2009/2010 Community Health Assessment Report

"Your Chance To Make A Difference"
NOR-MAN Regional Health Authority
Community Health Assessment Report

April 2010

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A Message from Vivian McKenzie
Board Vice-Chair

A Message to the Region

In accordance with Section 23(2B) of the Regional Health Authorities Consequential Amendment Act, I am pleased to present, on behalf of the Board of Directors of the NOR-MAN Regional Health Authority, a copy of NOR-MAN Regional Health Authority’s 2009/2010 Community Health Assessment.

Over one year ago, the NOR-MAN Regional Health Authority Board of Directors appointed the NRHA Community Health Assessment Advisory Committee to complete a comprehensive Community Health Assessment for the region. Building on the work that has been done since the RHA’s inception in 1997 and NRHA’s second comprehensive Community Health Assessment completed in 2004, the goal of the project was to provide a solid base of facts and data to guide future decision-making in the region.

Both the Community Health Assessment process and report will assist the NOR-MAN Regional Health Authority’s planning process and form the basis for the development of our NRHA’s 2011 - 2016 Strategic Plan. We hope you find the information useful and we encourage our community partners to use the information for your own planning purposes.

Sincerely,

Vivian McKenzie
Board Vice-Chair
A Message from Drew Lockhart
Chief Executive Officer

A Message to the Region

The NOR-MAN Regional Health Authority’s 2009/2010 Community Health Assessment (CHA) is the product of an intensive year of work by the Community Health Assessment Advisory and Research Teams.

I would like to thank all of our staff, physicians, community partners and residents of NOR-MAN and north eastern Saskatchewan who were involved in the Community Health Assessment. Whether you were on our Advisory or Research Team, District Health Councils or participated in one of our many community consultation activities, your commitment to health in this region is appreciated.

As can been seen as you read through the report, we have many health challenges facing our region. There is also some very good news stories where we have made great strides towards the priorities set out in our last Strategic Plan. This report will form the backbone for setting our strategic directions for 2011-16.

We are looking forward to the many initiatives planned in the coming years. We have a dedicated health care team of staff and community partners who continue to work together towards our Mission of “Healthy People in Healthy Communities, Working Together to Improve Our Health.”

Sincerely,

Andrew Lockhart
Chief Executive Officer
Acknowledgement

We would like to acknowledge the contribution of the many individuals and organizations whose efforts and expertise made it possible to produce this report.

A special thank you is extended to:

- NRHA Board of Directors
- NRHA Senior Management and Staff
- District Health Council members
- Advisory Team members
- Research Team members
- All NRHA staff and physicians who participated in the various staff consultation activities
- All community partners and residents who participated in the various community consultation activities

The NOR-MAN Regional Health Authority also acknowledges the dedicated financial support of Manitoba Health and the work of the Manitoba Community Health Assessment Network.

Our sincere thanks are extended to our Advisory and Research Team members for their contribution, support and ideas in the development and review of this document:

**CHA Advisory Team Members:**

- Doug Lauvstad, NRHA Board Member
- Doris Habermann, NRHA Board Member
- Joan Niquanicappo, NRHA Board Member
- Marie Jebb, NRHA Board Member
- Drew Lockhart, Chief Executive Officer
- Dr. Lawrence Elliott, Medical Officer of Health
- Corliss Patterson, Executive Director, Communication
- Lil Rourke, Executive Director, Finance and Support Services
• Pat Bilquist, Executive Director, Community and Long Term Care
• Tanis Campbell, Regional Care Advocate, Men’s Team
• Jocelyn Bruyere, Swampy Cree Tribal Council
• Judy Mayer, Manitoba Métis Federation, The Pas Region
• Various representatives from Manitoba Keewatinook Ininew Okimowin (MKO)
• Brenda Mishak Beckham, Mamawetan Churchill River Regional Health Authority
• Peter Nunoda, University College of the North

CHA Research Team members:

• Dr. Lawrence Elliott, Medical Officer of Health
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• Jamie Simard, Decision Support, Administrative Date Entry/ Programmer
• Carol Buchberger, MMF
• Andrew Basham, MKO

Finally, there were several individuals who helped us with the editing of this document. A special thanks to the following individuals for their assistance:

• Dr. Lawrence Elliot
• Drew Lockhart
We again thank all of the community residents, partners and NRHA staff who participated in the various community consultation activities. **Your valuable input has given us a greater understanding of the health care needs and concerns of the people living in our region.**

Your feedback and input are valued, and important to the ongoing community health assessment process. If you wish to provide feedback or require additional information, please e-mail [chynes@normanrha.mb.ca](mailto:chynes@normanrha.mb.ca) or call Catherine Hynes at (204) 687-1338.

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How to Read this Report

There is a wealth of information contained in this Community Health Assessment report - information that will prove useful to planners, decision-makers, and policy makers in the NOR-MAN region.

There are numerous graphs and tables contained in this report, each graph or table has been chosen to give information on key indicators deemed helpful to health planning and decision making. When reviewing this report, please note the following:

Report Key:

Teal Highlights and Clouds - identifies interesting information for the NOR-MAN region

Red Highlights and Clouds - identifies areas of concern or problems for the NOR-MAN region

Yellow Highlights and Clouds - identifies warnings for the NOR-MAN region

Green Highlights and Clouds - identifies good news for the NOR-MAN region

Blue Highlights and Clouds - identifies best practice

Yellow/Teal Filled Clouds with White Text - identifies consultation results
**Statistical Significance**

Statistical significance is used to indicate how much confidence to put in the reported rates. If a difference is “statistically significant” then this difference is large enough that we are confident it is not simply due to chance.

In most figures, the results from both time periods are shown, followed by a set of parentheses that can include the following indicators: (1, 2, t, s, d)

- a ‘1’ indicates, that in the first (1st) time period, the area’s rate was statistically different (either higher or lower) from the Manitoba average at that time

- a ‘2’ indicates, that in the second (2nd) time period, the area’s rate was statistically different (either higher or lower) from the Manitoba average at that time

- a ‘t’ indicates that for that area, the change in rates from time 1 to time 2 was significant (either higher or lower)

- A ‘d’ indicates the difference between two group was statistically different (higher or lower) for that area

- A ‘s’ indicates that the results were suppressed to ensure confidentiality (rates are suppressed where the counts upon which the rates were based represented one (1) to five (5) events)
Table of Contents Navigation Feature

For your convenience, the Table of Contents has been linked by topic and page number. This allows for easy navigation directly to the topic and page number chosen.

Example: By clicking on the topic “District Health Councils” or page number “1-9”, you will be taken directly to that requested page in the report.

Summary

When reading this report, it is important to remember that in any diverse community, indicators cannot tell the personal stories of the individuals, families or communities. The graphs and tables provide only the basic statistical information from which to raise the questions. The community consultation activities provided the stories to understand the data.

We are hopeful that our 2009/2010 NOR-MAN Regional Health Authority Community Health Assessment Report will get us talking about where we are and where we hope to be in the future. This report is a work in progress, that is providing the NRHA with the evidence to guide our strategic direction for the coming years.

As you read and use the information contained in this report and have questions, please do not hesitate to contact us with your questions.

Catherine Hynes
Regional Manager Decision Support

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Summary of Findings

What does the 2009/10 Community Health Assessment tells us?

Regional Health Authorities were established on April 1, 1997 under the provision of The Regional Health Authorities and Consequential Amendments Act (Bill 49). NOR-MAN Regional Health Authority was one of eleven Regional Health Authorities created under this Act.

Our Community Health Assessment is the cornerstone to all planning in the region. According to Manitoba Health’s Community Health Assessment Guidelines, 2009, a well-planned and thorough Community Health Assessment (CHA) will provide health authorities with evidence required to set priorities, choose actions and evaluate results. It will also examine current and future needs, capacities and community expectations within the health region.

Painting Our Picture

By its very nature, a report such as this has difficulty in showing the tremendous diversity that exist among individuals and communities within the NOR-MAN region.

When reading through the chapters of this report, it quickly becomes apparent that our region has a number of best practices, good news to celebrate, areas of concern and bad news that needs to be addressed.

Chapter 1 - What is a Community Health Assessment?

The Community Health Assessment process was legislated with the creation of the Regional Health Authorities of Manitoba in 1996. The NOR-MAN Regional Health Authority (NRHA) completed our first comprehensive Community Health Assessment in 1997/98 and a second
report in 2003/04. This report is our third comprehensive Community Health Assessment since we became a Regional Health Authority in 1997.

The CHA process is based on a five-year cycle that involves the collection, analysis and interpretation of information (qualitative) and statistical data (quantitative) on areas of community health issues and strengths.

Our third report, and the work leading up to its publication, reflects our attempt to develop a greater understanding of the health issues and concerns of the NOR-MAN residents. This report presents the results of our third Community Health Assessment process that was conducted between December 2008 and March 2010.

We explored the various consultation methods that were conducted throughout the NOR-MAN region and northeastern Saskatchewan. These included:

• CHA Retreat
• Forces of Change Assessment
• Key Knowledge Interviews
• Key Informant Interviews
• Women’s Health Focus Group
• Regional Youth Health Surveys
• Health System Performance and Health Priorities Staff, Physician and Partners Surveys

Finally, in writing this report we brought together the various qualitative/quantitative data and blended it with our consultation information to tell our story of our region and our residents.

Although, we are required to complete a comprehensive Community Health Assessment every five years, our CHA is an ongoing process that provides us with the evidence needed to continue to strive to meet our Mission.
Chapter 2 - Who is the NOR-MAN Regional Health Authority?

As one of the primary provider of health services in the NOR-MAN region, our Mission is Healthy People in Healthy Communities “Working Together to Improve Our Health.”

Consistent with our mandate, we deliver a wide range of services in eleven (11) core service areas through the following facilities:

- **Hospitals** - Flin Flon General Hospital, St. Anthony’s Hospital, Snow Lake Health Centre
- **Personal Care Homes** - St. Paul’s Residence, Northern Lights Manor, Flin Flon Personal Care Home
- **Addiction Centre** - Rosaire House
- **Primary Health Care** - The Pas, Primary Health Care - Flin Flon (two sites), Cranberry Portage Wellness Centre, Cormorant Health Care Centre, and the Sherridon Health Care Centre

We provide a range of services to approximately 30,000 – 32,500 people. In addition to the Manitoba-based population of 24,090, approximately 8,000 northeastern Saskatchewan residents utilize acute, ambulatory, diagnostic, emergency care and physician services in both Flin Flon and The Pas.

The NOR-MAN Regional Health Authority is not mandated to provide all health services in all communities. There are a number of other agencies providing health services in the NOR-MAN region.

**Good communication and strong partnerships with other health service providers is critical to ensure health care services are provided in a coordinated and seamless manner.**
Chapter 3 - What does the NOR-MAN region look like?

The NOR-MAN region is home to the following communities:

- **District I**
  - Flin Flon
  - Cranberry Portage
  - Snow Lake

- **District II**
  - The Pas
  - Opaskwayak Cree Nation (CN)
  - Rural Municipality (RM) of Kelsey

- **District III**
  - Cormorant
  - Sherridon / Cold Lake
  - Easterville
  - Chemawawin Cree Nation (CN)
  - Grand Rapids
  - Misipawistik Cree Nation (CN)
  - Moose Lake
  - Mosakahiken Cree Nation (CN)
  - Pukatawagan /
  - Mathias Colomb Cree Nation (CN)

Chapter 4 - Who are the people of the NOR-MAN region?

The NOR-MAN region covers a vast area of land spanning approximately 72,000 square kilometers in the central western part of the province. The people and the communities that make up the region display considerable diversity in origin, governance structure, economic base, service availability and interconnectedness.

The NOR-MAN region is home to about 2.1% of the total Manitoba population. There are approximately 24,090 people living in the NOR-MAN region, of which:
• our region’s rural and remoteness – the number of small widely scattered communities impacts the health of our region

• We have seen a small yearly decrease in our population over the past five (5) years

• 50.0% of NOR-MAN residents claim Aboriginal identity (Manitoba rate is 15%)

• 13.1% of NOR-MAN residents are registered members of The Pas MMF Region

• Approximately 61% of the NOR-MAN population lives in the communities of Flin Flon, The Pas and OCN

• 58.2% of NOR-MAN residents live in an urban population area

• 41.8% of NOR-MAN residents live in a rural population area

• 49.8% of NOR-MAN residents are female

• 50.2% of NOR-MAN residents are male

• 25.8% of NOR-MAN residents are under the age of 15 (Manitoba rate is 19.3%)

• 46.9% of NOR-MAN residents are under the age of 30 (Manitoba rate is 39.9%)

• 8.7% of NOR-MAN residents are 65 years or older (Manitoba rate is 13.7%)

• Flin Flon and Snow Lake’s 65 years and older age category rate is similar to the Manitoba rate

• The largest proportion of NOR-MAN males are in the 15-19 year age group

• The largest proportion of NOR-MAN females are in the 5-9 year age group

• NOR-MAN’s population is projected to decrease by −13.9% by the year 2036 (Manitoba +40.0% increase)

Working in one community and living in another was identified as a problem (family issues) during our consultations

Lack of employment opportunities for youth in their home communities was identified during our consultations
By 2036, there will be a significant decrease in the number of people who are in the age category of 20 - 54 years and an increase in the 55 years and older category.

46% of NOR-MAN residents are married, 38% are single, 7% are divorced, 6% are widowed and 3% are separated.

NOR-MAN’s unemployment rate is almost double the provincial unemployment rate.

When comparing NOR-MAN income sources to Manitoba as a whole, our total earnings percentage of income is higher at 80% vs. 75%.

There are 5,975 families living in the region, of which 61% are married-couple families, 16% are common-law families, and 23% are lone-parent families.

64% of NOR-MAN residents are living in the same residence as they were five years earlier.

82% of NOR-MAN residents speak only English, while 17% speak a language other than English or French, and 1% speak only French.

There has been a decrease in the use and understanding of Aboriginal language(s) since our last report.

Some of the factors hindering our ability to live a healthier lifestyle includes:

- our region’s rural and remoteness – the number of small widely scattered communities impacts the health of our region
- our lower education levels
- our higher than average unemployment rates
- our lower than average incomes in the smaller NOR-MAN communities

Economic uncertainty especially in the areas of forestry and mining were identified during our consultations.

Education was identified during the community consultation process as an important component of a healthy community.

Loss of forestry and mining jobs was identified as a concern during our consultations.

Loss of forestry and mining jobs was identified as a concern during our consultations.
• our inequality in income levels between the low and high wage earners

• our lone parent family income levels are significantly lower than our couple families income levels

• our population dependency ratios vary greatly between our districts

For the NOR-MAN Regional Health Authority, it is necessary to continue to monitor the demographics of our region, as they are the foundation for the development of quality health care programs and services.

Chapter 5 - How Healthy are the people of the NOR-MAN region?

Some of our Health Status highlights are:

• NOR-MAN has a statistically higher mortality rate than the province and our rate has experienced a slight increase

• NOR-MAN region continues to experience a decline in our Premature Mortality Rates (MPR) rate from 5.5/1,000 in 1990-1994 to 4.6/1,000 in 1995-1999 to our current rate of 4.4/1,000.

• Males are living longer lives (73.4 years) - Although we die approximately three (3) years earlier than the average Manitoba male (76.3 years)

• Females experienced a small decrease in life expectancy during the 2001 to 2005 time period (77.6 years) - we die approximately four (4) years earlier than the average Manitoba female (81.8 years)

• District I residents are living longer lives than both District II and III residents

• We have experienced a decrease in our Potential Years of Life Loss (PYLL)
The top cause of Personal Years of Life Lost (PYLL) in the NOR-MAN region continues to be due to deaths from unintentional injuries.

NOR-MAN infant mortality rates increased in the most recent time period, but this increase was not statistically significant - we need to continue to monitor.

NOR-MAN continues to experience higher rates of suicide than the provincial rate, with the largest increase over time being in the 15-24 year age group.

Suicide rate in Manitoba are three (3) times higher for males.

Leading causes of death in the NOR-MAN region is the same as Manitoba as a whole and are due to Diseases of the Circulatory System at 26.3% followed by Neoplasms (cancer) at 24.7%. These two causes account for 51% of our deaths.

The leading cause of death for NOR-MAN females is Diseases of the Circulatory System and Cancer for NOR-MAN males.

Lung cancer is the leading cause of cancer death for both males and females, which is similar to Manitoba as a whole.

NOR-MAN has seen an increase in our deaths due to Endocrine, Nutritional and Metabolic Disease from 3.3% in 1992/99 to 9.8% in 2002/06.

The leading cause of injury death in the NOR-MAN region is due to motor vehicle / traffic injuries - Manitoba’s leading cause is suicide.

Main cause of injury deaths for NOR-MAN males were due to suicides and motor vehicle / traffic injuries.

Mental health issues were identified as a health concern during all our consultations.

Suicide and suicide attempts were identified as a concern during our consultation activities.
• Main cause of injury deaths for NOR-MAN females were due to motor vehicle/traffic injuries and suicide

• **Hypertension** rates for NOR-MAN residents age 25 and older are statistically higher than the provincial rate and our increase over time was statistically significant

• **Ischemic Heart Disease (IHD)** rates in the NOR-MAN region have decreased, as have the provincial rates

• NOR-MAN District II and III residents are experiencing more **Strokes** than all Manitobans - the good news is that we have experienced a decrease in rates over time

• NOR-MAN residents have experienced more **Acute Myocardial Infarctions (AMI)** - heart attacks than all Manitobans - the good news is our rates have decreased since the last CHA

• **Diabetes** continues to be a growing problem in the NOR-MAN region with statistically significantly higher rates than the Manitoba average and our rates continue to trend upward from 6.3% in 1986/87 to 13.0% in the current reporting period

• NOR-MAN experienced a decrease in our Lower Limb Amputations rates among residents with diabetes from 3.3% to 1.9% and this change over time is statistical significant

• NOR-MAN cancer incidence rates have decreased over time

• NOR-MAN males have a higher incidence rate for both colorectal and lung cancer than all Manitoba males

• NOR-MAN females have a higher incidence rate for both cervical and lung cancer than all Manitoba females
• **Melanoma incidence** rates for all NOR-MAN residents has increased over time - the female rate is increasing faster than males

• The **cancer prevalence** rate for both NOR-MAN males and females is higher than the Manitoba rate

• NOR-MAN residents have been diagnosed with **Arthritis** more often than other Manitobans - although our rates have decreased over time

• NOR-MAN residents **Total Respiratory Morbidity (TMR)** rates are statistically lower than the provincial rate

• NOR-MAN has a statistically higher rate of **Osteoporosis** than other Manitobans, and our change over time was statistically significant

• NOR-MAN experienced a statistically significant decrease in our **injury hospitalization** rate - our rate is still almost double the provincial rate

• The top cause of **injury hospitalization** for both NOR-MAN males and females were injuries from **falls**

• Overall, 56.9% of NOR-MAN residents rated their **self-rated health** as either excellent or very good compared to the province at 60.7% (CCHS data)

• More NOR-MAN residents (57.9%) reported having **perfect physical functioning** than Manitobans as a whole (55.6%) (CCHS data)

• More NOR-MAN residents (47.7%) reported having better **overall mental health** than Manitobans as a whole (40.8%) (CCHS data)

• NOR-MAN’s **Cumulative Mental Disorders** rate is lower than the provincial rate
• NOR-MAN’s Depression, Personality Disorders and Schizophrenia rates are statistically lower than the provincial rate

• NOR-MAN’s Anxiety Disorders and Substance Abuse rates are statistically higher than the provincial rate

• NOR-MAN’s Dementia rates are similar to provincial rate

• NOR-MAN selective serotonin reuptake inhibitors (SSRI) and teen antidepressant rates have experienced a significant decrease, and our rates are lower than the provincial rate

Chapter 6 - What makes the people of the NOR-MAN region healthy?

