For future reporting, DHW agrees to identify KPIs where additional regional context would add value without compromising accuracy or ease of interpretation.

## **»» Lack of Comprehensive and Cohesive Health System Reporting Makes it Challenging for Nova Scotians to Understand Health System Performance**

### **Complex systems and processes, many partners involved in producing KPIs**

87. The Department relies on third-party data providers to obtain health system data for reporting. The examination of these 13 KPIs underscores the wide range of data sources, the number of healthcare partners involved in generating and preparing the data, and the variety of challenges encountered with data quality. The KPIs examined involved data provided by Nova Scotia Health (NSH), the Izaac Walton Killam Health Centre (IWK), the Nova Scotia College of Nursing, the Health Association of Nova Scotia, the Department of Seniors and Long-term Care, private home care providers, and Medavie Blue Cross.

We came to appreciate the complexity involved with the KPI program, and with individual KPIs, as well as the effort involved in providing the information to Nova Scotians.

88. Our audit revealed each KPI has its own procedures and approaches to indicator data quality controls, some have more developed and documented indicator quality control procedures than others. Most KPI procedures lack reference to a clear checklist to be done, nearly half of those examined were not written, and none included a sign-off on completion. Agreements with third parties often lack explicit provisions about indicator data quality controls.
89. During our testing with auditees, we observed procedures described and demonstrated by staff who perform the tasks. We observed wide variation in how the KPIs are prepared and some indicator data quality control errors were identified during our testing, as noted in the quality controls results on the KPI results summaries (pages 17-23). These errors, for example, two duplicates in a data set of over a thousand, do not themselves have a big impact on the overall KPI calculation. However, identifying them highlights the importance of having strong data quality controls in place.

### **New governance committee has a mandate for healthcare data quality and auditing**

90. The Department informed us of a new Data Governance Subcommittee formed in December 2024, co-chaired by the Department, NSH and IWK. The mandate of this committee is to provide strategic oversight and guidance for data governance policies; standards and practices, including data accuracy and completeness; data quality management; and, regular data audits to rectify data discrepancies.
91. It is not expected that data quality controls would be identical for all KPIs. The initiation of the Data Governance Subcommittee is an opportunity to review current practices so appropriate rigor and explicit expectations are in place for all partners. This could ensure everyone working to produce the KPIs has an established expectation, and standard reference points to support effective indicator data quality controls.

### **Recommendation 11**

We recommend the Department of Health and Wellness establish and implement clear data quality control expectations for all publicly reported key performance indicators.

### **Department of Health and Wellness Response**

As noted in the report there are a variety of data sources and data owners that contribute to Action for Health reporting, and although quality control procedures exist within these organizations, DHW has not published expectations for data quality for publicly reported indicators. DHW will review current indicators and develop quality control procedures as appropriate for publicly reported key performance indicators.

### **Other available performance indicators could enhance reporting on *Action for Health* and health system performance**

92. The Department selected key performance indicators to report on *Action for Health*. This audit identified numerous additional performance indicators that are available and being tracked by management internally that could improve reporting on *Action for Health* initiatives and could enhance Nova Scotians' understanding of what *Action for Health* has achieved.
93. For example, initiatives focused on placing Nova Scotians with primary care providers are reported internally, including the numbers of placements via various *Action for Health* initiatives with monthly targets set. These indicators provide clearer insight into the activities of *Action for Health* and more directly report on efforts to connect Nova Scotians to primary care.

94. Additionally, we assessed the *Percentage of Emergency Department Visits by People without Access to a Primary Healthcare Provider* as lacking consistency between what is being measured and what is being reported because it:
  - » reports on the percentage of total emergency room visits;
  - » includes visits to the emergency department triaged as 'urgent', but should not; and,
  - » excludes people who visited emergency for minor conditions when they have a primary care provider but could not access them in a timely way.
95. Our examination revealed internal measures used by management that more clearly and directly report on access to primary care because they report:
  - » the number of emergency room visits as well as a percentage of the total;
  - » only the visits triaged as minor (the two least severe categories); and,
  - » results for both individuals listed as having a family doctor and those listed as having no family doctor.