Some of the key findings are:

• The NOR-MAN region, in all three time periods, shows that we have a higher number of families experiencing more income inequality than the province as a whole

• There is a large discrepancy between high and low income earners in the NOR-MAN region - District I families are experiencing more inequality than NOR-MAN as a whole

• NOR-MAN’s median household income value is higher than the provincial value in all three time periods

• NOR-MAN female medium income values are significantly lower at $18,232.00 than our male level of $31,376.00

• Our main male occupations are trades, transportation and equipment operators at 29.6% followed by sales at 19.6% and unique to primary industry at 14.8%

Alcohol and drug issues were identified as health concern during all our consultation

Poverty was identified as a concern during our consultations
• Our main female occupations are sales at 36.6% followed by business, finance and administration at 20.4% and social sciences, education, government and other services at 15.5% and health at 12.9%

• NOR-MAN has the fourth (4th) highest overall rate of unemployment in Manitoba

• As the NOR-MAN population ages, economic issues will cause even bigger problems due to the fact that 25.8% of NOR-MAN residents are under the age of 15 and currently are not a part of the workforce

• When reviewing youth (age 15 to 24 years) unemployment stats, NOR-MAN males and females are more likely to be unemployed than were all Manitoba youth in all three time periods

• The NOR-MAN region has a higher percentage of residents with less than a high school or only a high school diploma in all ages compared to the provincial rates

• Approximately 16% of NOR-MAN residents have experienced a major stress event in their life through divorce, being widowed or being separated

• 5,975 families live in the NOR-MAN region, of those families, 23% are lone parent families - of the lone parent families in the NOR-MAN region, 78% are headed by women

• Limited housing options was identified as a concern during our consultations

• Most of our First Nation communities are reporting overcrowding in their homes

• Most of our First Nation communities are reporting mold and/or mildew as a major housing repair required
• There has been a decrease of 474 births over the five year time periods since our last CHA

• Our Preterm Birth Rate at 6.5% is statistically lower than the provincial rate

• NOR-MAN teens are two (2) times more likely to give birth than the province as a whole - NOR-MAN teen birth rates have started to decrease

• When looking at low birth weight rates over a five year period, both the NOR-MAN region and Manitoba have experienced increases in their rates

• We have higher high birth weight babies in our region

• Completed childhood immunizations have improved in the age one (1) and age seven (7) year old categories

• NOR-MAN breastfeeding initiation rates are statistically lower than the Manitoba rate

• NOR-MAN children deemed “Not Ready” for school require further development in language and thinking skills, emotional maturity, social competence and physical health and well-being

• We have more current smokers - we are concerned with the smoking rates of our youth and Aboriginal peoples

• We are home to a larger number of former smokers

• Overall, we have more reported occurrences of binge drinking - we are concerned with our increasing rates of youth binge drinking

• Our youth are reporting a high rate of illegal drug use and these rates increase by grade
• Approximately 70% of NOR-MAN residents do not consume five or more fruits and vegetables per day

• We are more likely to be either overweight or obese - this applies to both children and adults

• NOR-MAN residents reported being more active

• We have the third (3rd) lowest rate of cervical screening in the province

• We continue to see an increase in our mammography screening rates - the Manitoba Mobile Breast Screening Program has had a significant impact

• Adult pneumococcal immunization rates have continued to increase in the NOR-MAN region

• From September 2009 to January 2010, 10,306 or 42% of NOR-MAN residents received their H1N1 vaccinations

• Gonorrhea rates are increasing in our region - males report a higher rate than females

• Chlamydia rates in NOR-MAN have risen steadily since 1997 - we have the highest rate of all females in Manitoba

• Our exposure to second hand smoke is statistically different (higher) that the provincial rate

• According to Flin Flon / Creighton Community Health Status Assessment, the long term health and mortality has not likely been seriously impacted by metal exposures in the general Flin Flon / Creighton population

• Our drinking water quality is very good

Access to affordable nutritious food was identified as a concern during our consultations

Obesity was identified as a concern during our consultations

Air quality was identified as a concern during our consultations

Water quality and contamination was identified as a concern during our consultations
Chapter 7 - Where do NOR-MAN residents go for health services and are they receiving quality services?

The following provides a summary of the key findings in this chapter:

- NOR-MAN residents place greater importance on family physicians due to the extremely low levels of access to specialists within the NRHA

- NOR-MAN residents are seeing physicians approximately five (5) times per year with 80.9% of physician visits taking place in our region

- The top causes of physician visits are for respiratory at 12.4% and injury & poisonings at 9.0%

- Our ambulatory consultation rates are statistically different (lower) than the provincial rate

- Our ambulatory visits to specialists are statistically different (lower) than the provincial rate - and our change over time was statistically significant

- NOR-MAN females visit physicians more often for mental illness issues than do males

- Our continuity of care rates have decreased slightly from 70.4% to 67.3% - we are now similar to Manitoba

- We have a statistically (higher) rate of residents being admitted to hospital at 10.4% in comparison to Manitoba at 7.0%

- The majority of NOR-MAN patients are being hospitalized in NOR-MAN facilities at 68.0%
• Both NOR-MAN and Manitoba experienced a decline in our hospital short stays—but we are still statistically (higher)

• Our long stay hospital days experienced a statistically significant decrease over time due to our PCH clients being moved to the Northern Lights Manor in February 2001

• The top reasons for being hospitalized in NOR-MAN are for childbirth and pregnancy at 22.7%, followed by injuries and poisonings at 13.5%, diseases of the respiratory system at 10.0%

• The percentage of Non-Manitobans using our hospital facilities is 22%

• Our Hospitalizations for Ambulatory Care Sensitive Conditions are statistically higher than the provincial rate—however, we did experience a decrease

• NOR-MAN residents with mental illness disorders continue to be admitted to hospital more often

• NOR-MAN residents are receiving less knee replacement surgery than Manitobans as a whole - our rate is increasing

• NOR-MAN residents are receiving less hip replacement surgery than Manitobans as a whole - our rate is increasing

• NOR-MAN residents have lower levels of PCI than Manitobans as a whole - we experienced a statistically significant change over time (increase)

• NOR-MAN residents experienced higher rates of CABG - our rate increased
• NOR-MAN residents experienced similar rates of Cardiac Catheterization to provincial rate - our rate has increased

• NOR-MAN residents are having less cataract surgeries than Manitobans as a whole

• Our rates of antidepressant use are statistically different (lower) than the Manitoba rates - the change over time was a statistically significant increase

• More NOR-MAN diabetic residents are receiving eyes exams - in both time periods our rates are statistically different (higher) than the provincial rates

• NOR-MAN males are reporting an all cancer survival rate of 52% compared to a provincial rate of 58% and NOR-MAN females are reporting an all cancer survival rate of 57% compared to a provincial rate of 59%

• The good news is that NOR-MAN males have a higher 5 year cancer survival rate for both colorectal and lung cancer - Prostate cancer survival rates are of concern

• The good news is that NOR-MAN females have a higher 5 year cancer survival rate for colorectal cancer - Lung cancer survival rates are a concern

• Of note, District III has the lowest rates of C-sections in the NOR-MAN region and their rate decreased in the second time period and is now lower than the provincial rate

• NOR-MAN vaginal births rates after a C-section, is statistically different (lower) at 26.8% than Manitoba at 34.9% - the good news is we have had statistically significant increase over time

The top diseases of concern identified by our staff, physicians and partners were:
• Diabetes
• Obesity
• Heart Health
• Cancer
• Mental Health
• Our tonsillectomy / adenoidectomy rates have experienced a statistically significant change over time - lower

• NOR-MAN’s new home care case have decreased from 3.6% to 3.4%

• Our home care closing rates have remained constant at a rate of 1.3%

• Our average length of stay for home care has decreased slightly from 234.7 days to 222.0 days

• Our admission rates to PCH for residents age 75 and older was at 3%

• The good news for our region is that 75% of PCH admissions fall within the level three and four categories - this is significantly higher than the Manitoba percentage of 56.4%

• During the 2004/05 - 2005/06 time period, our median wait time for PCH admission was 2.9 weeks - which is statistically different (lower) than the provincial wait time of 6.9 weeks

• When reviewing the risk factors for the Families First Program, the NOR-MAN region’s rate for all seven risk factors are higher than the provincial rates

• Wait time areas of concern include: Physiotherapy, Audiology, Speech Language, Mental Health (children), Rosaire House and Long Term Care (Flin Flon)

• Telehealth use continues to increase - our main use was for clinical services at 41%

• Our NPTP costs continue to increase every year as do the number of warrants - of note, 7% of the total warrants were for air ambulance yet it accounted for the largest percentage of the NPTP budget at 52%
• When looking at why people are using NPTP travel for diagnostic purposes, Mammography is the top reason for The Pas and CT travel to The Pas for Flin Flon

• When looking at why people are using NPTP travel by physician specialty, Orthopedics was the top reason in The Pas and Internal Medicine in Flin Flon

• During the period of January 1 to December 31, 2008, EMS responded to 1,827 calls in The Pas, 1,203 calls in Flin Flon, 297 calls in Grand Rapids and 122 calls in Cranberry Portage

Chapter 8  -  How well does the NOR-MAN Regional Health Authority serve our residents?

Summary of the key findings include:

• As of March 31, 2009, the NRHA employed 989 individuals

• Our staff is comprised of 91.4% unionized members

• Our self-declared aboriginal workforce rate is 17.7%

• The majority of our staff work in the area of facility support at 41%, followed by nursing at 27%

• The smallest component of our workforce is Senior Management at 1%, followed by out of scope at 8%

• As part of our May 2008 Accreditation Survey, we participated in the Accreditation Canada’s Work Life Pulse in October 2007:
  • 57% of our staff responded that overall, they were satisfied with the organization
  • 92% said they are satisfied with their job
• Our physician profile is comprised of the following:
  • General Practice at 17
  • General Practice/Surgeon at 1
  • General Practice/OBS at 2
  • General Practice/Anesthesia at 2
  • Internal Medicine at 1
  • Psychiatry at 1
  • Medical Office of Health at 1

• We continue to incur a deficit annually, the majority of this deficit is directly related to the Northern Patient Transportation Program and our human capital issues

• The proportion of our total expenses going to Acute Care has remained fairly stable at 56%

• The proportion of our total expenses going to Community Care has remained fairly stable at 17%

• The proportion of our total expenses going to our Personal Care Homes (PCH) has remained fairly stable at 13%

• Our administration costs as a percentage of our total operating costs, remained stable at 5% which is on par with the provincial rate

• Our Information System costs as a percentage of our total operating costs are 0.5%, which is lowest in the province

• We have an external Complaint Management process which is coordinated through our Executive Director of Communications

• In 2008/09, we received 85 complaints - the majority of our complaints are related to staff/physician behaviour and physician resources

During the Fin Flon “Forces of Changes Assessment” the main item of discussion was the issue of physicians and the problems associated with accessing services and the inability to obtain a Family Physician
• We have a Regional Manager of Quality and Risk in place who oversees our integrated Quality, Risk and Patient Safety Strategy.

• We publish four (4) Quality Scorecards annually focusing on how our health system is performing based on the following areas:
  1. Work Life
  2. Responsiveness
  3. System Competency
  4. Client/ Community Focus

• NRHA was one of the first regions in Canada to participated in the new Qmentum program. We successfully participated in our Accreditation Canada survey visit in May 2008 receiving “Accreditation with Conditions.”

• Based on compliance with national standards, we exceeded the national compliance rate in six (6) of the eight (8) quality dimensions and met or exceeded the national compliance rate in twelve (12) of fourteen (14) standard sections.

• Through directed funding from Manitoba Health, a new Patient Safety Coordinator was hired and began work in May 2009. This position is responsible for investigating all Critical Incidents and coordinating a Patient Safety strategy for our region.

• As part of the Accreditation Canada survey process, we participated in an on-line Patient Safety Culture Survey in October 2009. As an organization, 93.2% of respondents rated our overall patient safety score as “Acceptable, Very Good or Excellent compared to the national average of 94%.

• Risk is managed through a number of mechanisms in our organization including:
  • Occurrence Reporting and Management

  Accreditation Canada has recognized our Quality Scorecard as a Best Practice and is using our model in their national education sessions.

  All outstanding 26 Recommendations and 3 ROP’s were successfully met with the submission of required reports in February and November 2009.

  Sustainable Governance, Effective Organization, Child and Youth Populations, and Maternal Child Population standards section received 100% compliance rate.
• Complaint Management
• Workplace, Safety and Health
• Accreditation
• HIROC Risk Assessment
• Quality Audits
• Satisfaction surveys
• Failure Mode Effects & Analysis
• Root Cause Analysis

• During the period of 2006/07 to 2008/09, we experienced an increase in the number of occurrences being reported from \textbf{1,346} in 2006/07 to \textbf{1,806} in 2008/09.

• Of the occurrences reported 34\% were falls, 22\% were aggressive/abusive, 14\% were medication variances and 6\% were workplace injury

• The following themes were consistently expressed as concerns in all our consultations activities - they include:
  • Economic stress
  • Access to services
  • Travel issues
  • Communications
  • Mental Health and wellness
  • Chronic Disease Prevention and Management

• Areas expressed as strengths during our consultations included:
  • Caring, committed and knowledgeable staff
  • Primary Health Care facilities
  • Adequate number of programs and services available

• Overall, the Health System Performance survey results show that a large majority of survey respondents agreed that we are responsive to the health care needs of our residents
• In terms of satisfaction levels, survey respondents felt residents were **most satisfied with the friendliness of staff** and **least satisfied with the timeliness of services**

• When reviewing the importance of services, survey respondents felt residents rated the **quality of service as most important**, followed by timeliness of services - delivery methods of NRHA services and programs was rated the **lowest** in importance

• Currently a number of departments are conducting ongoing client satisfaction surveying - the results of these surveys was highlighted

**Chapter 9  -  What has happen since our last Community Health Assessment?**

The 2006-11 Strategic Plan for the NOR-MAN Regional Health Authority (NRHA) is a progressive document that was built on the work and planning that was underway in the region since the Authority’s inception in April 1997.

To achieve our Mission, the Board set out four (4) Board Ends and twenty-eight (28) Strategic Priorities to guide the NRHA for the next five years. The four Board Ends were:

1. Healthy Communities
2. Healthy People
3. Optimal Access to Services
4. Excellence in Patient Safety and Quality of Care

This chapter has confirmed that since our last Community Health Assessment, we have made great strides towards the advancement of our Board Ends and Strategic Priorities.
A series of accomplishments were highlighted for each of the four Board Ends. In addition, a number of challenges were noted:

- Shifting resources to prevention and promotion while maintaining existing services
- As we are not mandated to provide all health services in all NOR-MAN communities, the need for ongoing partnerships with Aboriginal agencies is required
- The need for ongoing improvements and maintenance to our facilities as a result of our old infrastructure
- The need to continue investing in developing Northern Human Resources and recruiting and retaining a qualified workforce
- The need to increase resident knowledge of available health care services and how to access services
- The need to continue to strive for a health care delivery model that is culturally sensitive
- The need to extend Telehealth Services to our Primary Health Care Centres, Moose Lake, Cormorant, Cranberry Portage and Sherridon.

In addition, funding and infrastructure issues were identified as a significant challenge due to our ongoing funding levels and deficit situation in the past several years due to funding pressures including:

- Operating expenses
- Physician remuneration costs
- Northern Patient Transportation Program
- Insufficient basic and specialized equipment allocation
- Aging equipment
- IT challenges
Chapter 10 - What are our next steps?

To ensure that NOR-MAN residents continue to improve their health status, we are recommending that everyone needs to take responsibility for their own health.

As individuals, families, communities and our region as a whole, we all have a role to play to ensure “Healthy People in Healthy Communities.” and... “We Must Continue to Work Together to Improve our Health.”
# Table of Contents

## Forward
- Message from the Board Vice-Chair ............................................................. i
- Message from the Chief Executive Officer ...................................................... ii
- Acknowledgment ............................................................................................ iii
- How to Read this Report .............................................................................. vi

## Summary of Findings......................................................................................... ix

## List of Tables & Figures...................................................................................... xliii

### Chapter 1  What is a Community Health Assessment?
- Background ..................................................................................................... 1-2
- Historical Overview ....................................................................................... 1-3
  - Community Health Assessment Process - 1997/98 ........................................ 1-3
  - Community Health Assessment Process - 2003/04 ........................................ 1-5
- Community Health Assessment Current Process - 2009/10 ............................. 1-6
  - Manitoba Community Health Assessment Network ...................................... 1-6
  - NRHA’s Community Health Assessment Current Process - 2009/10 .......... 1-7
- Accountability Structure ................................................................................ 1-8
- Advisory Team ................................................................................................ 1-9
- Research Team ................................................................................................ 1-9
- District Health Councils ............................................................................... 1-9
- Terms of Reference ....................................................................................... 1-10
- Research Design ............................................................................................ 1-11
- Information Sources ..................................................................................... 1-11
- Data Limitations ............................................................................................ 1-13
- Consultation Process ..................................................................................... 1-14
- Community Consultation Activities ............................................................... 1-15
- Summary ........................................................................................................ 1-17

### Chapter 2  Who is the NOR-MAN Regional Health Authority?
- Overview of the NOR-MAN Regional Health Authority (NRHA) ................. 2-2
- NRHA Organization Structure ....................................................................... 2-3
  - NRHA Board of Directors ........................................................................... 2-3
  - NRHA Senior Management .......................................................................... 2-3
- Overview of NRHA Strategic Directions ........................................................... 2-4
  - Mission Statement ....................................................................................... 2-4
  - Values Statement ........................................................................................ 2-5
  - NRHA Board Ends ..................................................................................... 2-6
  - NRHA Strategic Priorities ........................................................................... 2-7
- Overview of Core Services Provided ............................................................... 2-9
- Overview of Health Service Providers in the Region ....................................... 2-11
- Summary ........................................................................................................ 2-14

### Chapter 3  What does the NOR-MAN Region look like?
- Regional Boundaries ...................................................................................... 3-2
Northern Regional Health Authority Boundaries.......................................................... 3-3
NOR-MAN RHA Districts.............................................................................................. 3-4
NOR-MAN RHA Communities..................................................................................... 3-5
  Cranberry Portage.................................................................................................... 3-6
  Cormorant ............................................................................................................... 3-7
  Easterville and Chemawawin Cree Nation.............................................................. 3-8
  Flin Flon ................................................................................................................... 3-9
  Grand Rapids and Misipawistik Cree Nation.......................................................... 3-11
  Moose Lake and Mosakahiken Cree Nation........................................................... 3-11
  Opaskwayak Cree Nation ....................................................................................... 3-12
  Pukatawagan / Mathias Colomb Cree Nation........................................................ 3-13
  RM of Kelsey .......................................................................................................... 3-13
  Sherridon / Cold Lake ............................................................................................ 3-15
  Snow Lake ............................................................................................................... 3-16
  The Pas .................................................................................................................... 3-17

Chapter 4  
Who are the People of the NOR-MAN Region?

NOR-MAN Population Profile .................................................................................. 4-2
NOR-MAN Aboriginal Profile .................................................................................. 4-3
  NOR-MAN Métis Profile ......................................................................................... 4-5
Saskatchewan Profile ................................................................................................ 4-6
NOR-MAN Population Distribution ...................................................................... 4-7
  Population Density ................................................................................................ 4-8
  Urban/Rural Populations ..................................................................................... 4-9
NOR-MAN Population by Sex and Age Structure ................................................. 4-9
NOR-MAN Population by Community .................................................................. 4-11
NOR-MAN Population Projections ........................................................................ 4-12
NOR-MAN Populations by Social Support Factors .............................................. 4-13
  Legal Marital Status ............................................................................................ 4-13
  Internal/External Migration - Changes in Place of Residence ......................... 4-16
Economic Factors .................................................................................................... 4-17
  Educational Attainment ....................................................................................... 4-17
    Regional Levels of Schooling by Age Group ..................................................... 4-18
    Community Levels of Schooling by Sex ............................................................ 4-19
    Aboriginal Educational Attainment Levels ....................................................... 4-22
  Labour Force Indicators ..................................................................................... 4-23
    Regional Labour Force Indicators ..................................................................... 4-23
    Labour Force Participation Rates by Community .......................................... 4-25
    Employment Rates by Community .................................................................. 4-26
    Unemployment Rates by Community ............................................................... 4-27
Income and Income Sources .................................................................................. 4-27
  Total Income Comparisons ................................................................................. 4-28
  Total Income Sources by Community ................................................................. 4-28
  Median Income .................................................................................................... 4-29
  Average Earnings by Community ...................................................................... 4-30
  Average Earnings For Full Time Employment ................................................... 4-31
## Table of Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Household Income</td>
<td>4-32</td>
</tr>
<tr>
<td>Median Family Income</td>
<td>4-34</td>
</tr>
<tr>
<td>Dependency Ratio</td>
<td>4-36</td>
</tr>
<tr>
<td>Language</td>
<td>4-37</td>
</tr>
<tr>
<td>Aboriginal Language(s)</td>
<td>4-38</td>
</tr>
<tr>
<td>Summary</td>
<td>4-40</td>
</tr>
</tbody>
</table>

### Chapter 5

**How healthy are the people of the NOR-MAN Region?**

- Mortality
  - Total Mortality Rates
  - Premature Mortality Rates
  - Life Expectancy (at birth)
  - Potential Years of Life Lost
  - Infant Mortality
  - Suicide Rates
  - Leading Causes of Death
  - Leading Causes of Cancer Deaths
  - Injury Mortality Rates
  - Leading Causes of Injury Deaths

- Illness Burden / Chronic Diseases
  - Hypertension
  - Ischemic Heart Disease (IHD) Prevalence
  - Stroke
  - Heart Attacks /Acute Myocardial Infarction (AMI)
  - Diabetes
  - Cancer Incidence
  - Cancer Prevalence
  - Arthritis
  - Total Respiratory Morbidity (TRM)
  - Osteoporosis
  - Injury Hospitalization

- Well Being
  - Self-Rated Health

- Functional Health
  - Physical Functioning
  - General Mental Health Scale

- Mental Illness
  - Cumulative Disorders
    - Depression
    - Anxiety Disorders
    - Substance Abuse
    - Personality Disorders
    - Schizophrenia
    - Dementia
    - Adolescents/Teenagers on SSRIs
    - Adolescents/Teenagers on Antidepressants
# Chapter 6  What makes people of the NOR-MAN Region Healthy?

## NOR-MAN Health Determinants

### Income
- Income Inequality: Low Income Cutoffs ...
- Income Inequality: Low Income
- Income Inequality: Median Household Income
- Income Inequality: Average Household Income
- Income Inequality: Median Income of Individuals - Males
- Income Inequality: Median Income of Individuals - Females

### Employment
- Labour Force Participation
- Occupations
- Unemployment Rates
- Youth Unemployment Rates

### Education
- School Attainment
- School Changes

### Living Conditions
- Marital Status
- Living Alone
- Lone Parent Families
- Housing Affordability
- Housing Characteristics

### Healthy Child Development
- Birth Counts
- Birth Weights
- Pre-term Birth Weights
- Teen Birth Rates
- Low Birth Weights
- High Birth Weights (HBW)

### Childhood Immunization Rates
- Childhood Immunization Rates - Age 1 Year
- Childhood Immunization Rates - Age 2 Years
- Childhood Immunization Rates - Age 7 Years

### Breastfeeding Initiation

### Readiness for School

### Personal Health Practices
- Smoking - Tobacco Use
- Alcohol Consumption / Binge Drinking
- Nutrition
- Body Mass Index (BMI)
- Physical Activity
- Cervical Screening
- Mammography Screening

---

2009/2010 NRHA Community Health Assessment

Table of Contents

Page xxxviii
Chapter 7

Where do NOR-MAN residents go for health services and are they receiving quality service?

NOR-MAN Health Services ................................................................. 7-2

Physician Services ............................................................................. 7-3

  Use of Physicians ........................................................................... 7-3
  Ambulatory Visits .......................................................................... 7-4
  Location of Visits to General and Family Practitioners .................. 7-6
  Reasons for Physician Visits .......................................................... 7-8
  Ambulatory Consultation Rates ...................................................... 7-9
  Ambulatory Visits to Specialists ..................................................... 7-10
  Location of Visits to Specialists ..................................................... 7-11
  Physician Visits for those with Mental Illness ............................... 7-12
  Continuity of Care ......................................................................... 7-13

Hospitals - Acute Care Facilities ...................................................... 7-14

  Hospital Bed Supply - Acute Care .................................................. 7-14
  Use of Hospitals ............................................................................ 7-15
  Hospital Separation - Where NRHA Residents Went for
  Hospitalizations ........................................................................... 7-17
  Hospital Separation - Where NRHA Patients Come From ............ 7-17
  Short Stay Hospital Days ............................................................... 7-18
  Long Stay Hospital Days ............................................................... 7-19
  Causes of Hospitalization .............................................................. 7-21
  Ambulatory Care Sensitive Conditions (ACSC) Hospitalizations..... 7-22
  Hospital Separations for Mental Illness Disorders .......................... 7-23
  High Profile Procedures ................................................................. 7-24

  Joint Replacement Surgery ........................................................... 7-24
  Knee Replacement Surgery ............................................................ 7-24
  Hip Replacement Surgery ............................................................. 7-25
  Percutaneous Coronary Intervention (PCI) / Angioplasty and
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stent Insertion</td>
<td>7-26</td>
</tr>
<tr>
<td>Coronary Artery Bypass Surgery (CABG)</td>
<td>7-27</td>
</tr>
<tr>
<td>Cardiac Catheterization (Diagnostic Angiogram)</td>
<td>7-28</td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td>7-29</td>
</tr>
<tr>
<td>Re-admission Rates AMI</td>
<td>7-31</td>
</tr>
<tr>
<td>Antidepressant Prescription Follow-up</td>
<td>7-31</td>
</tr>
<tr>
<td>Diabetes Care: Eye Examinations</td>
<td>7-33</td>
</tr>
<tr>
<td>5 Year Cancer Survival Rates</td>
<td>7-34</td>
</tr>
<tr>
<td>Caesarean Sections</td>
<td>7-35</td>
</tr>
<tr>
<td>Vaginal Birth After C-Section</td>
<td>7-36</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>7-37</td>
</tr>
<tr>
<td>Tonsillectomy / Adenoidectomy</td>
<td>7-38</td>
</tr>
<tr>
<td>Home Care</td>
<td>7-40</td>
</tr>
<tr>
<td>New Home Care Cases</td>
<td>7-40</td>
</tr>
<tr>
<td>Open Home Care Cases</td>
<td>7-41</td>
</tr>
<tr>
<td>Home Care Case Closing Rates</td>
<td>7-42</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>7-43</td>
</tr>
<tr>
<td>Personal Care Homes (PCH)</td>
<td>7-44</td>
</tr>
<tr>
<td>Bed Supply</td>
<td>7-44</td>
</tr>
<tr>
<td>Admission to PCH</td>
<td>7-44</td>
</tr>
<tr>
<td>Levels of Care on Admission</td>
<td>7-45</td>
</tr>
<tr>
<td>Median Length of Stay by Care Levels on Admission</td>
<td>7-46</td>
</tr>
<tr>
<td>Median Wait Times for PCH Admissions</td>
<td>7-47</td>
</tr>
<tr>
<td>Families First Program Risk Factors</td>
<td>7-47</td>
</tr>
<tr>
<td>Alcohol Use by Mother during Pregnancy</td>
<td>7-48</td>
</tr>
<tr>
<td>Smoking Use by Mother during Pregnancy</td>
<td>7-48</td>
</tr>
<tr>
<td>Maternal Depression and Anxiety Disorder combined of Mothers with Newborns</td>
<td>7-48</td>
</tr>
<tr>
<td>Income Support or Financial Difficulties by Mothers with Newborns</td>
<td>7-49</td>
</tr>
<tr>
<td>Less than Grade 12 Education by Mothers with Newborns</td>
<td>7-49</td>
</tr>
<tr>
<td>Where Parents Experienced Relationship Distress</td>
<td>7-50</td>
</tr>
<tr>
<td>With Three or More Risk Factors</td>
<td>7-50</td>
</tr>
<tr>
<td>Screening For and Use of Families First Programs</td>
<td>7-51</td>
</tr>
<tr>
<td>Number of Families Screened for Family First Programs</td>
<td>7-51</td>
</tr>
<tr>
<td>Wait Times</td>
<td>7-52</td>
</tr>
<tr>
<td>Telehealth</td>
<td>7-53</td>
</tr>
<tr>
<td>Northern Patient Transportation Program (NPTP)</td>
<td>7-54</td>
</tr>
<tr>
<td>Emergency Medical Services (EMS)</td>
<td>7-55</td>
</tr>
<tr>
<td>Summary</td>
<td>7-57</td>
</tr>
</tbody>
</table>

Chapter 8  **How well does the NOR-MAN Regional Health Authority serve NOR-MAN residents?**

Human Resources .................................................................................................................. 8-2

Work Life Staff Satisfaction ................................................................................................ 8-3

Physician Profile .................................................................................................................... 8-4
### Fiscal Resources
- Acute Care Costs
- Community Costs
- Personal Care Home Costs
- Administrative Costs
- Information System Costs

### Complaint Management

### Quality Improvement
- NOR-MAN Quality Management Structure
- Quality Scorecards
- Accreditation
- Standards
- Quality Dimensions
- Patient Safety
- Risk Management
- Occurrence Reporting and Management

### Issues / Concerns expressed by our Residents
- Economic Stress
- Access to Services
- Travel Issues
- Communications
- Mental Health and Wellness
- Chronic Disease Prevention and Management

### Health System Performance
- Survey Results by Question

### Client Satisfaction
- Long Term Care Resident Satisfaction Experience
- Rosaire House Client Satisfaction Experience
- Home Care Client Satisfaction Experience
- Hospice and Palliative Care Family Satisfaction Survey
- Support Services Client Satisfaction Experience - Acute Care
- Support Services Client Satisfaction Experience - Long Term Care
- Primary Health Care Client Satisfaction Experience
- Community Mental Health Consumer Satisfaction Experience

### Summary

### Chapter 9

**What has happened since our last Community Health Assessment?**
- Background
- NOR-MAN 2006-11 Strategic Plan
- Priority Setting Criteria
- Situational Assessment
- Progress since the first Community Health Assessment
- Challenges
- Opportunities / Common Themes

### Accomplishments since our last Community Health Assessment

### Current Challenges

---

2009/2010 NRHA Community Health Assessment

Table of Contents
Page xli
Funding / Infrastructure Issues ................................................................. 9-21
Summary ........................................................................................................ 9-23

Chapter 10  What Are Our Next Steps?
As Individuals ............................................................................................ 10-1
As Families .................................................................................................... 10-1
As a Community ............................................................................................ 10-2
As the NOR-MAN Regional Health Authority ........................................... 10-2

References ..................................................................................................... Reference-1

Index .............................................................................................................. Index-1

Appendix A  Terms of Reference .................................................................. A-1
Appendix B  Community Consultation Questions ...................................... B-1
Appendix C  NRHA Organizational Overview ............................................. C-1
Appendix D  NRHA Organizational Chart .................................................... D-1
Appendix E  NRHA Service Overview .......................................................... E-1
Appendix F  NRHA Quality Scorecards ....................................................... F-1
Appendix G  Required Organizational Practices ........................................ G-1
Appendix H  NOR-MAN Youth Health Survey - Quick Facts .................... H-1
List of Tables & Figures

List of Tables:

Chapter 2  Who is the NOR-MAN Regional Health Authority?
Table 2.1  Providers of Health Care Services.................................................................2-12

Chapter 3  What does the NOR-MAN Region Look Like?
Table 3.1  Communities in the NOR-MAN Region by Community Type........................3-6

Chapter 4  Who are the People of the NOR-MAN Region?
Table 4.1  NOR-MAN RHA Population Trends.................................................................4-2
Table 4.2  Registered Indian Population by Sex and Band, 2006.................................4-4
Table 4.3  Registered Indian Populations by Type of Residence, 2006..........................4-4
Table 4.4  Registered Métis Population by Community, 2003.......................................4-6
Table 4.5  Saskatchewan Populations...............................................................................4-7
Table 4.6  Population Density............................................................................................4-8
Table 4.7  Population Density by NOR-MAN District....................................................4-8
Table 4.8  2007/08 NOR-MAN Populations by Age and Community Type...................4-12
Table 4.9  Five Year Mobility Status - Place of Residence.............................................4-17
Table 4.10  Community Levels of Schooling - Ages 15-64 Years.................................4-20
Table 4.11  Community Levels of Schooling - Males Ages 15-64 Years........................4-21
Table 4.12  Community Levels of Schooling - Females Ages 15-64 Years.....................4-21
Table 4.13  Highest Level of Schooling Attainment - Aboriginal Identity by NOR-MAN Community..........................................................4-22
Table 4.14  Highest Level of Schooling Attainment - Aboriginal Identity by NOR-MAN Community..........................................................4-23
Table 4.15  Composition of Total Income for 2006 vs. 2001........................................4-29
Table 4.16  Median Income by Community....................................................................4-30
Table 4.17  Language(s) First Learned and Still Understood........................................4-37

Chapter 5  How Healthy Are The People Of The NOR-MAN Region?
Table 5.1  Premature Mortality Rates.............................................................................5-3
Table 5.2  Life Expectancy Chart....................................................................................5-4
Table 5.3  Life Expectancy Chart by NOR-MAN District..............................................5-4
Table 5.4  2000 - 2005 Top 5 Cancer Mortalities - Males............................................5-11
Table 5.5  2000 - 2005 Top 5 Cancer Mortalities - Females..........................................5-11
Table 5.6  Leading Cause of Injury Deaths.................................................................5-13
Table 5.7  Cancer Incidence Rate per 100,000...............................................................5-24
Table 5.8  Leading Cause of Injury Hospitalizations: NOR-MAN.................................5-30

Chapter 6  What makes people of the NOR-MAN Region healthy?
Table 6.1  Income Inequality: Low Income..................................................................6-3
Table 6.2  Income Inequality: Income Status (LICO) by NOR-MAN Districts for 2006....6-4
Table 6.3  Income Inequality: Median Household Income by NOR-MAN Districts........6-5
Table 6.4  Income Inequality: Average Household Income by NOR-MAN Districts........6-6
Table 6.5  Income Inequality: Median Income - Males by NOR-MAN Districts...............6-7
Table 6.6  Income Inequality: Median Income - Females by NOR-MAN Districts..........6-8
Table 6.7  Tobacco Smoking Rates by Sex.................................................................6-35

2009/2010 NRHA Community Health Assessment
List of Tables and Figures
Page xliii
Table 6.8  Average Daily Consumption of Fruits and Vegetables by Sex ......................................6-39
Table 6.9  Body Mass Index Rates by Sex............................................................................................6-41
Table 6.10  Total Physical Activity Levels by Sex ................................................................................6-42
Table 6.11  H1N1 NOR-MAN Vaccine Report, 01/09/2009 to 31/01/2010.........................................6-50
Table 6.12  Exposure to Second Hand Smoke ......................................................................................6-54

Chapter 7 Where do NOR-MAN residents go for health services and are they receiving quality service?

Table 7.1  Bed Type by NOR-MAN Facility ..........................................................................................7-15
Table 7.2  Ambulatory Care Sensitive Conditions by NOR-MAN District .........................................7-22
Table 7.3  Knee Replacement Surgery by NOR-MAN District ..........................................................7-24
Table 7.4  Hip Replacement Surgery by NOR-MAN District .............................................................7-25
Table 7.5  Percutaneous Coronary Interventions by NOR-MAN District .............................................7-26
Table 7.6  Coronary Artery Bypass Surgery Rates by NOR-MAN District ..........................................7-28
Table 7.7  Cardiac Catheterization Rates by NOR-MAN District .......................................................7-29
Table 7.8  Cataract Surgery Rates by NOR-MAN District .....................................................................7-30
Table 7.9  Cancer Survival Rates - Males...............................................................................................7-34
Table 7.10  Cancer Survival Rates - Females ........................................................................................7-35
Table 7.11  Vaginal Births after Caesarean Section by NOR-MAN District ........................................7-37
Table 7.12  NRHA Wait Times ............................................................................................................7-52
Table 7.13  NPTP Travel by Physician Specialty, The Pas ..................................................................7-55
Table 7.14  NPTP Travel by Physician Specialty, Flin Flon .................................................................7-55

Chapter 8 How well does the NOR-MAN Regional Health Authority serve our residents?

Table 8.1  Acute Care Costs by RHA ...................................................................................................8-5
Table 8.2  Community Costs by RHA ..................................................................................................8-5
Table 8.3  Personal Care Home Costs by RHA ....................................................................................8-6
Table 8.4  NRHA Health System Performance Survey, 2009/10 - Question 1.................................8-25
Table 8.5  NRHA Health System Performance Survey, 2009/10 - Question 2 .....................................8-25
Table 8.6  NRHA Health System Performance Survey, 2009/10 - Question 3 .....................................8-25
Table 8.7  NRHA Health System Performance Survey, 2009/10 - Question 4 .....................................8-26
Table 8.8  NRHA Health System Performance Survey, 2009/10 - Question 5 .....................................8-26
Table 8.9  NRHA Health System Performance Survey, 2009/10 - Question 6 .....................................8-26
Table 8.10 NRHA Health System Performance Survey, 2009/10 - Question 7 .....................................8-26
Table 8.11 NRHA Health System Performance Survey, 2009/10 - Question 8 .....................................8-26
Table 8.12 NRHA Health System Performance Survey, 2009/10 - Question 9 .................................8-27
Table 8.13 NRHA Health System Performance Survey, 2009/10 - Question 10 ..............................8-27
Table 8.14 NRHA Health System Performance Survey, 2009/10 - Question 11 ..............................8-27
Table 8.15 NRHA Health System Performance Survey, 2009/10 - Question 12 ..............................8-27
Table 8.16 NRHA Health System Performance Survey, 2009/10 - Question 13 ..............................8-27

List of Figures:

Chapter 3 What Does The NOR-MAN Region Look Like?

Figure 3.1  Manitoba Regional Health Authorities ...........................................................................3-2
Figure 3.2  Northern Regional Health Authority Regions .................................................................3-3
Figure 3.3  NOR-MAN Regional Health Authority Regional Boundaries .......................................3-4
Figure 3.4  NOR-MAN Regional Health Authority Districts by Community .................................3-5
Chapter 4  Who are the People of the NOR-MAN Region?

Figure 4.1  Provincial Aboriginal Population Percentages by RHA, 2006 Census ......................... 4-3
Figure 4.2  Provincial Aboriginal Population Percentages, 2006 Census ........................................ 4-5
Figure 4.3  NOR-MAN Population Percentages by Community ......................................................... 4-7
Figure 4.4  NOR-MAN Population Breakdown by Sex ................................................................. 4-9
Figure 4.5  NOR-MAN Population Breakdown by Age and Sex ..................................................... 4-10
Figure 4.6  Projected Population Pyramid ...................................................................................... 4-12
Figure 4.7  Legal Marital Status ........................................................................................................ 4-13
Figure 4.8  Legal Marital Status - Single by Community ................................................................. 4-13
Figure 4.9  Legal Marital Status - Married by Community ............................................................... 4-14
Figure 4.10  Legal Marital Status - Separated by Community ......................................................... 4-14
Figure 4.11  Legal Marital Status - Divorced by Community .......................................................... 4-15
Figure 4.12  Legal Marital Status - Widowed by Community ......................................................... 4-15
Figure 4.13  Highest Level of Schooling Attainment - Ages 15 - 24 .............................................. 4-18
Figure 4.14  Highest Level of Schooling Attainment - Ages 25 - 64 ............................................... 4-18
Figure 4.15  Highest Level of Schooling Attainment - Ages 65+ ................................................... 4-19
Figure 4.16  Labour Force Indicator .............................................................................................. 4-24
Figure 4.17  Labour Force Indicator - Males ..................................................................................... 4-24
Figure 4.18  Labour Force Indicator - Females ................................................................................ 4-25
Figure 4.19  Labour Force Indicators by Community - Participation Rate ..................................... 4-25
Figure 4.20  Labour Force Indicators by Community - Employment Rate .................................... 4-26
Figure 4.21  Labour Force Indicators by Community - Unemployment Rate .............................. 4-27
Figure 4.22  Composition of Total Income ..................................................................................... 4-28
Figure 4.23  Average Earnings by Community ............................................................................... 4-31
Figure 4.24  Average Earnings - Worked Full-Time by Community ............................................... 4-32
Figure 4.25  Median Household Income ........................................................................................ 4-33
Figure 4.26  Median Family Incomes by Family Type ..................................................................... 4-35
Figure 4.27  Population Dependency Ratio .................................................................................... 4-36
Figure 4.28  Aboriginal Language(s) Spoken at Home ................................................................. 4-39
Figure 4.29  Aboriginal language(s) as Mother Tongue ................................................................. 4-39

Chapter 5  How Healthy Are The People of The NOR-MAN Region?

Figure 5.1  Total Mortality Rates by RHA ....................................................................................... 5-2
Figure 5.2  Infant Mortality Rates by RHA ...................................................................................... 5-6
Figure 5.3  Suicide Rates by RHA .................................................................................................. 5-7
Figure 5.4  Leading Cause of Death .............................................................................................. 5-9
Figure 5.5  Leading Cause of Death by Sex ................................................................................... 5-10
Figure 5.6  Hypertension Treatment Prevalence Rates ................................................................. 5-15
Figure 5.7  Hypertension Treatment Prevalence Rates by NOR-MAN District ............................ 5-15
Figure 5.8  Ischemic Heart Disease Prevalence ............................................................................. 5-16
Figure 5.9  Ischemic Heart Disease by NOR-MAN District .......................................................... 5-17
Figure 5.10  Stroke Rates per 1,000 Residents ............................................................................ 5-18
Figure 5.11  Stroke Rates by NOR-MAN District .......................................................................... 5-19
Figure 5.12  AMI (Heart Attack) Rates per 1,000 Residents ......................................................... 5-19
Figure 5.13  AMI (Heart Attack) Rates per 1,000 Residents by NOR-MAN District .................. 5-20
Figure 5.14  Diabetes Rate ............................................................................................................ 5-21
Figure 5.15  Diabetes Treatment Prevalence by NOR-MAN District ............................................ 5-21
Figure 5.16  Cancer Incidence - Males ......................................................................................... 5-23
Figure 5.17  Cancer Incidence - Females ....................................................................................... 5-24
Figure 5.18  Cancer Prevalence - Males ....................................................................................... 5-26
### Chapter 6

**What makes people of the NOR-MAN Region healthy?**

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Income Inequality: Median Income</td>
<td>6-5</td>
</tr>
<tr>
<td>6.2</td>
<td>Income Inequality: Average Household Income</td>
<td>6-6</td>
</tr>
<tr>
<td>6.3</td>
<td>Income Inequality: Median Individual Income - Males</td>
<td>6-7</td>
</tr>
<tr>
<td>6.4</td>
<td>Income Inequality: Median Individual Income - Females</td>
<td>6-8</td>
</tr>
<tr>
<td>6.5</td>
<td>Top Six Occupation Comparisons</td>
<td>6-9</td>
</tr>
<tr>
<td>6.6</td>
<td>Top Three Occupation Comparisons - Males</td>
<td>6-10</td>
</tr>
<tr>
<td>6.7</td>
<td>Top Four Occupation Comparisons - Females</td>
<td>6-11</td>
</tr>
<tr>
<td>6.8</td>
<td>Youth Unemployment Rates - Males</td>
<td>6-12</td>
</tr>
<tr>
<td>6.9</td>
<td>Youth Unemployment Rates - Females</td>
<td>6-13</td>
</tr>
<tr>
<td>6.10</td>
<td>School Changes by NOR-MAN District</td>
<td>6-15</td>
</tr>
<tr>
<td>6.11</td>
<td>Housing Affordability - Tenant Spending</td>
<td>6-17</td>
</tr>
<tr>
<td>6.12</td>
<td>Housing Affordability by NOR-MAN District - Tenant Spending</td>
<td>6-17</td>
</tr>
<tr>
<td>6.13</td>
<td>Housing Affordability - Owner Spending</td>
<td>6-17</td>
</tr>
<tr>
<td>6.14</td>
<td>Housing Affordability by NOR-MAN District - Owner Spending</td>
<td>6-18</td>
</tr>
<tr>
<td>6.15</td>
<td>Dwellings With More Than One Person Per Room</td>
<td>6-18</td>
</tr>
<tr>
<td>6.16</td>
<td>Dwellings Requiring Major Repairs</td>
<td>6-19</td>
</tr>
<tr>
<td>6.17</td>
<td>Preterm Birth Weight Rates</td>
<td>6-21</td>
</tr>
<tr>
<td>6.18</td>
<td>Teen Birth Rates - Ages 15-19 Years</td>
<td>6-22</td>
</tr>
<tr>
<td>6.19</td>
<td>Teen Birth Rates by NOR-MAN District</td>
<td>6-22</td>
</tr>
<tr>
<td>6.20</td>
<td>High Birth Weights by NOR-MAN District</td>
<td>6-24</td>
</tr>
<tr>
<td>6.21</td>
<td>Completed Childhood Immunizations - Age 1 Year</td>
<td>6-25</td>
</tr>
<tr>
<td>6.22</td>
<td>Completed Childhood Immunizations - Age 1 Year by NOR-MAN District</td>
<td>6-26</td>
</tr>
<tr>
<td>6.23</td>
<td>Completed Childhood Immunizations - Age 2 Years</td>
<td>6-27</td>
</tr>
<tr>
<td>6.24</td>
<td>Completed Childhood Immunizations - Age 2 Years by NOR-MAN District</td>
<td>6-27</td>
</tr>
<tr>
<td>6.25</td>
<td>Completed Childhood Immunizations - Age 7 Years</td>
<td>6-28</td>
</tr>
<tr>
<td>6.26</td>
<td>Completed Childhood Immunizations - Age 7 Years by NOR-MAN District</td>
<td>6-29</td>
</tr>
<tr>
<td>6.27</td>
<td>Breastfeeding Initiation Rates by NOR-MAN District</td>
<td>6-30</td>
</tr>
<tr>
<td>6.28</td>
<td>Percentage of Kindergarten Children “Not Ready” (bottom 10%) for School</td>
<td>6-32</td>
</tr>
<tr>
<td>6.29</td>
<td>Percentage of Kindergarten Children “Very Ready” (top 30%) for School</td>
<td>6-32</td>
</tr>
<tr>
<td>6.30</td>
<td>Tobacco Smoking Rates</td>
<td>6-34</td>
</tr>
<tr>
<td>6.31</td>
<td>Tobacco Smoking Rates by NOR-MAN District</td>
<td>6-35</td>
</tr>
<tr>
<td>6.32</td>
<td>Binge Drinking Rates</td>
<td>6-37</td>
</tr>
<tr>
<td>6.33</td>
<td>Average Daily Consumption of Fruits and Vegetables</td>
<td>6-38</td>
</tr>
<tr>
<td>6.34</td>
<td>Body Mass Index Rates</td>
<td>6-40</td>
</tr>
<tr>
<td>6.35</td>
<td>Total Activity Level (Work+Leisure+Travel) Rates</td>
<td>6-42</td>
</tr>
</tbody>
</table>
Chapter 7 Where do NOR-MAN residents go for health services and are they receiving quality service?