### **Action for Health reporting adds to the complicated health data landscape**

96. The *Action for Health* website was launched in 2022 and is in addition to other Nova Scotia health system data, reported in different ways and found in different internet locations, including:
  - » Nova Scotia Wait Times website
  - » Nova Scotia Health Daily Dashboard website
  - » Open Data Nova Scotia website
  - » Canadian Institute for Health Information (CIHI) website
97. *Action for Health* is the only Nova Scotia website we identified where performance targets are set and reported. However, the relationship between the information reported on each of the websites is not always clear. For example, results reported for net new family physicians on both the *Action for Health* website and the CIHI website show what appears to be the same indicator with dramatically different results reported. In 2021-22, *Action for Health* reported 13 net new family physicians and CIHI reported -31, a difference of 44 net new family physicians. The reason for the significant difference in reported results for what appear to be the same indicator was not evident through a review of publicly available information or through inquiry with the Department.
98. Multiple sources of reported data make it difficult for Nova Scotians to understand and make connections about the information. For example, information about surgeries is reported on Nova Scotia's Wait Times website as the number of days within which 50% or 90% of surgeries were completed. The information is provided for all types of surgery, broken down by specific procedure. The *Action for Health* website reports the percentage of wait times within benchmark for two broad categories of surgery (endoscopic and non-endoscopic). There may be reasons for differences in reporting and for constructing an indicator in one way or another. However, with the limited methodology and explanation, it is difficult to understand how these reported results are related, even when they appear to be reporting on the same health system performance, in this case surgery wait times.

### **Models of cohesive health system reporting are available in other provinces**

99. Knowledge and full transparency are better imparted to Nova Scotians through easily accessible comprehensive performance measures, data and statistics, presented with full explanation/methodology and with cross-referencing multiple websites. A cohesive approach to reporting on health system performance could help provide more useful and relevant information for Nova Scotians to understand what is happening and why decisions are being made.

100. Models of cohesive health system reporting exist in other provinces, providing a platform, definitions, and reporting that is easier to navigate than the array of website sources maintained in Nova Scotia. Examples in other provinces include Health Quality Ontario and the New Brunswick Health Council. Indicator libraries on these sites, for example, make searching for available indicators easier.
101. More comprehensive health system reporting would also include more and different kinds of indicators. For example, the current roster of *Action for Health* KPIs does not include any measurements for health inequities or population health measures, both components of *Action for Health*. In New Brunswick, the Health Quality Council collects and reports a range of indicators related to population health, leveraging innovative sources of public data conducting a population health survey, and generating population health profiles for New Brunswick communities.

#### **Recommendation 12**

We recommend the Department of Health and Wellness implement cohesive and comprehensive health system reporting.

#### **Department of Health and Wellness Response**

Currently DHW provides public reporting on health and the health system through a number of different sites and locations. This includes Action for Health Progress Updates Dashboard, Public Reporting Daily Dashboard, Healthcare Wait Times, Patient Safety Indicators and Serious Reportable Events. DHW agrees to review all existing public reporting and work towards a complete and accessible set of monitoring resources, including a balance of system and population-based metrics.

## Appendix I

### Reasonable Assurance Engagement Description and Conclusions

We completed an independent assurance report of the *Action for Health* Key Performance Indicators at the Department of Health and Wellness. The purpose of this performance audit was to determine if the *Action for Health* key performance indicators are reliable and sufficient to communicate health system performance to Nova Scotians.

It is our role to independently express a conclusion whether the *Action for Health* Key Performance Indicators comply in all significant respects with the applicable criteria. Management at the Department of Health and Wellness have acknowledged its responsibility for the *Action for Health* Key Performance Indicators.

This audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001—Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook - Assurance; and sections 18 and 21 of the *Auditor General Act*.

We apply the Canadian Standard on Quality Management 1 (CSQM 1), and we have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Nova Scotia.

The objectives and criteria used in the audit are below:

**Objective:** Are the *Action for Health* key performance indicators reliable and sufficient to communicate health system performance to Nova Scotians.

**Criteria:**

1. The KPIs are calculated using data that is reasonably accurate, complete, and timely.
2. The calculation of the KPIs is consistent and logically correct.
3. The KPIs use sufficient targets/benchmarks to track performance and trends.
4. The KPIs provide Nova Scotians with relevant and meaningful information about *Action for Health* and health system performance.

Generally accepted criteria consistent with the objectives of the audit did not exist. Audit criteria were developed specifically for this engagement. Criteria were accepted as appropriate by senior management at the Department of Health and Wellness.

Our audit approach included interviews with management and staff, reviewing policies and procedures, examining data and results. Testing included tracing randomly selected samples of data from data sets to source systems and from source systems to data sets, comparing date-stamped data sets, recalculating results, and performing data analytics processes. Our audit period was from January 2022 through November 2024. We examined information outside of that period as necessary.

We believe the evidence we have obtained is sufficient and appropriate to provide the basis for our conclusion. Our report is dated January 20, 2026 in Halifax, Nova Scotia.

Based on the reasonable assurance procedures performed and evidence obtained we have formed the following conclusions with respect to the *Action for Health* Key Performance Indicators:

The *Action for Health* key Performance Indicators are partially reliable but are not sufficient to communicate health system performance to Nova Scotians.

1. Five of the KPIs examined used data that is not fully accurate, complete or timely.
2. Six of the KPIs examined were not consistent and logically correct.
3. Ten of the KPIs examined do not use sufficient targets/benchmarks to track performance and trends.
4. Reporting weaknesses affecting the 13 KPIs examined detract from the relevance and meaningfulness of the information provided to Nova Scotians about *Action for Health* and health system performance.

## Appendix II

### Key Performance Indicators Reported on *Action for Health* as of June 2025

Family Physicians new inflow
Family Physicians annual net increase
Nurse Practitioners new inflow
Nurse Practitioners annual net increase
Registered Nurses new inflow
Registered Nurses annual net increase
Total registered Continuing Care Assistants
Family Physicians per 100,000 Nova Scotians
Volume of the home care waitlist
Number of admissions to long-term care (from hospital and community)
Percentage of hospital admissions for people whose complex needs could have been addressed with primary healthcare
Percentage of endoscopic surgical services completed or wait times within benchmark
Percentage of non-endoscopic surgical services completed or wait times within benchmark
Percentage of Nova Scotians seeking a primary care provider (as tracked by the Need a Family Practice Registry)
Percentage of emergency department visits by patients without access to a primary healthcare provider
Nova Scotia Health Positive employee satisfaction
IWK Positive employee satisfaction
Vacancy rate
Turnover rate
Nova Scotia Health positive patient hospital rating
Hours of administrative tasks removed
Emergency department availability and closures (based on 24-hour access) - Hours available
Emergency department availability and closures (based on 24-hour access) - Scheduled closure
Emergency department availability and closures (based on 24-hour access) - Unscheduled closure
Surgical waitlist growth rate ratio
Percentage of ambulance response times below target
Percentage of ambulance offload intervals in less than thirty minutes
Emergency department wait times within benchmark
Percentage of urgent addictions and mental health first treatment wait times within benchmark
Percentage of non-urgent addictions and mental health first treatment wait times within benchmark
Percentage of full series immunization coverage for school vaccines among 17 year olds - Men-C-ACYW
Percentage of full series immunization coverage for school vaccines among 17 year olds - Tdap
Percentage of full series immunization coverage for school vaccines among 17 year olds - HPV
Percentage of full series immunization coverage for school vaccines among 17 year olds - HB

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