Figure 7.1 Use of Physicians ................................................................. 7-3
Figure 7.2 Use of Physicians by NOR-MAN District ......................... 7-4
Figure 7.3 Ambulatory Visit Rates .................................................... 7-5
Figure 7.4 Ambulatory Visit Rates by NOR-MAN District ............... 7-5
Figure 7.5 Location of Visits to GP/FPs ............................................. 7-6
Figure 7.6 Location of Visits to GP/FPs by NOR-MAN District, 2000/01 7-7
Figure 7.7 Location of Visits to GP/FPs by NOR-MAN District, 2005/06 7-7
Figure 7.8 Cause of Physician Visits ................................................... 7-8
Figure 7.9 Ambulatory Consultation Rates ....................................... 7-9
Figure 7.10 Ambulatory Consultation Rates by NOR-MAN District .... 7-9
Figure 7.11 Ambulatory Visit Rates to Specialists ............................. 7-10
Figure 7.12 Ambulatory Visit Rates to Specialists by NOR-MAN District 7-11
Figure 7.13 Location of Visits to Specialist ........................................ 7-12
Figure 7.14 Continuity of Care Rates .................................................. 7-13
Figure 7.15 Continuity of Care Rates by NOR-MAN District .......... 7-14
Figure 7.16 Use of Hospitals .............................................................. 7-15
Figure 7.17 Use of Hospitals by NOR-MAN District ......................... 7-16
Figure 7.18 Where RHA Residents Went for Hospital Separations .... 7-17
Figure 7.19 Where RHA Residents Came From: Separations .......... 7-18
Figure 7.20 Hospital Days Used in Short Stays .................................. 7-18
Figure 7.21 Hospital Days Used in Short Stays by NOR-MAN District 7-19
Figure 7.22 Hospital Days Used in Long Stays ................................. 7-20
Figure 7.23 Hospital Days Used in Long Stays by NOR-MAN District 7-20
Figure 7.24 Causes of Hospitalization, North .................................... 7-21
Figure 7.25 Hospital Separations for Mental Illness Disorders - Cumulative Disorders 7-23
Figure 7.26 Antidepressant Prescription Follow-up ......................... 7-32
Figure 7.27 Antidepressant Prescription Follow-up by NOR-MAN District 7-32
Figure 7.28 Diabetes Care: Eye Exam ................................................. 7-33
Figure 7.29 Diabetes Care: Eye Exam by NOR-MAN District .......... 7-33
Figure 7.30 Caesarean Section Rates .................................................. 7-35
Figure 7.31 Caesarean Section Rates by NOR-MAN District .......... 7-36
Figure 7.32 Hysterectomy Rates .......................................................... 7-38
Figure 7.33 Tonsillectomy and Adenoidectomy Rates ..................... 7-39
Figure 7.34 Tonsillectomy and Adenoidectomy Rates by NOR-MAN District 7-39
Figure 7.35 New Home Care Cases by NOR-MAN District ............. 7-41
Figure 7.36 Open Home Care Cases .................................................. 7-41
Figure 7.37 Open Home Care Cases by NOR-MAN District .......... 7-42
| Figure 7.38 | Home Care Case Closing Rates by NOR-MAN District ................................................. 7-42 |
| Figure 7.39 | Average Length of Home Care Cases ............................................................................ 7-43 |
| Figure 7.40 | Average Length of Home Care Cases by NOR-MAN District ......................................... 7-43 |
| Figure 7.41 | Levels of Care on Admission to PCH Aged 75 and Older ........................................... 7-45 |
| Figure 7.42 | Median Length of Stay (years) by Level of Admission ..................................................... 7-46 |
| Figure 7.43 | MBTelehealth Overall Network Utilization Summary - NOR-MAN ................................ 7-53 |
| Figure 7.44 | NPTP Warrants by Type of Referral ............................................................................... 7-54 |

**Chapter 8**

**How well does the NOR-MAN Regional Health Authority serve our residents?**

| Figure 8.1 | Regional Staffing Profile .............................................................................................. 8-2 |
| Figure 8.2 | Occurrence Reporting by Type ...................................................................................... 8-18 |
Chapter 1

What is a Community Health Assessment?

Our Community Health Assessment is the cornerstone to all planning in the region. According to Manitoba Health’s Community Health Assessment Guidelines, 2009, a well-planned and thorough Community Health Assessment (CHA) will provide health authorities with evidence required to set priorities, choose actions and evaluate results. It will also examine current and future needs, capacities and community expectations within the health region.

This chapter will explore the following:

- Background on CHA requirements in Manitoba
- Overview of what CHA means
- Historical review of past CHA’s undertaken
- Review of the 2009/10 CHA process both provincially and regionally

A Community Health Assessment (CHA) is the cornerstone on which the future activities and plans of the NOR-MAN Regional Health Authority are built.
Introduction to the Community Health Assessment

Background

The Community Health Assessment process was legislated with the creation of the Regional Health Authorities of Manitoba in 1996. The NOR-MAN Regional Health Authority (NRHA) completed our first comprehensive Community Health Assessment in 1997/98 and a second report in 2003/04. This report is our third comprehensive Community Health Assessment since we became a Regional Health Authority in 1997.

The Community Health Assessment process is based on a five-year cycle that involves the collection, analysis and interpretation of information (qualitative) and statistical data (quantitative) on areas of community health issues and strengths.

What is a Community Health Assessment?

A Community Health Assessment (CHA) is a dynamic, ongoing process undertaken to identify the strengths and needs of the population and to enable community-wide establishment of health priorities.

According to the Manitoba Health’s 2009 Community Health Assessment Guidelines, the purpose of the CHA is to collect, analyze and present information so that the health of the population can be understood and improved. It also ensures that health services are planned according to evidence. The information from the CHA helps to:

- Provide baseline information about the health status of community residents

Community Health Assessment is

An active way to identify the strengths and needs of the region.

An open method that asks for community input.

An ongoing way that identifies, measures and tracks the health of NOR-MAN residents.

A joint facts-based method that gives direction to long-term health planning.

CHA Goals

1. to understand the health of residents
2. to be responsive to local issues
3. to plan health services informed by evidence
4. to track changes over time

(Manitoba Health)
• Encourage collaboration with a wide variety of partners and stakeholders involved in decision-making processes within the health care system

• Focus public discussion on health issues and expectations of the health system and increase understanding about difficult choices that need to be made

• Provide insight into fundamental causes and pathways of disease and ill health and provide population-based information to identify opportunities for disease prevention, health promotion and health protection

• Influence evidence-informed decision-making and priority setting in the health system

• Assess health outcomes and results in the longer term

• Provide information on which to base funding allocations

• Guide policy and program development

• Assist in mapping out links and opportunities to collaborate with others

Historical Overview

Community Health Assessment Process - 1997/98

The NOR-MAN Regional Health Authority (NRHA) completed our first comprehensive Community Health Assessment process between May 1997 and January 1998. This was the first time a comprehensive assessment was done in our region. The information collected during this process provided us with a baseline of information and statistical data on our region. This information formed the baseline from which...
all future NRHA planning and decision-making has been done.

In 1997/98, our Community Health Assessment used a participatory process that involved the establishment of community committees in each of the participating NRHA communities. At the request of the communities, we agreed to author both a regional report as well as separate community reports. The community of Pukatawagan/Mathias Colomb Cree Nation was not included in the study as the legislative boundary changes transferring the community from the Burntwood RHA region to the NOR-MAN RHA region was in progress at the time of the assessment.

The communities of The Pas, Opaskwayak Cree Nation and Flin Flon did not receive separate community reports from the NRHA, as they were involved in an assessment done in 1996/97 for the Community Nurse Resource Centre concept that was being implemented in those communities. The information from this report (prepared by WESTARC Group Inc.) was highlighted in our comprehensive CHA report.

During our first community health assessment process, the following areas were explored:

- The NOR-MAN Region and its Environment
- The People of the NOR-MAN Region
- Population Health and Illness Statistics
- The Community Voice (survey & focus groups)
- Inventory of Health & Social Services in the NOR-MAN Region
Community Health Assessment Process - 2003/04

The 2003/04 Community Health Assessment process was built from the work of our first Community Health Assessment as well as ongoing CHA activities. The information collected provided us with a second baseline of information and data to assist in the development of the 2006-11 Strategic Plan.

The methodology used included three main areas of focus:

1. **Collection and analysis of statistical data** - Gathering the existing data on demographics, health status, determinants of health, health service utilization and health system performance from a variety of national, provincial and regional sources.

2. **Collection and analysis of data on areas where information is poor or unavailable** - This was done through a Community Health Telephone survey, which seven RHA’s participated in, focusing on three areas: (1) Quality of Life; (2) Safety/ Injury Prevention; and (3) Health System Performance.

3. **Collection and analysis of qualitative data on health needs and priorities** - This was done through a variety of community consultation methods including: public forums; focus groups; forces of change assessment; key knowledge and informant interviews; and health system performance staff and physician surveys and focus groups.

The report was structured around the following questions:

- What is a Community Health Assessment?
• Who is the NOR-MAN Regional Health Authority?
• What does the NOR-MAN Region look like?
• Who are the people of the NOR-MAN Region?
• How healthy are the people of the NOR-MAN Region?
• What makes people of the NOR-MAN Region healthy?
• Where do NOR-MAN residents go for healthy services?
• How well does the NOR-MAN Regional Health Authority serve NOR-MAN residents?
• Which issues can we work on?

The NRHA Board of Directors established an accountability structure to drive the CHA process which included an Advisory Team, Research Team and a community ownership link through our District Health Councils.

Community Health Assessment Current Process - 2009/10

Manitoba Community Health Assessment Network

The NRHA participates at the provincial level on Manitoba’s Community Health Assessment Network (CHAN). CHAN was established to provide a forum for health authorities to work collaboratively and steer the CHA process for Manitoba.

The role of CHAN is intended for Manitoba Health and the RHA’s to work together to coordinate a standardized Community Health Assessment (CHA) process for Manitoba. Over the past several years, CHAN has been building
on the lessons learned from previous CHA processes and has achieved a number of significant outcomes:

- **CHA Funding** - each RHA was provided with one time funding by Manitoba Health to assist with the coordination of their Community Health Assessment and to undertake comprehensive community consultations.

- **Community Health Assessment Guidelines 2009** document was developed and published by CHAN. This guide set out a standardized process to assist regions to carry out a comprehensive Community Health Assessment.

- **CHAN Indicators Working Group** was formed and recommended a common and comparable set of indicators (108) that all RHA’s were required to report on as part of their CHA.

- **Regional Profile Document** was then compiled by Manitoba Health and was provided to each RHA providing data on a specific set of core indicators.

- **CHAN Community Consultation Working Group** was established to support all RHA’s with their community consultation process. They also hosted a number of skill building workshops for CHAN members.

- **CHAN Evaluation Working Group** was established to develop and coordinate an outcome evaluation of this third CHA process.

**NRHA’s Community Health Assessment Current Process - 2009/10**

Our third report, and the work leading up to its publication, reflects our attempt to develop a...
greater understanding of the health issues and concerns of NOR-MAN residents. This report presents the results of our Community Health Assessment process that we conducted between December 2008 and March 2010.

Our process was built on the premise that for a Community Health Assessment to be successful, it should not be done in isolation and needs to be done with the community rather than to the community.

Our process has been designed to ensure the systematic gathering of statistical data, solicitation of perspectives from community members and ongoing collection of information about health services and other community resources.

Accountability Structure

The NRHA Board of Directors established the following Accountability Structure to coordinate the CHA process in 2009/10:

**NRHA Community Health Assessment Accountability Structure**

- NOR-MAN Communities
- NRHA Board of Directors
- NRHA Community Health Assessment Advisory Team
- NRHA Community Health Assessment Working Teams
  - CHA Research Team
  - Community Linkages - District Health Councils
Advisory Team

The NRHA Community Health Assessment Advisory Team consisted of representatives from the Board of Directors, Senior and Regional Management, the Medical Officer of Health and a number of community partners including Swampy Cree Tribal Council, Manitoba Métis Federation, Manitoba Keewatinook Ininew Okimowin (MKO), Mamawetan Churchill River Regional Health Authority, and University College of the North (UCN).

The primary function of the Advisory Team was to provide input and direction into the development of the goals and objectives for our CHA process and to bring forward information on current and future health needs from various sources.

Research Team

The NRHA Community Health Assessment Research Team consisted of the chair of the Advisory Team, CHA Coordinator, Medical Officer of Health, Regional Care Advocate-Men’s Team, CHA Data Programmer, Regional Community Health Developers and a representative from both the MMF and MKO.

The primary function of the Research Team was to assist in the development of the 2009/10 CHA action plan/ timelines, and to actively participate in the planned consultation activities at both the regional and community levels.

District Health Councils

The District Health Councils provided the communication link to their community and helped coordinate and provide input on community consultation activities.
Terms of Reference

The CHA Advisory and Research Teams established Terms of Reference to guide their work including the following Mandate, Goal and Objectives (see Appendix A):

Mandate:
• To complete a comprehensive Community Health Assessment of the NOR-MAN region that will provide the data necessary to link health needs with the resources available to achieve positive health outcomes

Goal:
• To provide a solid base of facts and data to guide decision making within the NOR-MAN Regional Health Authority

Objectives:
• To provide a third baseline of information from which the NRHA can compare and contrast health status changes over time

• To present initial findings to community residents and other stakeholders in order to better understand reasons for health status changes and potential new emerging health care issues

• To involve community residents and groups in the planning process as a vehicle for community development and action

• To use the information collected to help set priorities for future planning based on sound evidence and consultation with key stakeholders (NRHA 5 Year Strategic Plan)

• To use the information collected to guide policy and program development within the NOR-MAN Regional Health Authority (NRHA Annual Health Plan)
• To provide information on which to base funding allocations

• To widely disseminate the report so that other community agencies can have information for their planning

• To ensure structured and ongoing processes for Community Health Assessment

Research Design

The research design for the 2009/10 Community Health Assessment was based on the following principles and assumptions:

• In order to understand all of the factors that contribute to individual and community well-being, a broad definition of health was adopted

• A multi-method research approach would be used to allow the CHA Research Team to assess needs from different perspectives

• The CHA would incorporate a community development approach in its research design

• There would be wide community consultation throughout all phases of the project

• The report will not sit on the shelf. It would be widely disseminated and form the basis for strategic planning

Information Sources

Quality data is the foundation for a comprehensive community health assessment process. A variety of existing (secondary) data sources were reviewed including (specific citations are included throughout the report):

• Canadian Institute for Health Information
  • 2009 Health Indicator Report
- **Department of Indian Affairs and Northern Development**
  - Registered Indian Population by Sex and Residence (2006)

- **Manitoba Bureau of Statistics**
  - Manitoba Regional Health Authorities
    Population Projections (June 1, 2006 to June 1, 2036)
  - Manitoba Regional Health Authorities First Nations Population Projections (June 1, 2006 to June 1, 2036)

- **Manitoba Centre for Health Policy**
  - Manitoba RHA Indicators Atlas (2009)
  - Patterns of Regional Mental Illness Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study (2004)
  - Sex Differences in Health Status, Health Care Use and Quality of Care: A Population-Based Analysis for Manitoba’s Regional Health Authorities (2005)

- **Manitoba Health**
  - NOR-MAN Regional Profile (2008/09)
  - HINI Influenza Pandemic, Manitoba and Canada (2009)

- **Manitoba Intergovernmental Affairs**
  - Community Profiles

- **Manitoba Métis Federation**
  - NOR-MAN Regional Health Authority
  - Regional Youth Health Survey
• NOR-MAN Quality Scorecards

• **Prairie Women’s Health Centre**
  • A Profile of Women’s Health in Manitoba

• **Saskatchewan Health**
  • Community Demographics

• **Statistics Canada**
  • Community Profiles (2006)
  • Aboriginal Population Profile (2006)
  • Aboriginal People’s Survey (2006)
  • Aboriginal Children’s Survey (2006)

• **Other Reports**
  • Manitoba First Nations Regional Longitudinal Survey Report, Assembly of Manitoba Chiefs (2002/03)
  • Student Smoking in Manitoba First Nations Communities, First Nation Inuit Health Branch (2007)
  • First Nation and Inuit Regional Survey, First Nations and Inuit Regional Health Survey National Steering Committee (1999)
  • First Nation Children’s Environmental Health, Union of Ontario Indians Anishinabek Health Secretariat (2009)

**Data Limitations**

There are some data limitations that must be noted when reading this report:

• For the NOR-MAN region, it is difficult to give an accurate population count. This is due to the fact that each data source reports a different population total.

• Physician data from the Manitoba Centre for Health Policy Reports must be interpreted with caution. The completeness of data for physician services was noted as a concern, particularly among physicians working in rural and northern areas. Many of these
physicians are paid by alternative payments systems (e.g. salary) and may not be completing ‘shadow billing’ claims for all services they provide.

- The survey sample from the Canadian Community Health Survey (CCHS) does not include any residents of First Nation communities (though Aboriginal peoples living in other areas may well be included in the survey).

Consultation Process

Community consultation was key to the successful completion of our third community health assessment process. To this end, a series of public consultation activities were held with each community in the region as well as with north-eastern Saskatchewan communities.

All of the various community consultation activities that were used during our Community Health Assessment were participatory, and involved local community members.

The individuals, groups and organizations contacted to participate in the consultation activities represented a wide variety of community interests including seniors, adults, youth, service organizations, business owners, health care providers, local government, environment, RCMP, justice and education.

A letter was sent out to all First Nation Chiefs informing them of our Community Health Assessment and community consultation process as well as requesting permission to conduct consultations on Reserve. In addition, prior to conducting a consultation with Band membership, we also sent out the consultation package advising the Chief of the consultation activity and the questions that would be asked.
Community Consultation Activities:

The following community consultations activities were held:

- **CHA Retreat** - was held to kick off the Community Health Assessment process in December 2008. Participants included NRHA Board of Directors, Senior Management, CHA Advisory Team, CHA Research Team and District Health Councils members

- **Forces of Change Assessment** - Ten (10) sessions were completed in each of the NRHA communities including Wanless with the exception of Pukatawagan/Mathias Colomb CN

- **Key Knowledge Interviews** - Thirty (30) interviews were completed throughout the region and in northeastern Saskatchewan

- **Key Informant Interviews** - Twenty-five (25) interviews were completed throughout the region and in northeastern Saskatchewan

- **Women’s Health Focus Group** - was held in conjunction with the Prairie Women’s Health Centre via telehealth connection with The Pas, Flin Flon and Snow Lake

- **Regional Youth Health Surveys** - were completed in all schools in the region in grades six (6) to twelve (12)

- **Health System Performance and Health Priorities Staff Survey** - was distributed to NRHA staff - (33% response rate)

- **Health System Performance and Health Priorities Physician Survey** - was distributed to all physicians providing services for the NRHA - (54% response rate)
• Health System Performance and Health Priorities Partners Survey - was distributed to 168 partner organizations - (33% response rate)

(Consultation Questions – refer to Appendix B)

Our Community Health Assessment report merges both quantitative and qualitative data that has been analyzed and adds the community voice to provide us with a comprehensive report.

The following diagram shows how the different pieces of our community health assessment fit together… “how it paints our picture and tells our story.”

Community Participation

Although we are required to complete a comprehensive Community Health Assessment every five years, our CHA is an ongoing process that provides us with the ongoing evidence needed to strive for our mission of: “Healthy People in Healthy Communities... Working Together to Improve our Health.”

It is hoped that this report will be used by residents and our many partners to help understand and plan where we are and where we hope to be in the future.
Summary

The Community Health Assessment process was legislated with the creation of the Regional Health Authorities of Manitoba in 1996. The NOR-MAN Regional Health Authority (NRHA) completed our first comprehensive Community Health Assessment in 1997/98 and a second report in 2003/04. This report is our third comprehensive Community Health Assessment since we became a Regional Health Authority in 1997.

The CHA process is based on a five-year cycle that involves the collection, analysis and interpretation of information (qualitative) and statistical data (quantitative) on areas of community health issues and strengths.

We completed our first comprehensive CHA between May 1997 and January 1998. This was the first time a comprehensive assessment was done in our region. The information collected during this process provided the NRHA with a baseline of information and statistical data in the following areas:

- The NOR-MAN Region and its Environment
- The People of the NOR-MAN Region
- Population Health and Illness Statistics
- The Community Voice (survey & focus groups)
- Inventory of Health & Social Services in the NOR-MAN Region

Our second report in 2003/04 was built on the work of the first Community Health Assessment as well as ongoing CHA activities. The report addressed the following questions:

- What is a Community Health Assessment?
- Who is the NOR-MAN Regional Health Authority?
• What does the NOR-MAN Region look like?
• Who are the people of the NOR-MAN Region?
• How healthy are the people of the NOR-MAN Region?
• What makes people of the NOR-MAN Region healthy?
• Where do NOR-MAN residents go for healthy services?
• How well does the NOR-MAN Regional Health Authority serve NOR-MAN residents?
• Which issues can we work on?

The Manitoba’s Community Health Assessment Network (CHAN) has been working at the provincial level to provide a forum for health authorities to work collaboratively and steer the CHA process for Manitoba.

CHAN’s role is intended for Manitoba Health and all RHA’s to work together to coordinate a standardized Community Health Assessment (CHA) process for Manitoba. A set of 108 core indicators were agreed to and all RHA’s are required to report on them as part of their CHA.

Our third report, and the work leading up to its publication, reflects our attempt to develop a greater understanding of the health issues and concerns of the NOR-MAN residents. This report presents the results of our third Community Health Assessment process that we conducted between December 2008 and March 2010.

The NRHA Board of Directors established an Accountability Structure and Terms of Reference for 2009/10 CHA process which included the establishment of:

• Advisory Team
• Research Team
• Community linkages through our District
Health Councils

This report is based on information from the following sources:

- Canadian Institute for Health Information
- Department of Indian Affairs and Northern Development
- Manitoba Bureau of Statistics
- Manitoba Centre for Health Policy
- Manitoba Health
- Manitoba Intergovernmental Affairs
- Manitoba Métis Federation
- NOR-MAN Regional Health Authority
- Prairie Women’s Health Centre
- Saskatchewan Health
- Statistics Canada
- Various Other Reports

Our population figures, physician data and CCHS survey results were noted as data limitations that must be considered when reading the report.

Finally, we explored the various consultation methods that were conducted throughout the NOR-MAN region and northeastern Saskatchewan. These included:

- CHA Retreat
- Forces of Change Assessment
- Key Knowledge Interviews
- Key Informant Interviews
- Women’s Health Focus Group
- Regional Youth Health Surveys
- Health System Performance and Health Priorities Staff, Physician and Partners Surveys

Although we are required to complete a comprehensive Community Health Assessment every five years, our CHA is an ongoing process that provides us with the evidence needed to continue to strive for our mission of: “Healthy People in Healthy Communities… Working Together to Improve our Health.”
Regional Health Authorities were established on April 1, 1997 under the provision of The Regional Health Authorities and Consequential Amendments Act (Bill 49). NOR-MAN Regional Health Authority was one of eleven Regional Health Authorities created under this Act.

This chapter provides an overview of who the NOR-MAN Regional Health Authority is and a summary of the programs and services we provide in the region. It will also discuss other jurisdictions that are providing health services in our region.

The following sections will be discussed:

- Overview of our NOR-MAN Regional Health Authority
- Overview of the NRHA Organizational Structure
- Overview of our Strategic Directions including our Mission and Values Statements, Board Ends and Strategic Priorities
- Overview of Core Services we provide
- Overview of Health Service Providers in the Region
Overview of the NOR-MAN Regional Health Authority (NRHA)

The NOR-MAN Regional Health Authority (NRHA) was established on April 1, 1997 under the provisions of The Regional Health Authorities and Consequential Amendments Act (Bill 49). Bill 49 created Regional Health Authorities with the responsibility for delivering and administering health services in specific parts of Manitoba.

As the primary provider of health services in the NOR-MAN region, our Mission is Healthy People in Healthy Communities “Working Together to Improve Our Health”.

Consistent with our mandate, the NRHA delivers a wide range of services in eleven (11) core service areas through the following facilities:

- **Hospitals** - Flin Flon General Hospital, St. Anthony’s Hospital, Snow Lake Health Centre
- **Personal Care Homes** - St. Paul’s Residence, Northern Lights Manor, Flin Flon Personal Care Home
- **Addiction Centre** - Rosaire House
- **Primary Health Care** - The Pas, Primary Health Care - Flin Flon (two sites), Cranberry Portage Wellness Centre, Cormorant Health Care Centre, and the Sherridon Health Care Centre

We provide a range of services to approximately 30,000 – 32,500 people. In addition to the Manitoba-based population of 24,090, approximately 8,000 northeastern Saskatchewan residents utilize acute, ambulatory, diagnostic, emergency care and physician services in both Flin Flon and The Pas.
**NRHA Organization Structure**

**NRHA Board of Directors**

The Minister of Health appoints the Board of Directors for all Regional Health Authorities. Board appointments represent both geographic representation as well as a broad cross-section of interests and experiences. The Minister’s criteria when selecting Board members is to look for a strong commitment to restructuring the health system and improving the health of all Manitobans.

Members of a RHA Board of Directors are usually appointed to a three-year term and the Minister of Health has the option of re-appointing a Director for an additional three-year term. However, no Director is permitted to sit for a period exceeding six consecutive years.

In 2009-10, the NOR-MAN Regional Health Authority Board of Directors was comprised of thirteen (13) members representing the various NOR-MAN and northeastern Saskatchewan communities.

The NRHA Board of Directors operates using a policy board model of governance. On March 6th and 7th, 2005, the Board reviewed and revised our Mission and Values Statements, Board Ends and Strategic Priorities.

(NRHA Organization Overview, 2008-09 – refer to Appendix C).

**NRHA Senior Management**

We have had a very stable Senior Management structure over the past several years. The NRHA Senior Management team consists of the following portfolios:

- Chief Executive Officer
As of March 31, 2009 the NRHA employed 989 individuals. The majority of our staff is unionized at 91.4%. Senior Management represents 1% of our workforce.

(NRHA Organizational Chart – refer to Appendix D)

Overview of NRHA Strategic Directions

Mission Statement

Our Mission reflects the need for individual and collective responsibility for improving personal health and well-being. It also recognizes the need to work in partnership to improve the health of our region.

OUR MISSION

Healthy People in Healthy Communities

“Working Together to Improve Our Health”
Values Statement

In establishing Board policies, making decisions and evaluating the performance of the Board and of the organization, the Board also developed a fundamental set of values and principles that they would be governed by. These values are the basis of all health services provided, all decisions made and all actions taken within the NOR-MAN Regional Health Authority.

OUR VALUES STATEMENT

We believe in:

- Dynamic, innovative, realistic, inclusive and stable leadership
- Honesty, respect, truthfulness and effective, open communication with those we work with and serve
- Informed choices for people and personal responsibilities for health, wellness and safety
- Being responsive to the unique needs of individuals and communities
- A fundamental quest for excellence in all facets of our organization
- The person’s right to informed, participatory decision making
- The person’s right and need for confidentiality of information
- Innovative cost-effective approaches in an evidence-based environment
- Proper accountability and prudent expenditure of public funds
- Personal and professional growth and development for Board and staff to meet emerging challenges
NRHA Board Ends

In March 2005, the NRHA Board of Directors adopted the following set of four (4) End Statements for guiding the ongoing evolution of the health system in the NOR-MAN region. In order to achieve our Mission, the Board set out the following four (4) Board Ends to guide the NRHA:

1. **Healthy Communities** - This Board End speaks to the collective responsibility for health and the need to increase public awareness of available health care services. It also recognizes that in order to improve the health of our people and our communities, we have a collective responsibility for improving health and we can achieve improvements by working in partnership with our community partners.

2. **Healthy People** - This Board End speaks to the many health issues that were identified through our Community Health Assessment on the health status of NOR-MAN residents. It was identified that many of our health issues relate to lifestyle issues and in order to improve health status, we need to focus on health promotion and primary prevention.

3. **Optimal Access to Services** - This Board End speaks to improving access to services. It is recognized that, where possible, we need to be creative using technology and bringing specialty services to the region. It addresses the priority of continuing to work on our Primary Health Care model and the need to continue to work towards reducing the jurisdictional and infrastructural barriers that exist so not to impact on an individual’s ability to access the necessary services.
4. **Excellence in Patient Safety and Quality of Care** - This was a new Board End, which focuses on our commitment to patient safety and continuous quality improvement. It also speaks to the need to be accountable to those we serve and that with finite resources, all planning must be done in an evidence-based environment. Also emphasized, is the fact that in order to be sustainable as a Regional Health Authority, we need to be efficient and effective in the use of our resources and ensure an adequate and skilled workforce.

**NRHA Strategic Priorities**

Under each Board End, the Board established a number of Strategic Priorities to further guide the direction of our organization. Our Strategic Priorities are as follows:

**Healthy Communities**

1. Increased public awareness of health care services
2. Increased resident involvement in activities that promote healthy lifestyles and personal well being
3. Increased awareness of illness caused by physical environment factors
4. Increased culture of trust, cooperation and strong partnership with Aboriginal groups, community agencies and other jurisdictions responsible for health service delivery
5. Increased understanding of regional health needs

**Healthy People**

1. Decreased incidence and prevalence of chronic illnesses
2. Increased awareness of Mental Health and Co-Occurring Disorders Initiative (CODI) and
expansion of services accordingly
3. Reduced incidence of suicides
4. Decreased incidence and prevalence of addictive practices and behaviors
5. Improved infant/child/youth health and promotion of healthy lifestyles
6. Reduced incidence of injuries and poisonings
7. Improved women’s health and promotion of healthy lifestyles
8. Improved men’s health and promotion of healthy lifestyles
9. Improved senior’s health and promotion of healthy lifestyles
10. Improved Aboriginal health and promotion of healthy lifestyles
11. Improved staff health and promotion of healthy lifestyles

Optimal Access to Services

1. Increased on-site resources in our outlying communities
2. Improved access to service through Primary Health Care
3. Improved knowledge of Primary Health Care
4. Increased specialty services and programs based on demonstrated need and cost effectiveness
5. Maintenance and improvement to our infrastructure
6. Increased use of technology
7. Increased awareness of Northern Patient Transportation Program (NPTP)
8. Reduced jurisdictional barriers to improve access to services

Excellence in Patient Safety and Quality of Care

1. Ensure safety & quality of care by:
- Creating a culture of safety
- Coordinating services across the continuum
- Creating a work life and physical environment that supports the safe delivery of care

2. Ensure accountability within the health care system

3. Ensure evidence-based decision-making is used throughout the organization

4. Ensure sustainability within the health care system by:
   - Optimizing the efficiency and effectiveness in the use of resources
   - Ensuring an adequate and skilled workforce
   - Developing northern Human Resources

Overview of Core Services Provided

Core services include the full range of health services funded by Manitoba Health. Manitoba Health states that all residents should have access to all core services. If a core service is not provided within a region, it must be available in another region or through a provincial program. Manitoba Health has identified ten (10) core services. Consistent with our Mission, we provide all core services as outlined below. Of note, we have included Physician services as an additional core service.

1. Physician Services
   - To recruit, hire and retain the number and type of physicians that are required to improve the health status of NOR-MAN residents

2. Prevention & Community Health Services
   - To deliver effective community based interventions that can prevent health

Physician services include:
- Family Medicine
- Obstetrics
- General Surgery
- Anesthesiology
- Radiology
- Gynecology
- Internal Medicine
- Psychiatry
- Emergency
- Itinerant Specialists
problems from arising and/or reduce their impact on individuals, families and communities

3. Health Promotion / Education
   - To support individuals and communities to improve their own health

4. Health Protection
   - To protect residents from exposure to preventable disease
   - To reduce the spread of communicable diseases

5. Mental Health Services
   - Access to the full range of mental health services at a regional level, including mental wellness and prevention programs, community–based assessment and treatment, and an in-patient treatment centre

6. Substance Abuse / Addictions
   - To address the health related needs of young victims of FASD and prevent their occurrence
   - To intervene directly in the addictive process, access to a residential addiction centre

7. Home-Based Care Services
   - To promote the independence of individuals who require in-home health services or supports and prevent institutionalization

8. Long Term Care Services
   - To provide personal and extended care services
   - To ensure that residents of long term care facilities maintain or improve their quality of life
9. Palliative Care
   • To provide care to people whose disease does not respond to curative approaches
   • To provide support to these individuals and their families during the end stage of illness

10. Development & Rehabilitation Support Services
   • To develop services that help people to live productive lives in their communities

11. Treatment, Emergency & Diagnostic Services
   • To offer high quality, cost effective treatment, emergency and diagnostic services

We publish a NRHA Services Overview document annually which provides a comprehensive listing of NRHA services and programs offered by service area and community.

(NRHA Service Overview—refer to Appendix E).

Overview of Health Service Providers in the Region

The NOR-MAN Regional Health Authority is not mandated to provide all health services in all communities. There are a number of agencies providing health services in the NOR-MAN region. NRHA is responsible for providing Acute and Long Term Care services to all residents in the region. Although, we do not have jurisdiction to provide community-based services on reserve land, we do provide itinerant community-based services in our outlying communities.

Table 2.1 outlines the providers of health care services within each NOR-MAN community:

<table>
<thead>
<tr>
<th>NRHA Acute Care Services</th>
<th>Flin Flon General Hospital has 42 beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Units (Medical, Pediatric, Surgical)</td>
<td>St. Anthony’s General Hospital has 40 beds</td>
</tr>
<tr>
<td>Aboriginal Services</td>
<td>Snow Lake Health Center has 2 beds</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
</tr>
<tr>
<td>Emergency Department/ Special Care Unit</td>
<td></td>
</tr>
<tr>
<td>Infection Control/ Staff Health</td>
<td></td>
</tr>
<tr>
<td>Dietitian Services</td>
<td></td>
</tr>
<tr>
<td>Laboratory Services</td>
<td></td>
</tr>
<tr>
<td>Medivac Services</td>
<td></td>
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<tr>
<td>NPTP</td>
<td></td>
</tr>
<tr>
<td>Palliative Care</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Unit</td>
<td></td>
</tr>
<tr>
<td>Obstetrics</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
</tr>
<tr>
<td>Operating Room/ Surgery</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td></td>
</tr>
<tr>
<td>Social Work</td>
<td></td>
</tr>
<tr>
<td>Spiritual Care</td>
<td></td>
</tr>
<tr>
<td>Telehealth</td>
<td></td>
</tr>
</tbody>
</table>

2009/2010 NRHA Community Health Assessment
Chapter 2 - Who is the NOR-MAN Regional Health Authority?
Page 2 - 11
Community-based Itinerant Services may include the following:

- Chronic Disease Prevention
- Diabetes Education Resource
- District Health Councils
- Health Education
- Health Promotion
- Heart to Heart
- Home Care Services
- Mental Health Services
- Midwifery
- Mobile Breast Screening
- Palliative Care
- Retinal Screening
- STD Contact Tracing
- Tobacco Reduction and Prevention

### Table 2.1: Providers of Health Care Services

<table>
<thead>
<tr>
<th>Community</th>
<th>Health Care Provider</th>
<th>Type of Service Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Pas</td>
<td>NRHA</td>
<td>All core services</td>
</tr>
<tr>
<td>Flin Flon</td>
<td>NRHA</td>
<td>All core services</td>
</tr>
<tr>
<td>Snow Lake</td>
<td>NRHA</td>
<td>All core services</td>
</tr>
<tr>
<td>Cranberry Portage</td>
<td>NRHA</td>
<td>All core services</td>
</tr>
<tr>
<td>Cormorant</td>
<td>NRHA</td>
<td>All core services</td>
</tr>
<tr>
<td>Sherridon</td>
<td>NRHA</td>
<td>All core services</td>
</tr>
<tr>
<td>Grand Rapids Misipawistik Cree Nation</td>
<td>Manitoba Health Northern Medical Unit Misipawistik Health Authority NRHA</td>
<td>Nursing Station Physician Services First Nation Community Health Services Acute Care, Long Term Care Community itinerant services</td>
</tr>
<tr>
<td>Easterville Chemawawin Cree Nation</td>
<td>Manitoba Health Northern Medical Unit Chemawawin Health Authority NRHA</td>
<td>Nursing Station Physician Services First Nation Community Health Services Acute Care, Long Term Care Community itinerant services</td>
</tr>
<tr>
<td>Moose Lake Mosakahiken Cree Nation</td>
<td>Manitoba Health NRHA Mosakahiken Health Authority NRHA</td>
<td>Nursing Station Physician Services First Nation Community Health Services Acute Care, Long Term Care Community itinerant services</td>
</tr>
<tr>
<td>Opaskwayak Cree Nation</td>
<td>Opaskwayak Health Authority NRHA</td>
<td>Community-based services McGillivray Care Home Kawechetonanow Centre Acute Care Physician services</td>
</tr>
<tr>
<td>Pukatawagan Mathias Colomb Cree Nation</td>
<td>Mathias Colomb Health Authority NRHA</td>
<td>Nursing Station Physician Services First Nation Community Health Services Acute Care services</td>
</tr>
</tbody>
</table>

First Nation Community-Based Services may include the following:

- Public Health Nurses
- Community Health Nurses
- Community Health Representatives
- National Native Alcohol and Drug Abuse Program
- Fetal Alcohol Syndrome Disorder
- National Aboriginal Youth Suicide Prevention Strategy
- HIV/ AIDS
- Canadian Prenatal Nutrition Program
- Brighter Futures
- Aboriginal Health Start
- Dental Health Promotion

Table 2.1: Providers of Health Care Services
Source: NOR-MAN Regional Health Authority and Swampy Cree Tribal Health
Table 2.1 illustrates that in addition to NRHA, there are a variety of jurisdictions who provide health services to residents of the NOR-MAN region.

The federal government supports the provision of most services on-reserve, though these are increasingly devolved to band administration – as is the case with the Opaskwayak Cree Nation through Opaskwayak Health Authority and with Mathias Colomb Cree Nation through Mathias Colomb Health Authority.

Opaskwayak, Mathias Colomb and Misipawistik Cree Nations have Health Transfer Agreements in place with First Nation Inuit Health. While, Chemawawin and Mosakahiken Cree Nations have Contribution Agreements.

Federal-funded programs include child and family services, alcohol and substance abuse (NADAP), care for seniors, and municipal infrastructure such as sewer and water, administration and recreation buildings. The federal government also supports the cost of post-secondary education and extended health benefits under the Non-Insured Health Benefits Program (NIHB) for Status Indians including those living off reserve. However, Métis and Non-Status people are ineligible for this program.

Manitoba Health delivers health services through provincial Nursing Station in Grand Rapids and Misipawistik Cree Nation, Easterville and Chemawawin Cree Nation and Moose Lake and Mosakahiken Cree Nation.

The Northern Medical Unit provides Physician Services to Grand Rapids and Misipawistik Cree Nation and Easterville and Chemawawin Cree Nation.
Summary

As the primary provider of health services in the NOR-MAN region, our Mission is **Healthy People in Healthy Communities** “Working Together to Improve Our Health.”

Currently, we deliver services and programs in eleven core services areas to approximately 30,000 to 33,000 residents of the NOR-MAN region as well as northeastern Saskatchewan. Consistent with our mandate, the NRHA delivers a wide range of services in eleven (11) core service areas through the following facilities:

- **Hospitals** - Flin Flon General Hospital, St. Anthony’s Hospital, Snow Lake Health Centre
- **Personal Care Homes** - St. Paul’s Residence, Northern Lights Manor, Flin Flon Personal Care Home
- **Addiction Centre** - Rosaire House
- **Primary Health Care** - The Pas, Primary Health Care - Flin Flon (two sites), Cranberry Portage Wellness Centre, Cormorant Health Care Centre, and the Sherridon Health Care Centre

The Minister of Health appoints a Board of Directors for all Regional Health Authorities. In 2009-10, the NOR-MAN Regional Health Authority Board of Directors was comprised of thirteen (13) members representing NOR-MAN and northeastern Saskatchewan communities.

The NRHA Board of Directors last reviewed and revised our Mission and Values Statements in March 2005. At that time, they also refined our Board Ends and related Strategic Priorities.

Within the parameters established by Bill 49 and our own mission statement, we must make a number of decisions about the relative emphasis placed on each of our mandate services. Within
each individual core service area, the nature and scope of the programs and services offered by the NRHA must be determined. The most important factors to consider in making these decisions are the health issues of NOR-MAN residents.

The NOR-MAN Regional Health Authority is not mandated to provide all health services in all communities. There are a number of agencies providing health services in the NOR-MAN region.

The federal government supports the provision of most services on-reserve, though these are increasingly devolved to band administration – as is the case with the Opaskwayak Cree Nation through Opaskwayak Health Authority and with Mathias Colomb Cree Nation through Mathias Colomb Health Authority.

Manitoba Health delivers health services through provincial nursing stations in Grand Rapids and Misipawastik Cree Nation, Easterville and Chemawawin Cree Nation and Moose Lake and Mosakahiken Cree Nation.

The Northern Medical Unit provides Physician Services to Grand Rapids and Misipawastik Cree Nation and Easterville and Chemawawin Cree Nation.

**Good communication and strong partnerships with other health service providers is critical to ensure health care services are provided in a coordinated and seamless fashion.**
Chapter 3

What does the NOR-MAN region look like?

Chapter three will explore the NOR-MAN region which covers a large geographic area (72,000 sq. km) and services a population of approximately 30,000 - 33,000 people. The NOR-MAN region is made up of a combination of wilderness areas that are located among an abundance of natural habitats and an array of diverse ecosystems. Located within this diverse geographic area are the eleven NOR-MAN communities.

This chapter covers the following:

- NOR-MAN Regional Boundaries
- NOR-MAN Regional Health Authority Districts
- NOR-MAN Communities
  - Cranberry Portage (member of RM of Kelsey)
  - Cormorant
  - Easterville and Chemawawin Cree Nation
  - Flin Flon
  - Grand Rapids and Misipawistik Cree Nation
  - Moose Lake and Mosakahiken Cree Nation
  - Opaskwayak Cree Nation
  - Pukatawagan/Mathias Colomb Cree Nation
  - RM of Kelsey
  - Sherridon/Cold Lake
  - Snow Lake
  - The Pas
NOR-MAN Regional Profile

This chapter describes the geographic boundaries of the NOR-MAN Regional Health Authority (NRHA) region. It is also highlights each community that is located within the NOR-MAN boundaries.

Regional Boundaries

Figure 3.1 below shows the Regional Health Authorities (RHAs) of Manitoba. The NOR-MAN Regional Health Authority is one (1) of eleven (11) authorities located in the province of Manitoba.

Figure 3.1 Manitoba Regional Health Authorities
Source: RHAM (Regional Health Authorities of Manitoba)
Northern Regional Health Authority Boundaries

The NRHA is one of three northern RHA’s in the province of Manitoba. Figure 3.2 below shows the northern region of Manitoba.

The NOR-MAN Regional Health Authority provides services to about 2.1% of the total population of the Province of Manitoba.

Figure 3.2  Northern Regional Health Authority Regions
Source:  Manitoba IGA, Community Profiles
The NOR-MAN RHA region extends from Grand Rapids and Misipawistik Cree Nation in the southeast to Flin Flon in the west to Pukatawagan/Mathias Colomb Cree Nation in the north. The Mamawetan Churchill River Health Region is our neighbor to the west along the Manitoba/Saskatchewan border. Figure 3.3 shows the boundaries for both Health regions.

![Figure 3.3 NOR-MAN Regional Health Authority Regional Boundaries](source: NOR-MAN Regional Health Authority)

**NOR-MAN RHA Districts**

The NRHA region is divided into three distinct districts. Figure 3.4 on the next page shows each community by district. **District I** is identified by the **purple markers** and is comprised of the communities of Flin Flon, Cranberry Portage and Snow Lake. **District II** is identified by the **orange markers** and is comprised of the communities of The Pas, Opaskwayak Cree Nation and the Rural Municipality of Kelsey (with the exclusion of Cranberry Portage). **District III** is identified by the **turquoise markers** and is comprised of the communities of Cormorant, Sherridon/Cold Lake, Easterville, Chemawawin Cree Nation, Grand Rapids, Misipawistik Cree Nation, Moose Lake,
Mosakahiken Cree Nation, Pukatawagan/Mathias Colomb Cree Nation.

The NRHA region has three distinct types of communities: (1) First Nations Communities; (2) Aboriginal and Northern Affairs Communities and (3) Cities, Towns and Municipalities.

**First Nation** communities are located on Reserve lands and are governed locally by Chief and Council, under the jurisdiction of the federal government.

**Aboriginal and Northern Affairs** communities are governed by a local community council under the jurisdiction of the provincial Northern Affairs Act.

**Cities, towns and municipalities** are under provincial jurisdiction and typically are
incorporated and governed by a Mayor and Council or Reeve and Council. Table 3.1 below provides an overview of the communities in the NRHA region by community type.

<table>
<thead>
<tr>
<th>First Nation Communities</th>
<th>Aboriginal and Northern Affairs Communities</th>
<th>Cities, Towns and Municipalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemawawin Cree Nation</td>
<td>Cormorant</td>
<td>Cranberry Portage</td>
</tr>
<tr>
<td>Misipawistik Cree Nation</td>
<td>Easterville</td>
<td>Flin Flon</td>
</tr>
<tr>
<td>Mosakahiken Cree Nation</td>
<td>Moose Lake</td>
<td>Grand Rapids</td>
</tr>
<tr>
<td>Opaskwayak Cree Nation</td>
<td>Sherridon/Cold Lake</td>
<td>RM of Kelsey</td>
</tr>
<tr>
<td>Pukatawagan/ Mathias Colomb Cree Nation</td>
<td></td>
<td>Snow Lake</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Pas</td>
</tr>
</tbody>
</table>

Table 3.1: Communities in the NOR-MAN Region by Community Type
Source: NOR-MAN Regional Health Authority

**Cranberry Portage**

The Local Urban District (L.U.D.) of Cranberry Portage is located in the RM of Kelsey. Cranberry Portage is situated 48 kilometers south of the City of Flin Flon and 695 kilometers northwest of Winnipeg, Manitoba. Other neighbouring communities to the south include The Town of The Pas, 100 kilometers away and the Village of Wanless, 50 kilometers away.

Situated along the southern shores of Lake Athapapuskow, Cranberry Portage is surrounded by lakes, rivers and streams. The community is located in the western portion of the Grass River Provincial Park on a beautiful strip of land about 2.5 kilometers in width. The community is on a glacier ridge that separates Athapapuskow Lake.
on the west and First Cranberry Lake on the east, which provides access to both the Saskatchewan River and the Nelson River systems. Cranberry Portage was formed in 1928 as an Unincorporated Village District (UVD) within the Local Government District of Consol (now known as the Rural Municipality of Kelsey). As of January 1, 1997, the UVD is now referred to as the Local Urban District (LUD) of Cranberry Portage. The local elected Council consists of 5 members, two of which represent Cranberry Portage on the Rural Municipality of Kelsey Council.

Prior to 1928, Cranberry Portage was little more than its name implied a portage in the route used by fur traders and Aboriginal peoples. The year 1928 saw the coming of the railway to Cranberry Portage. Since this time, Cranberry Portage has experienced population increases and decreases, a tragedy of fire, a radar site opening and closing, and the opening of Frontier Collegiate Residential School in 1965. Today, Cranberry Portage, a community of 606 (Statistics Canada, 2006 Census), continues as a northern educational hub with a large residential education site servicing many northern rural communities. Cranberry Portage is known for its abundance of beautiful lakes with excellent fishing and scenic landscapes.

**Cormorant**

The Aboriginal and Northern Affairs Community of Cormorant is a remote community situated on the east shore of Cormorant Lake, in west-central Manitoba, approximately 77 kilometers (45 kilometers are gravel road) northeast of the Town of The Pas on Paved Provincial Road # 287, which provides access to Paved Provincial Highway # 10 going to the Town of The Pas.

Cormorant’s history dates back to the early 1900s, and was originally a campsite for fishing, trapping and agriculture activities. Today, the community of Cormorant is divided into two sections. The
main section of the community is on a point along the north shore of “The Narrows” which connects Cormorant Lake with Little Cormorant Lake. A single-lane timber bridge and causeway connect the balance of the community on the south shore of “The Narrows”. Cormorant’s physical location is in a relatively flat marshy region, which is part of the Paleozoic geological zone of Manitoba, and is a factor in the economic base of the community. To the west and surrounding Cormorant Lake, is the Cormorant Forest Reserve. The remaining forest areas surrounding Cormorant are part of Tolko Manitoba’s logging area.

The Hudson Bay Railway owned and operated by Omni Trax Ltd. passes through the community.

Cormorant is a Aboriginal and Northern Affairs community of 334 (Statistics Canada, 2006 Census), which is governed by a Mayor and Council, under “The Northern Affairs Act”.

Easterville and Chemawawin Cree Nation

Easterville and Chemawawin Cree Nation are both remote communities situated approximately 204 kilometers from the Town of The Pas, and 100 kilometers from the Town of Grand Rapids and Misipawistik Cree Nation. Road access to both communities requires travel on gravel roads for approximately 13 miles on Provincial Gravel Road #327 to Paved Provincial Highway #60. There is an airstrip adjacent to the communities but there are no scheduled flights to and from Easterville and Chemawawin Cree Nation.

Easterville and Chemawawin Cree Nation consist of two separate communities, the Northern Affairs community of Easterville and Chemawawin Cree Nation, which are situated adjacent to each other on the south shore of Cedar Lake. The community and the Reserve relocated to this site in 1962-63 as a result of flooding of Cedar Lake caused by construction of the hydro dam on the Saskatchewan River, where it enters Lake
Winnipeg at Grand Rapids. The flooding transformed Cedar Lake into a great reservoir. The area is a mixture of rock outcrops, small pockets of marsh and black spruce timber.

The community of Easterville developed beside the Chemawawin Cree Nation Reserve. A mayor and council under “The Northern Affairs Act” governs Easterville a community of 80 (Statistics Canada, 2006 Census).

Chemawawin Cree Nation, a community of 983 (Statistics Canada, 2006 Census) includes three reserve parcels of land, two of which are populated. Chemawawin Cree Nation No. 1 is located at Oleson Point on the south shore of Cedar Lake west of Easterville. This was the original site of the Reserve and is no longer populated. Chemawawin Cree Nation No. 2 is located adjacent to the community of Easterville on the southeast shore of Cedar Lake. Chemawawin Cree Nation No. 3 is located at the junction of Paved Provincial Highway #60 and Provincial Gravel Road #327.

**Flin Flon**

The City of Flin Flon, which is built on basaltic rock, is a changing mining community and a vacationer’s destination nestled in the middle of nature’s magnificence. Located on the Manitoba/Saskatchewan border north of the 54th parallel, the Flin Flon area is part of the Precambrian Amisk Volcanic Belt. This belt was formed millions of years ago by underwater volcanic eruptions and is the source of the vast mineral deposits in the Flin Flon area including zinc, copper, silver and gold.

The discovery of the initial Flin Flon ore body occurred in 1915. This makes Flin Flon the oldest surviving community in the area that is still actively engaged in mining. The community of Flin Flon was formed in 1929 and was incorporated as a municipality in 1933. Flin Flon became a town in 1946 and was granted the status

Unfortunately for the City of Flin Flon and surrounding area, the current volatility of the mining and processing industry is impacting their residents. Hudson Bay Mining and Smelting (HBM&S) announced the closure of the Flin Flon smelter as of July 1st, 2010. Major reasons for this closure are due to global smelting overcapacity, rising costs to operate and the ongoing pollution-reduction targets. Also at this time, HBM&S announced the anticipated closure of Trout Lake Mine their oldest active mine in Flin Flon. With anticipated decrease in the workforce of about 225 employees, HBM&S offered a retirement package to both Smelter and Trout Lake Mine employees to reduce the number of necessary layoffs.

There are a number of people living in the outlying areas of Channing, Big Island and Baker’s Narrows Provincial Park that access Flin Flon for both services and employment and consider themselves Flin Flon residents.

Flin Flon, a community of 5,836 (Statistics Canada, 2006 Census) shares an economic base with two separate and distinct Saskatchewan communities: Creighton and Denare Beach. The Town of Creighton is located 3 kilometers south west of Flin Flon, and has a population of 1,502 (Statistics Canada, 2006 Census). The Northern Village of Denare Beach, a community of 785 (Statistics Canada, 2006 Census) and the Amiskosakahikan Reserve are approximately 18 kilometers south of Creighton. Both of these communities have their own local and provincial governance structure, but this does not stop them from working together and sharing resources.

The City of Flin Flon also provides various services to a number of other northeastern Saskatchewan communities, including Peter Ballantyne Cree Nation population 1,342, Pelican
Narrows population 599, Kimosom Pwatinahk 203 (Deschambault Lake) population 821 and Sandy Bay population 1,175 (Statistics Canada, 2006 Census).

**Grand Rapids and Misipawistik Cree Nation**

Grand Rapids and Misipawistik Cree Nation are located on Paved Provincial Highway # 6 with the closest neighboring urban communities being Ashern and The Pas. The communities are approximately 250 kilometers southeast of the Town of The Pas and 400 kilometers north of the City of Winnipeg.

Geographically, Grand Rapids and Misipawistik Cree Nation are adjacent to one another, separated by the Saskatchewan River, on the north western shore of Lake Winnipeg, downstream from Manitoba Hydro’s Grand Rapids hydroelectric station.

The Town of Grand Rapids, a community of 336 (Statistics Canada, 2006 Census) was incorporated on January 1, 1977. Grand Rapids is governed by a Mayor and Council and contains land under provincial jurisdiction including the area known as the hydro sub-division. The hydro sub-division is where many of the staff and their families who work for Manitoba Hydro reside.

Misipawistik Cree Nation (formally Grand Rapids Cree Nation), a community of 651 (Statistics Canada, 2006) is governed by Chief and Council. The Misipawistik Cree Nation is a signatory to the Treaty 5 signing in 1875.

**Moose Lake and Mosakahiken Cree Nation**

Moose Lake and Mosakahiken Cree Nation are two closely related but independent communities located on the northern limits of the Saskatchewan River Delta, on the western shore of Cedar Lake.
Moose Lake and Mosakahiken Cree Nation are remote communities situated approximately 74 kilometers southeast of The Pas. Both communities are accessible by gravel road, which is approximately 68 kilometers from the nearest highway, Paved Provincial Road # 287 which runs through Clearwater Provincial Park before meeting up with Paved Provincial Highway #10. Both the communities rely on the Town of the Pas and Opaskwayak Cree Nation for many of their services.

The community of Moose Lake is an Aboriginal and Northern Affairs community of 205 (Statistics Canada, 2006 Census) situated on provincial crown land. An elected mayor and council under “The Northern Affairs Act” have represented Moose Lake since June 1971.

Mosakahiken Cree Nation a community of 698 (Statistics Canada, 2006 Census) located on Reserve 31A, which includes Big Island, Trader’s Lake (is situated three kilometers from the main community), Crossing Bay (is located north of the main community) and Little Limestone.

**Opaskwayak Cree Nation**

The Opaskwayak Cree Nation (OCN) a community of 2,187, (Statistics Canada, 2006 Census) is located on the north shore of the Saskatchewan River, adjacent to the Town of The Pas since 1906. OCN is known as one of the most progressive First Nations in Canada and has long been recognized as a model for self-government. One of the seven members of the Swampy Cree Tribal Council, Opaskwayak was the first band in Canada to be recognized as a municipality. Opaskwayak Cree Nation encompasses a total area of approximately 14,700 acres with 17 geographically separate sites.

The Bignell Bridge spans the Saskatchewan River and provides the link between the Town of The Pas and Opaskwayak Cree Nation, as well as
linking communities on the south shore of the river with other northern destinations.

Every two years, band elections are held to choose a Chief and 12 Councillors. This governing body then serves to establish policy and provide direction to a full-time staff that administers the day-to-day commercial, social, health and community operations of the band.

**Pukatawagan/Mathias Colomb Cree Nation**

Pukatawagan/Mathias Colomb Cree Nation a community of 1,478 (Statistics Canada, 2006 Census) is a remote northern community located 216 kilometers north of the Town of The Pas and 819 kilometers northwest of the City of Winnipeg, Manitoba located on the shore of the Missinippi River. Pukatawagan and Mathias Colomb Cree Nation are connected by gravel road to both the train station and the airport; and for a period of appropriately three months a year enjoys a winter road. The community is serviced by Pukatawagan Railway (purchased from Omnitrax), and Missinippi Air, which is own by Mathias Colomb Cree Nation.

The Mathias Colomb Cree Nation was formed in 1910 with Mathias Colomb as Chief when a group of people separated from the Peter Ballantyne Cree Nation of Saskatchewan. Originally the Mathias Colomb band settled along the Churchill River at Highrock Lake in the Prayer River area. A fire destroyed the Prayer River community in the late 1960’s and the band was forced to relocate to the Pukatawagan reserve currently known as Mathias Colomb Cree Nation.

**RM of Kelsey**

The Rural Municipality (RM) of Kelsey is located just outside the surrounding area of the Town of The Pas. Governed by Reeve and Council, the RM...
of Kelsey covers a large geographical area, which stretches in distance approximately 120 kilometers from just south of the Town of The Pas to Cranberry Portage in the north. The RM of Kelsey consists of five different areas. These areas include Carrot River Valley (Pasquia Settlement), Young Point, Big Eddy and Umpherville Settlements; Ralls Island, Wanless and the Local Urban District of Cranberry Portage. Each of these areas are individually too small to form an effective government, but combined form an effective, well-managed jurisdiction.

Carrot Valley (Pasquia Settlement) was developed in the 1950s, and is one of Canada’s oldest farming areas. The very first grain grown in Western Canada was seeded in the Carrot River Valley in 1735. Carrot Valley, is also one of the most northern agricultural area in Canada with a population of 1,600 (Statistics Canada, 2006 Census). The Valley consists of approximately 75,000 acres of prime land that is used for grain and other specialty crops, and to support cattle farms that are located in the Valley.

Young Point, Big Eddy and Umpherville Settlements are small Métis communities with a total population of approximately 300 people.

Ralls Island is located east of The Pas and was settled in the early 1900’s as a farming area. Developed now primarily into rural residential lots, subdivisions have been created to provide opportunities for country living, small mixed agricultural farming and some hobby farming.

Wanless is a small village of 194 people (Statistics Canada, 2006 Census), that is located approximately 50 kilometers north of the Town of The Pas. Situated on the shores of Rocky Lake, are also homes to both year round and summer cottages of people who appreciate the great outdoors.
Sherridon/Cold Lake

Sherridon/Cold Lake is located on Kississing Lake, north of the 54\textsuperscript{th} parallel. The two communities are located on the Pukatawagan rail line (recently purchased from Omni Trax Ltd.) to Lynn Lake approximately 156 kilometers north of The Pas. A 78 kilometer gravel access road was constructed in 1985 as part of the Puffy Lake Mine development making this community road accessible. The community is now connected to Paved Provincial Highway\# 10 between Cranberry Portage and Flin Flon, which the community relies on for many of its services. Sherridon is also accessible by rail. Mathias Colomb Cree Nation is located 72 kilometers north of Sherridon/Cold Lake by winter road and train access.

Sherridon/Cold Lake is a Métis community of 98 (Statistics Canada, 2006 Census) which covers an area of four square kilometers. Cold Lake is built around Kississing Lake, and is where most of the people in the community reside. Sherridon originated as the service center for the Sherritt-Gordon Mines, from which Sherridon received its name. It is located approximately one mile away from Cold Lake. Sherridon is an Aboriginal and Northern Affairs community and is governed by a Mayor and Council under “The Northern Affairs Act”.

The Sherritt-Gordon Mine closed in 1940, resulting in the relocation of many families to the community of Lynn Lake. The most recent gold mine, operated by Pioneer Metals at Puffy Lake, closed in 1989. There have been various mines that have been operated since then and active exploration continues to occur. Sherridon prides itself on the natural beauty of its community. The area is rich in wildlife and plants, and has many beautiful and well-stocked lakes.
Snow Lake

Snow Lake is a mining community situated midway between Flin Flon, The Pas and Thompson, in north-central Manitoba on Paved Provincial Road #392, 685 kilometers north of the City of Winnipeg. Snow Lake was designated a Local Government District (LGD) in June 1947 and in September 1976, it was formally incorporated as a Town. Snow Lake a community of 837 (Statistics Canada, 2006 Census), is governed by a Mayor and Council and is one of Canada’s largest municipalities covering 1,209 square kilometers.

Mining has been the mainstay of Snow Lake since the discovery of significant ore deposits in the 1950’s which led to Snow Lake’s development as a major mining center. The Hudson Bay Mining and Smelting (HBM&S) Company has operated many mines in Snow Lake since the 1950’s. In 1993, 1995, 2004 and again in early 2009 tough times fell on the community of Snow Lake when Chisel North mine, the HBM&S concentrator and New Britannia mine were all placed on care and maintenance. This saw HBM&S Snow Lake employees transferred to Flin Flon.

On October 30, 2009 HudBay Minerals Inc. (formally HBM&S) announced that it will re-start operations at its Chisel North mine and concentrator effective immediately, with full production expected in the second quarter of 2010. The re-start will be carried out at the same time as the start of the development of Lalor Lake deposit (discovered in March 2007).

Although mining has traditionally been the mainstay of the local economy, this friendly and hospitable town has been developing its tourism industry. Snow Lake is located on the east shore of the beautiful and well-stocked Snow Lake, which gives the town its name. The lake’s quiet and natural ambience, excellent fishing and abundant flora and fauna continue to attract tourist from all over.
The Pas

The Town of The Pas originally started as a trading post during a time when the Europeans were focused on furs to feed the fashion houses of Europe. The Town of The Pas is one of the oldest (dating back to when Henry Kelsey visited the area) surviving communities in Western Canada. Sitting between the thick northern forests and the fertile southern farmlands, the community is proud of its heritage. Aboriginal people lived in this area for thousands of years before the first permanent settlement was constructed in 1741. The Town of The Pas was incorporated in 1912 and is governed by a Mayor and Council.

Today, the Town of The Pas is a modern community of 5,589 (Statistics Canada, 2006 Census). The Pas is located on the south shore of the Saskatchewan River 630 kilometers north of the City of Winnipeg and 144 kilometers south of the City of Flin Flon on Paved Provincial Highway# 10.

Four years ago, TOLKO nearly closed the sawmill and adjacent paper mill permanently, until workers at both the facilities agreed to pay cuts. Today the paper mill is open and states that they have a full order booked for 2010. Unfortunately, it has now been a year since Tolko stopped producing lumber in The Pas and putting about 100 people out of work. Tolko has stated that the closure is not permanent and they do intend to resume operation at the saw mill when the markets dictate that it can be done profitably. But it likely will not be in 2010.

Known as “Adventure Territory”, the Town of The Pas serves as a major center for agriculture, forestry, transportation, tourism, government and other services. The Town of The Pas is also considered home to a growing number of “Lake Residents” who reside year round at either Rocky Lake or Clearwater Provincial Park.
Chapter 4

Who are the People of the NOR-MAN Region?

The growth or decline of the population is dependant on the number of people who die, the number of babies born, and the number of people who move in and out of our region every year.

Understanding our region’s population composition is important to our understanding of how certain economic factors influence our residents health overall.

In this chapter, the specific population characteristics that will be reviewed are:

1. Demographic
   - Population Profiles
   - Population Distribution

2. Economic Factors
   - Educational Attainment
   - Labour Force Indicator
     - Regional Indicators
     - Income and Income Sources

3. Language
NOR-MAN Demographics

This section of the report presents a demographic profile of the population that resides within the NOR-MAN Regional Health Authority boundary. In developing this profile, various data sources were accessed and it is important to note that each data source was unique in their gathering, analyzing and reporting of statistical information. For the NOR-MAN region, it is difficult to give an accurate population count. This is due to the fact that each data source reports a different population total.

NOR-MAN Population Profile

According to the 2006 census data from Statistics Canada, the NRHA region has a population of 21,606. While, Manitoba Health shows 24,090 people living in the NOR-MAN region as of June 1, 2008. However, for comparison purposes we will be using 2005/06 Manitoba Health statistical data, which shows 24,340 people living in the NOR-MAN region.

<table>
<thead>
<tr>
<th>Community</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon</td>
<td>6369</td>
<td>6280</td>
<td>6179</td>
<td>6144</td>
<td>6013</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td>696</td>
<td>686</td>
<td>699</td>
<td>687</td>
<td>685</td>
</tr>
<tr>
<td>RM of Kelsey</td>
<td>2947</td>
<td>3025</td>
<td>2569</td>
<td>2590</td>
<td>2508</td>
</tr>
<tr>
<td>Snow Lake</td>
<td>1171</td>
<td>1025</td>
<td>904</td>
<td>883</td>
<td>915</td>
</tr>
<tr>
<td>The Pas</td>
<td>7619</td>
<td>7499</td>
<td>7285</td>
<td>7138</td>
<td>7060</td>
</tr>
<tr>
<td>Chemawawin CN</td>
<td>600</td>
<td>608</td>
<td>605</td>
<td>619</td>
<td>671</td>
</tr>
<tr>
<td>Misipawistik CN</td>
<td>371</td>
<td>379</td>
<td>389</td>
<td>406</td>
<td>425</td>
</tr>
<tr>
<td>Mathias Colomb CN</td>
<td>1241</td>
<td>1219</td>
<td>1223</td>
<td>1232</td>
<td>1242</td>
</tr>
<tr>
<td>Mosakahiken CN</td>
<td>382</td>
<td>389</td>
<td>388</td>
<td>401</td>
<td>433</td>
</tr>
<tr>
<td>Opaskwayak CN</td>
<td>1080</td>
<td>1001</td>
<td>1623</td>
<td>1631</td>
<td>1670</td>
</tr>
<tr>
<td>Unorganized Territories</td>
<td>2426</td>
<td>2433</td>
<td>2476</td>
<td>2478</td>
<td>2468</td>
</tr>
<tr>
<td>Totals</td>
<td>24,902</td>
<td>24,544</td>
<td>24,340</td>
<td>24,209</td>
<td>24,090</td>
</tr>
</tbody>
</table>

Table 4.1 NOR-MAN RHA Population Trends
As shown in Table 4.1, NOR-MAN’s current population trend continues to show a small yearly decrease in each of the last five (5) years. Within the NOR-MAN region, it is generally agreed that neither Statistics Canada nor Manitoba Health’s population data accurately reflects our population totals, especially our Aboriginal population numbers.

NOR-MAN Aboriginal Profile

Figure 4.1 shows the Aboriginal population percentages for each RHA in the Province of Manitoba. As shown, NOR-MAN has the third highest percentage with 50% of our population claiming Aboriginal identity in comparison to the Manitoba percentage of 15%.

Aboriginal Populations

refers to those person who report with at least one Aboriginal group, that is North American Indian, Métis, or Inuit, and/or those who report being a Treaty Indian or a Registered Indian, as defined by the Indian Act of Canada and/or those who report they were a member of an Indian Band or First Nation

(Statistics Canada)

Manitoba Aboriginal Populations by RHA 2006 Census

Based on 2006 census information, the breakdown of Aboriginal population percentages by NRHA District are:

- District I at 18%
- District II at 55%
- District III at 79%
Table 4.2 and 4.3 provides population data from the Department of Indian Affairs and Northern Development Indian Register. The Indian Register is meant to record individual names in accordance with specific sub-sections of the Indian Act. The Indian Register covers only those who have applied to be registered and whose entitlement has been verified.

<table>
<thead>
<tr>
<th>First Nation Band</th>
<th>Males</th>
<th>Females</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemawawin CN (501-309)</td>
<td>771</td>
<td>766</td>
<td>1537</td>
</tr>
<tr>
<td>Misipawistik CN (501-310)</td>
<td>713</td>
<td>727</td>
<td>1440</td>
</tr>
<tr>
<td>Mathias Colomb CN (501-311)</td>
<td>1593</td>
<td>1560</td>
<td>3153</td>
</tr>
<tr>
<td>Mosakahiken CN (501-312)</td>
<td>817</td>
<td>853</td>
<td>1670</td>
</tr>
<tr>
<td>Opaskwayak CN (501-315)</td>
<td>2451</td>
<td>2480</td>
<td>4931</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>6,345</strong></td>
<td><strong>6,386</strong></td>
<td><strong>12,731</strong></td>
</tr>
</tbody>
</table>

Table 4.2: Registered Indian Population by Sex and Band, 2006
Source: Department of Indian Affairs and Northern Development

<table>
<thead>
<tr>
<th>First Nation Band</th>
<th>On Reserve &amp; On Crown Land</th>
<th>Off Reserve</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemawawin CN (501-309)</td>
<td>1254</td>
<td>283</td>
<td>1537</td>
</tr>
<tr>
<td>Misipawistik CN (501-310)</td>
<td>888</td>
<td>552</td>
<td>1440</td>
</tr>
<tr>
<td>Mathias Colomb CN (501-311)</td>
<td>2227</td>
<td>926</td>
<td>3153</td>
</tr>
<tr>
<td>Mosakahiken CN (501-312)</td>
<td>1203</td>
<td>467</td>
<td>1670</td>
</tr>
<tr>
<td>Opaskwayak CN (501-315)</td>
<td>2983</td>
<td>1948</td>
<td>4931</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>8,555</strong></td>
<td><strong>4,176</strong></td>
<td><strong>12,731</strong></td>
</tr>
</tbody>
</table>

Table 4.3: Registered Indian Populations by Type of Residence, 2006
Source: Department of Indian Affairs and Northern Development

Band simply refers to a group of “First Nation people” for whose collective use and benefit lands have been set apart or money held by the Crown or declared to be a band for the purpose of the Indian Act of Canada.

Reserve means a tract of land, the legal title to which is vested in Her Majesty, that has been set apart by Her Majesty for the use and benefit of a band

On Reserve – Indian Register individuals who are band members or who are descendants of band members whose residency on the Indian Register is captured as one of the following five types: On reserve Own Band; On Reserve Other Band, On Crown Land Own Reserve; On Crown Land Other Reserve; On Crown Land No Band

Off Reserve – Indian Register individuals who are band members or who are descendants of band members residing neither on reserve nor on Crown land

(Department of Indian Affairs and Northern Development)
The information contained in Table 4.3 provides useful data regarding the percentage of people living on and off reserve. According to the Department of Indian Affairs and Northern Development, of the five First Nation Bands in the NOR-MAN region, Chemawawin Cree Nation has the largest percentage of its members (1,254 or 81.6%) living on reserve. In comparison, Misipawistik Cree Nation has the largest percentage of its members (552 or 38.3%) living off reserve.

Based on the past three census, the NOR-MAN region has seen an increase in the number of aboriginal people living in our region as shown in Figure 4.2.

![Aboriginal Population Growth](image)

Figure 4.2: Provincial Aboriginal Population Percentages, 2006 Census
Source: Manitoba Health, NRHA Profile Document, 2008/09

**NOR-MAN Métis Profile**

Similar to the accuracy issue on identifying our Aboriginal population numbers in the NOR-MAN region, we also have an accuracy issue when identifying Métis population from various data sources. Of note, we are currently a partner with the MMF Aboriginal Health Transition Fund project, to develop a Métis specific Health Atlas.

**Métis Populations**

Those persons who self-identifies as Mets, is distinct from the Aboriginal people, is of Historic Métis Nation ancestry, and is accepted by the Métis Nation

(Manitoba Métis Federation)
Release of this report is anticipated in late spring 2010.

Our best source of population information is from the Manitoba Métis Federation Inc. - The Pas Region. Their current registered membership is **3,157 individuals** which makes-up approximately **13.1%** of the NOR-MAN populations.

Table 4.4 shows the MMF population numbers for each NOR-MAN community with the exclusion of Métis individuals living in Pukatawagan.

<table>
<thead>
<tr>
<th>Community</th>
<th>Population Numbers</th>
<th>Community</th>
<th>Population Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Pas</td>
<td>1,331</td>
<td>Easterville</td>
<td>41</td>
</tr>
<tr>
<td>Umpherville</td>
<td>35</td>
<td>Grand Rapids</td>
<td>149</td>
</tr>
<tr>
<td>Young Point</td>
<td>40</td>
<td>Flin Flon</td>
<td>605</td>
</tr>
<tr>
<td>Big Eddy</td>
<td>10</td>
<td>Snow Lake</td>
<td>144</td>
</tr>
<tr>
<td>Rall’s Island</td>
<td>48</td>
<td>Cranberry Portage</td>
<td>135</td>
</tr>
<tr>
<td>Wanless</td>
<td>28</td>
<td>Sherridon/Cold Lake</td>
<td>47</td>
</tr>
<tr>
<td>Moose Lake</td>
<td>100</td>
<td>Regional Members</td>
<td>173</td>
</tr>
<tr>
<td>Cormorant</td>
<td>271</td>
<td><strong>Total</strong></td>
<td><strong>3,157</strong></td>
</tr>
</tbody>
</table>

Table 4.4: Registered Métis Population by Community, 2010
Source: Manitoba Métis Federation

**Saskatchewan Profile**

Another population group that needs to be highlighted is the approximately **8,322** northeastern Saskatchewan residents living in the communities of Creighton, Denare Beach, Pelican Narrows, Sandy Bay, Deschambault Lake and Sturgeon Landing that may access services (primarily acute care) and programs from the NRHA.

There is a formal service agreement between Manitoba and Saskatchewan Health for northeastern Saskatchewan residents to access service from the NOR-MAN Regional Health Authority.
Table 4.5 shows the population numbers for the Saskatchewan communities who maybe accessing services in the NOR-MAN region. These population figures are from Saskatchewan Health.

<table>
<thead>
<tr>
<th>Community</th>
<th>Population Numbers</th>
<th>Community</th>
<th>Population Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon, SK</td>
<td>305</td>
<td>Pelican Narrows</td>
<td>2121</td>
</tr>
<tr>
<td>Creighton</td>
<td>1784</td>
<td>Sandy Bay</td>
<td>1287</td>
</tr>
<tr>
<td>Denare Beach</td>
<td>840</td>
<td>Peter Ballantyne Cree Nation</td>
<td>1925</td>
</tr>
<tr>
<td>Sturgeon Landing</td>
<td>60</td>
<td>Totals</td>
<td>8322</td>
</tr>
</tbody>
</table>

Table 4.5: Saskatchewan Populations
Source: Health Information Solutions Centre, Ministry of Health, June 30, 2008

NOR-MAN Population Distribution

When reviewing our population distribution percentages at the community level, a number of interesting facts and trends need to be highlighted. Figure 4.3 shows the NOR-MAN population percentages by community. As shown, approximately 61% of the NOR-MAN population lives in the communities of Flin Flon (25%), The Pas (29%) and OCN (7%).

Population Percentages by Community

Figure 4.3: NOR-MAN Population Percentages by Community
Source: Manitoba Health Population Report - June 2008
Population Density

When reviewing Manitoba population density data, the province has been divided into the following population density categories: Urban, Semi Urban and Rural.

NOR-MAN is one of six regions in the rural population densities grouping. NOR-MAN covers a vast area of land and water of approximately 72,000 km$^2$. Excluding water, our service area coverage is approximately 41,471km$^2$.

As shown in Table 4.6, we have the second least densely populated region in the province. Our region has experienced a slight decrease from 0.61 in 1996 to 0.59 people per km$^2$ in 2006.

Table 4.6: Population Density

<table>
<thead>
<tr>
<th>RHA</th>
<th>Population Density</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba</td>
<td>2.09</td>
<td>2.11</td>
</tr>
<tr>
<td>Burntwood</td>
<td>0.13</td>
<td>0.13</td>
</tr>
<tr>
<td>NOR-MAN</td>
<td>0.61</td>
<td>0.60</td>
</tr>
<tr>
<td>Parkland</td>
<td>1.51</td>
<td>1.46</td>
</tr>
<tr>
<td>N. Eastman</td>
<td>0.94</td>
<td>0.97</td>
</tr>
<tr>
<td>Assiniboine</td>
<td>2.08</td>
<td>2.01</td>
</tr>
</tbody>
</table>

Table 4.6: Population Density by NOR-MAN District

Source: Manitoba Health, NRHA Profile Document, 2008/09

Table 4.7 shows our district population densities by district:

- District I has seen a decrease from 1996 - 2006
- District II has seen a decrease from 1996 - 2006
- District III has seen an increase from 1996 - 2006

Table 4.7: Population Density by NOR-MAN District

Source: Manitoba Health, NRHA Profile Document, 2008/09
Urban/Rural Populations

Within the NOR-MAN region, 58.2% of our residents live in a urban population area and 41.8% live in a rural population area according to the 2001 census. When comparing our 2001 to 1996 percentages, we have experienced a decrease in our urban population area from 60.5% in 1996 to 58.2% in 2001.

Our rural population areas have experienced an increase from 39.5% in 1996 to 41.8% in 2001.

NOR-MAN Population by Sex and Age Structure

Figure 4.4 shows the 2007/08 NOR-MAN population distribution by sex. These percentages have remained fairly constant for the last five (5) years.

**Urban Population**
refers to the percentage of the population living in an urban area - an urban population is defined as having a minimum of 1,000 people per square kilometer

(Manitoba Health)

**Rural Population**
refers to the percentage of the population living in an rural area - an rural population is defined as having a minimum of 400 people per square kilometer

(Manitoba Health)

NOR-MAN 2007/08 Population Distribution by Sex

- **Females** 49.82%
- **Males** 50.18%

Figure 4.4: NOR-MAN Population Breakdown by Sex
Source: Manitoba Health Population Report - June 2008
Of note for NOR-MAN, is that the largest percentage of males are aged 15 - 19 years of age compared to Manitoba males aged 45 - 49. The largest percentage of NOR-MAN females are aged 5 - 9 years compared to Manitoba females aged 75+.
When comparing the highlights between the NOR-MAN region and the Province of Manitoba as a whole the following differences are seen:

- **25.8% of NOR-MAN residents are under the age of 15** - 19.3% of Manitoba residents are under the age of 15
- **46.9% of NOR-MAN residents are under the age of 30** - 39.9% of Manitoba residents are under the age of 30
- **65.6% of NOR-MAN residents are between the ages of 15 and 64** - 67% of Manitoba residents are between the ages of 15 and 64
- **8.7% NOR-MAN residents are aged 65 years and older** - 13.7% of Manitoba residents are 65 years and older

**NOR-MAN Population by Community**

When reviewing age distributions at the community level, a number of interesting facts and trends need to be highlighted.

Table 4.8 provides an overview of the population age categories by community. This table shows both the total number of individuals in each age category, and the percentage rate for each age category.

As can be seen, Flin Flon and Snow Lake have the largest percentage of individuals 65 and over at 13% living in the community. In comparison, the First Nation communities only have 3% to 4% of their population over the age of sixty-five years (65).

When looking at our communities with the largest percentage of “young people,” each of the five First Nation communities and our Unorganized Territories all report that 57.3% to a high of 68.1% of their population is under the age of 30 years.

---

2006 census information reports the Median age of Manitoba is 38.1 years compared to NOR-MAN at 34.1 years (excluding the population of Pukatawagan / Mathias Colomb Cree Nation - which is reporting a Median age of 19.6 years)

(Statistics Canada)
When reviewing our population profile, it is important to also review our projected population in the years to come. Figure 4.6 compares the NOR-MAN population of 2006 to the projected population numbers for 2036.

The NOR-MAN region in 2006 had a population of 24,340 and currently is projected to have a population base of 20,950 people in 2036. Based on these projections, there will be fewer children age 0 - 14 years and fewer adults age 20 - 54 years. By 2036 we are expected to see a slight increase in adults age 65 - 85+.

Of note, the NOR-MAN region will experience a slow population decline of –13.9% compared to a +40.0% increase for the province as a whole. These projections are based on the assumption that current trends will continue to 2036.
NOR-MAN Populations by Social Support Factors

There are various demographic characteristics related to the social circumstances in which we live that are known to affect our health. These demographic characteristics for individuals 15 years and over include marital status, changes in place of residence and living alone

Legal Marital Status

In the NOR-MAN region, the largest percentage of our population is married at 46%. This rate is lower than both the provincial and the Canadian percentage at 50%.

Figure 4.7 shows the legal marital status by type for the NOR-MAN region as a whole.

Figures 4.8 to 4.12 show the legal marital status by NOR-MAN community for each of the following categories:

- Single, Married, Separated, Divorced, Widowed

Mathias Colomb Cree Nation has the highest percentage of single individuals in the NOR-MAN region at 66.3%
The Unorganized Territory has the highest percentage of married individuals in the NOR-MAN region at 58.1%.

Figure 4.9: Legal Marital Status - Married by Community
Source: Statistics Canada, 2006 Community Profile

Chemawawin Cree Nation has the highest percentage of separated individuals in the NOR-MAN region at 6.3%.

Figure 4.10: Legal Marital Status - Separated by Community
Source: Statistics Canada, 2006 Community Profile
### Marital Status - Widowed

Flin Flon - 7.1%
Snow Lake - 6.7%
Misipawistik CN - 4.9%
Opaskwayak CN - 4.7%
Grand Rapids - 6.1%
The Pas - 6.4%
RM of Kelsey - 4.2%
Chemawin CN - 4.5%
Mathias Colomb CN - 5.1%
Mosakahiken CN - 2.4%
Unorganized Territory - 5.3%

Flin Flon has the highest percentage of widowed individuals in the NOR-MAN region at 7.1%.

**Figure 4.12: Legal Marital Status - Widowed by Community**

Source: Statistics Canada, 2006 Community Profile

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### Marital Status - Divorced

Flin Flon - 7.9%
Snow Lake - 7.5%
Misipawistik CN - 4.9%
Opaskwayak CN - 3.9%
Grand Rapids - 2.0%
The Pas - 8.4%
RM of Kelsey - 5.5%
Chemawin CN - 3.6%
Mathias Colomb CN - 2.8%
Mosakahiken CN - 3.5

The Pas has the highest percentage of divorced individuals in the NOR-MAN region at 8.4%.

**Figure 4.11: Legal Marital Status - Divorced by Community**

Source: Statistics Canada, 2006 Community Profile
Internal/External Migration - Changes in Place of Residence

Review of mobility percentage rates within the NOR-MAN region helps to provide a clear picture of our changing community makeup.

According to Statistics Canada, the one-year mobility status rate for all NOR-MAN residents shows that 14% have changed their place of residence similar to the Manitoba rate at 13%. The positive story is that 85.7% of NOR-MAN residents are still living in the same location one year later.

When reviewing the one-year mobility status rate at the community level, we discover that the community of Grand Rapids has the lowest percentage of individuals living in the same location they did a year earlier at 77% and the community of Misipawistik Cree Nation has the highest percentage of individuals living in the same location at 96%. Other NOR-MAN communities showing a low rate of mobility and individuals who are still living in the same residence one year later are: Snow Lake at 95%, Mosakahiken CN at 94%, Unorganized Territories at 93%, Chemawawin CN at 92% and Mathias Colomb CN at 90%.

Table 4.9 shows the five-year mobility status for each NOR-MAN community. This table shows both the total numbers and percentage of individuals in each mobility category.

When reviewing the five year mobility status rates, we discover that the NOR-MAN rate is 36%, which is lower that the provincial rate of 37%.

This means that 64.0% of NOR-MAN residents are living in the same residence as they were five years earlier.
Economic Factors

Many characteristics relate to economic circumstances in which we live, and are known to affect our health. These demographic characteristics include educational attainment, labour force activity, income, earnings, and dependence rates.

Educational Attainment

Overall a large portion of the NOR-MAN population has less than a high school diploma. Research shows that people with less education are more likely to have low paying jobs that are not very fulfilling.
Regional Levels of Schooling by Age Group

Figure 4.13 shows the educational attainment levels for ages 15 - 24 years for both NOR-MAN and the Province of Manitoba. Our high school completion rate at 26.0% is lower than the provincial rate at 36.0%. Of note, is the fact that individuals under the age of 18 years are most likely still in school.

Our district high school completion rates are:
- District I - 39%,
- District II - 24%,
- District III - 15%.

Unfortunately due to changes in census age groupings, we are unable to show comparisons between 2006 and 2001 data.

The highest level of schooling attained by age group is shown in Figure 4.13:

- Less than high school: NOR-MAN 66.0%, Manitoba 48.0%
- High school: NOR-MAN 26.0%, Manitoba 36.0%
- Trades: NOR-MAN 3.0%, Manitoba 3.0%
- Other non-university: NOR-MAN 3.0%, Manitoba 7.0%
- University: NOR-MAN 2.0%, Manitoba 2.0%

Figures 4.14 shows the educational attainment levels for ages 25 - 64 years for both NOR-MAN and the Province of Manitoba. Our high school completion rate at 21.0% is lower than the provincial rate at 25.0%.

A large number of 25 - 64 year old NOR-MAN residents have completed either a Trade or Other Non-university certificate program than other Manitobans.

Our district high school completion rates are:
- District I - 28%,
- District II - 21%,
- District III - 13%.

The highest level of schooling attained by age group is shown in Figure 4.14:

- Less than high school: NOR-MAN 29.0%, Manitoba 48.0%
- High school: NOR-MAN 21.0%, Manitoba 36.0%
- Trades: NOR-MAN 3.0%, Manitoba 3.0%
- Other non-university: NOR-MAN 13.0%, Manitoba 19.0%
- University: NOR-MAN 16.0%, Manitoba 24.0%
Figure 4.15 shows the educational attainment levels for ages 65+ years for both NOR-MAN and the Province of Manitoba. Our high school completion rate at 26.0% is lower than the provincial rate at 36.0%.

When reviewing our educational attainment levels for NOR-MAN as a whole, we are more likely in each age category to have less education than most other Manitobans. This clearly shows the need to continually promote the benefits of education and the role that education plays in health.

**Community Levels of Schooling by Sex**

When looking at our levels of schooling for our 15 to 64 year olds by community, we see both similarities and differences. Table 4.10 highlights the top two highest levels of education obtained by community members in the NOR-MAN region. When reviewing the data table, it is important to remember that individuals age 15 to 19 years of age are mostly likely still in the school system and will be included in the less than grade 12 category.

When reading Table 4.10 the percentages shaded in light blue represent the largest proportion of

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**Figure 4.15: Highest Level of Schooling Attainment – Ages 65+ Years**

Source: Manitoba Health, NRHA Profile Document, 2008/09

Our district high school completion rates are:
- District I - 18%
- District II - 10%
- District III - 15%

NOR-MAN has a higher percentage of residents with less than a high school education or only a high school diploma in all age groups compared to provincial rates.

NOR-MAN has a total of 2071 individuals aged 15 - 19 years of age living in the region.
individuals at their highest level of schooling obtained and light green shading represents the second highest level of schooling obtained. According to the Youth Health Survey 61.0% of NOR-MAN respondents reported that they spend less than one hour a week reading and 66.0% reported that they spend less than one hour a week doing homework.

Highest Level of Schooling by NOR-MAN Community
Ages 15 - 64 Years

<table>
<thead>
<tr>
<th></th>
<th>Total Pop</th>
<th>Less than grade 12</th>
<th>High school diploma or equivalent</th>
<th>Apprenticeship or trades certificate or diploma</th>
<th>College, CEGEP, or other non-university certificate or diploma</th>
<th>University certificate or diploma below the bachelor level</th>
<th>University certificate, diploma or degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon</td>
<td>4490</td>
<td>33%</td>
<td>28%</td>
<td>13%</td>
<td>16%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td>245</td>
<td>29%</td>
<td>14%</td>
<td>12%</td>
<td>6%</td>
<td>27%</td>
<td>12%</td>
</tr>
<tr>
<td>Kelsey</td>
<td>1890</td>
<td>29%</td>
<td>24%</td>
<td>14%</td>
<td>19%</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Snow Lake</td>
<td>665</td>
<td>25%</td>
<td>35%</td>
<td>24%</td>
<td>17%</td>
<td>17%</td>
<td>2%</td>
</tr>
<tr>
<td>The Pas</td>
<td>4145</td>
<td>30%</td>
<td>22%</td>
<td>12%</td>
<td>22%</td>
<td>4%</td>
<td>11%</td>
</tr>
<tr>
<td>Chemawawin CN</td>
<td>560</td>
<td>79%</td>
<td>9%</td>
<td>2%</td>
<td>6%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Misipawistik CN</td>
<td>415</td>
<td>67%</td>
<td>19%</td>
<td>3%</td>
<td>2%</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Mathias Colomb CN</td>
<td>890</td>
<td>70%</td>
<td>10%</td>
<td>6%</td>
<td>6%</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Mosakahiken CN</td>
<td>425</td>
<td>74%</td>
<td>14%</td>
<td>7%</td>
<td>6%</td>
<td>3%</td>
<td>14%</td>
</tr>
<tr>
<td>OCN 21E</td>
<td>1365</td>
<td>60%</td>
<td>14%</td>
<td>7%</td>
<td>4%</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Unorganized Territory</td>
<td>1510</td>
<td>29%</td>
<td>16%</td>
<td>20%</td>
<td>7%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>16,660</strong></td>
<td><strong>39%</strong></td>
<td><strong>22%</strong></td>
<td><strong>11%</strong></td>
<td><strong>16%</strong></td>
<td><strong>4%</strong></td>
<td><strong>8%</strong></td>
</tr>
</tbody>
</table>

Table 4.10: Community Levels of Schooling - Ages 15-64 Years
Source: Statistics Canada, 2006 Community Profile

As shown in Table 4.10, the largest proportion of our 15 to 64 year olds have less than grade 12 at 39% or only a high school diploma or equivalent at 22%. At the individual community level, the same trend is occurring with the exception of Snow Lake.

When reviewing the same data for males as shown in Table 4.11 and females as shown in Table 4.12, we are again seeing a similar trend with the majority of NOR-MAN males at 62% and NOR-MAN females at 59% having less than grade 12 or only a high school diploma or equivalent.
### Male Highest Level of Schooling by NOR-MAN Community  
**Ages 15 - 64 years**

<table>
<thead>
<tr>
<th>Community</th>
<th>Total Pop</th>
<th>Less than grade 12</th>
<th>High school diploma or equivalent</th>
<th>Apprenticeship or trades certificate or diploma</th>
<th>College, CEGEP, or other non-university certificate or diploma</th>
<th>University certificate or diploma below the bachelor level</th>
<th>University certificate, diploma or degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon</td>
<td>2230</td>
<td>35%</td>
<td>26%</td>
<td>19%</td>
<td>11%</td>
<td>2%</td>
<td>7%</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td>115</td>
<td>17%</td>
<td>13%</td>
<td>22%</td>
<td>9%</td>
<td>30%</td>
<td>9%</td>
</tr>
<tr>
<td>Kelsey</td>
<td>980</td>
<td>35%</td>
<td>23%</td>
<td>18%</td>
<td>14%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Snow Lake</td>
<td>330</td>
<td>26%</td>
<td>32%</td>
<td>23%</td>
<td>12%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>The Pas</td>
<td>1965</td>
<td>33%</td>
<td>24%</td>
<td>15%</td>
<td>17%</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Chemawawin CN</td>
<td>285</td>
<td>81%</td>
<td>9%</td>
<td>0%</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Misipawistik CN</td>
<td>205</td>
<td>73%</td>
<td>15%</td>
<td>5%</td>
<td>0%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>Mathias Colomb CN</td>
<td>470</td>
<td>68%</td>
<td>9%</td>
<td>11%</td>
<td>4%</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Mosakahiken CN</td>
<td>220</td>
<td>75%</td>
<td>11%</td>
<td>7%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>OCN 21E</td>
<td>665</td>
<td>62%</td>
<td>14%</td>
<td>11%</td>
<td>10%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Unorganized Territory</td>
<td>785</td>
<td>29%</td>
<td>16%</td>
<td>22%</td>
<td>16%</td>
<td>3%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>8250</strong></td>
<td><strong>41%</strong></td>
<td><strong>21%</strong></td>
<td><strong>18%</strong></td>
<td><strong>12%</strong></td>
<td><strong>3%</strong></td>
<td><strong>7%</strong></td>
</tr>
</tbody>
</table>

**Table 4.11: Community Levels of Schooling - Males Ages 15-64 Years**  
**Source:** Statistics Canada, 2006 Community Profile

### Female Highest Level of Schooling by NOR-MAN Community  
**Ages 15 - 64 years**

<table>
<thead>
<tr>
<th>Community</th>
<th>Total Pop</th>
<th>Less than grade 12</th>
<th>High school diploma or equivalent</th>
<th>Apprenticeship or trades certificate or diploma</th>
<th>College, CEGEP, or other non-university certificate or diploma</th>
<th>University certificate or diploma below the bachelor level</th>
<th>University certificate, diploma or degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon</td>
<td>2255</td>
<td>31%</td>
<td>29%</td>
<td>8%</td>
<td>20%</td>
<td>4%</td>
<td>7%</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td>125</td>
<td>36%</td>
<td>12%</td>
<td>0%</td>
<td>8%</td>
<td>24%</td>
<td>16%</td>
</tr>
<tr>
<td>Kelsey</td>
<td>905</td>
<td>24%</td>
<td>24%</td>
<td>10%</td>
<td>25%</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>Snow Lake</td>
<td>340</td>
<td>24%</td>
<td>37%</td>
<td>9%</td>
<td>22%</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>The Pas</td>
<td>2180</td>
<td>28%</td>
<td>21%</td>
<td>7%</td>
<td>26%</td>
<td>5%</td>
<td>13%</td>
</tr>
<tr>
<td>Chemawawin CN</td>
<td>280</td>
<td>77%</td>
<td>11%</td>
<td>0%</td>
<td>9%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Misipawistik CN</td>
<td>205</td>
<td>61%</td>
<td>24%</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Mathias Colomb CN</td>
<td>425</td>
<td>71%</td>
<td>11%</td>
<td>2%</td>
<td>7%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Mosakahiken CN</td>
<td>210</td>
<td>71%</td>
<td>17%</td>
<td>0%</td>
<td>5%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>OCN 21E</td>
<td>695</td>
<td>58%</td>
<td>14%</td>
<td>4%</td>
<td>16%</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>Unorganized Territory</td>
<td>725</td>
<td>28%</td>
<td>14%</td>
<td>5%</td>
<td>24%</td>
<td>12%</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>8345</strong></td>
<td><strong>37%</strong></td>
<td><strong>22%</strong></td>
<td><strong>6%</strong></td>
<td><strong>20%</strong></td>
<td><strong>5%</strong></td>
<td><strong>10%</strong></td>
</tr>
</tbody>
</table>

**Table 4.12: Community Levels of Schooling - Females Ages 15-64 Years**  
**Source:** Statistics Canada, 2006 Community Profile
Aboriginal Educational Attainment Levels

For the NRHA, with 50% of our population claiming Aboriginal identity, it is important to review the educational attainment levels at both the regional and community levels for this specific population. The overall NOR-MAN percentage of individuals age 15 and over claiming Aboriginal identity with less than a High School Diploma is 52.57% and 18.93% for having only a High School Diploma.

Table 4.13 shows by community, the rates for those age 15 and over who have claimed Aboriginal identity and have less than a grade 12 education to those with a high school graduation or equivalent. Unfortunately, there is no data available for the communities of Grand Rapids and Snow Lake.

<table>
<thead>
<tr>
<th>Community</th>
<th>Aboriginal Population</th>
<th>Less Than High School Graduation</th>
<th>High School Graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon</td>
<td>635</td>
<td>42.5 %</td>
<td>35.4 %</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td></td>
<td>No data available</td>
<td></td>
</tr>
<tr>
<td>RM of Kelsey</td>
<td>690</td>
<td>41.3 %</td>
<td>21.7 %</td>
</tr>
<tr>
<td>Snow Lake</td>
<td></td>
<td>No data available</td>
<td></td>
</tr>
<tr>
<td>The Pas</td>
<td>1520</td>
<td>39.5 %</td>
<td>21.1 %</td>
</tr>
<tr>
<td>Chemawawin CN</td>
<td>545</td>
<td>80.7 %</td>
<td>8.3 %</td>
</tr>
<tr>
<td>Misipawistik CN</td>
<td>415</td>
<td>66.3 %</td>
<td>19.3 %</td>
</tr>
<tr>
<td>Mathias Colomb CN</td>
<td>895</td>
<td>72.6 %</td>
<td>8.9 %</td>
</tr>
<tr>
<td>Mosakahiken CN</td>
<td>425</td>
<td>74.1 %</td>
<td>14.1 %</td>
</tr>
<tr>
<td>Opaskwayak CN</td>
<td>1345</td>
<td>59.9 %</td>
<td>13.8 %</td>
</tr>
<tr>
<td>Unorganized Territory</td>
<td>520</td>
<td>45.2 %</td>
<td>15.4 %</td>
</tr>
</tbody>
</table>

Table 4.13: Highest Level of Schooling Attainment - Aboriginal Identity by NOR-MAN Community
Source: Statistics Canada, 2006 Aboriginal Population Profile

Table 4.14 shows some college or university, trade certificate or diploma and university degree percentages by NOR-MAN community for those who have claimed Aboriginal identity. Aboriginal people living in the communities of The Pas, RM of Kelsey and the Unorganized Territory have the highest percentage of people living in the community with a University Degree.
In most of the NOR-MAN First Nation communities, people over the age of 15 years appear to be at a disadvantage from an educational perspective, when compared to people residing in non-First Nations communities. Although this problem is less serious in the Opaskwayak Cree Nation, OCN has the smallest percentage of people from their community not having completed high school at a rate of 59.9%.

### Labour Force Indicators

Information on the labour force activities provides us with an indication of how many NOR-MAN residents are earning their income through full and part-time employment.

### Regional Labour Force Indicators

Figure 4.16 shows the labour force comparisons between the NOR-MAN region (excluding the community of Pukatawagan / Mathias Colomb Cree Nation) and the Province of Manitoba. The NOR-MAN region has almost double the provincial unemployment rate at 10.8% vs. 5.5%.

<table>
<thead>
<tr>
<th>Community</th>
<th>Aboriginal Population</th>
<th>Apprenticeship or Trade Certificate or Diploma</th>
<th>Some College or Non-University Certificate or Diploma</th>
<th>Some University</th>
<th>University Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon</td>
<td>635</td>
<td>9.4%</td>
<td>10.2%</td>
<td>1.6%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td>No data available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RM of Kelsey</td>
<td>690</td>
<td>10.1%</td>
<td>18.1%</td>
<td>4.3%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Snow Lake</td>
<td>No data available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Pas</td>
<td>1520</td>
<td>8.6%</td>
<td>19.4%</td>
<td>5.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Chemawasin CN</td>
<td>545</td>
<td>1.8%</td>
<td>5.5%</td>
<td>1.8%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Misipawistik CN</td>
<td>415</td>
<td>2.4%</td>
<td>2.4%</td>
<td>6.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Mathias Colomb CN</td>
<td>895</td>
<td>6.1%</td>
<td>5.0%</td>
<td>3.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Mosakahiken CN</td>
<td>425</td>
<td>3.5%</td>
<td>4.7%</td>
<td>0.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Opaskwayak CN</td>
<td>1345</td>
<td>7.4%</td>
<td>13.0%</td>
<td>2.6%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Unorganized Territory</td>
<td>520</td>
<td>14.4%</td>
<td>18.3%</td>
<td>3.8%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

Table 4.14: Highest Level of Schooling Attainment - Aboriginal Identity by NOR-MAN Community
Source: Statistics Canada, 2006 Aboriginal Population Profile

**Labour Force**

- **Participation Rate** - refers to the labour force (employee and unemployed) in the week (Sunday to Saturday) prior to the Census Day (May 16, 2006), expressed as a percentage of the population 15 years and over excluding institutional residents.

- **Employment Rate** - refers to the number of people employed expressed as a percentage.

- **Unemployment Rate** - refers to the number of people unemployed expressed as a percentage of the labour force.

- **In the Labour Force** - refers to person who were either employed or unemployed during the week prior to Census Day.

(Statistics Canada)
With the NOR-MAN population being composed of 50.2% males and 49.8% females it is important to compare labour force indicators by sex as shown in Figures 4.17 and 4.18.

The following differences are to be noted:

- Labour Force participation rates for NOR-MAN males are 71.1% which is similar to the provincial rate of 72.8%
- Labour Force participation rates for NOR-MAN females are 62.2% which is similar to the provincial rate of 62.0%
- Labour Force participation rates for NOR-MAN males are 71.1% which is higher than the participation rate of NOR-MAN females at 62.2%.
• Both NOR-MAN males at 11.5% and NOR-MAN females at 10.0% have higher unemployment rates than the provincial rates of 5.5% for males and 5.4% for females.

• NOR-MAN females at 10% have lower unemployment rates than Nor-Man males at 11.5%.

Labour Force Participation Rates by Community

When reviewing our labour force participation rates at the community level, differences between the smaller and larger NOR-MAN communities are easily seen.

Figure 4.19 shows the labour force participation rates at the NOR-MAN community level.

The communities of Flin Flon (70.7%), RM of Kelsey (74.5%) and The Pas (69.5%) have the...
highest labour force participation rates in the region while Mathias Colomb CN (36.2%) and Mosakahiken CN (37.6%) have the lowest rates.

Employment Rates by Community

When reviewing our employment rates at the community level, differences between the smaller and larger NOR-MAN communities are easily seen.

Figure 4.20 shows the employment rates at the NOR-MAN community level.

Lack of employment opportunities for youth in their home communities was identified during our consultations.

The communities of Flin Flon (67.5%), Grand Rapids (67.3%), RM of Kelsey (65.5%) and The Pas (64.5%) have the highest employment rates in the region.

The communities of Snow Lake (56.4%), Unorganized Territory (56.1%), Misipawistik CN (44.6%), OCN (40.4%), Chemawawin CN (32.1%), Mathias Colomb CN (29.4%) and Mosakahiken CN (27.1%) have lowest employment rates in the region.
Unemployment Rates by Community

Figure 4.21 shows the unemployment rates at the NOR-MAN community level.

A large difference between the smaller and larger NOR-MAN communities is also easily seen when reviewing the unemployment rates in the NOR-MAN region.

The communities of Grand Rapids at 0%, Flin Flon at 4.6%, Snow Lake at 5.1% and The Pas at 7.3% have the lowest unemployment rates in the region.

The communities of RM of Kelsey at 12.1%, Unorganized Territory at 13.3%, Mathias Colomb CN at 18.8%, OCN at 23.6%, Mosakahiken CN at 28.1%, Misipawistik CN at 32.7%, Chemawawin CN at 43.8% have the highest unemployment rates in the region.

Income and Income Sources

Household income and personal income come from a variety of sources. These include
employment, government transfer incomes and other sources such as personal savings.

**Total Income Comparison**

Figure 4.22 shows the types of income comparisons between NOR-MAN (excluding the community of Pukatawagan / Mathias Colomb Cree Nation) and the Province of Manitoba.

**Income Comparisons**

<table>
<thead>
<tr>
<th>Type of Income</th>
<th>Manitoba</th>
<th>NOR-MAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td>Government Transfers</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Other Money</td>
<td>12%</td>
<td>8%</td>
</tr>
</tbody>
</table>

When comparing NOR-MAN income sources to Manitoba as a whole, our total earnings percentage of income is higher at 80% vs. 75%.

**Total Income Sources by Community**

Table 4.15 compares the composition of total income by community and type for both the 2006 and 2001 census.

Although government transfers continue to be highest in First Nation communities, we have experienced a reduction since our last CHA report.

---

**Government Transfer Income Payments:**

are made to individuals by federal or provincial governments, organizations or institutions. Government transfer income includes some of the following types of payments: Employment Insurance, GST Credits, Child Tax Credits, Old Age Security Payments, Net Federal Supplements, Canadian Pension Plan, superannuation and other (private) pensions, non-taxable income and provincial refundable tax credits. Individuals who receive these types of payment do so without providing any goods or services in return.

(Statistics Canada)
Based on the 2006 census data, the NOR-MAN region had 15,235 residents over the age of 15 who reported income. The median total income for NOR-MAN residents over the age of 15 was $23,320.00 (excluding Pukatawagan/ Mathias Colomb Cree Nation – which is located in a different census division) compared to the Manitoba median total income of $24,194.00.

Table 4.16 compares the median total income by community for both the NOR-MAN region and Manitoba as a whole for the 2001 and 2006 census.

Although we have a slightly lower median total income than the provincial average, NOR-MAN ‘s rate of median total income has increased overall by $3,133.00 which is trending similar to the Manitoba increase.

Those communities highlighted in red are currently experiencing median total incomes lower than the NOR-MAN value of $23,320.00.
Average Earnings by Community

Of those individuals with earnings, the average earnings for NOR-MAN residents is **$25,130.00** (Manitoba average earnings was **$24,484.00**). Figure 4.23 shows the average earnings for all NOR-MAN residents by community.

Based on the 2006 census data, the NOR-MAN region had **11,310 individuals with earnings**. (These figures do not include the community of Pukatawagan / Mathias Colomb Cree Nation. Pukatawagan / Mathias Colomb Cree Nation had 345 individuals with earnings). As is clearly shown, the residents of our smaller communities are at a disadvantage due to the lack of economic opportunities in their communities for earning income.

---

**Table 4.16: Median Total Income by Community**

<table>
<thead>
<tr>
<th>Community</th>
<th>Median Total Income—2006</th>
<th>Median Total Income—2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon</td>
<td>$26,245.00</td>
<td>$24,380.00</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td>$23,838.00</td>
<td>$20,416.00</td>
</tr>
<tr>
<td>RM of Kelsey</td>
<td>$24,108.00</td>
<td>$25,989.00</td>
</tr>
<tr>
<td>Snow Lake</td>
<td>$34,696.00</td>
<td>$25,244.00</td>
</tr>
<tr>
<td>The Pas</td>
<td>$27,665.00</td>
<td>$23,501.00</td>
</tr>
<tr>
<td>Chemawawin CN</td>
<td>$15,392.00</td>
<td>$9,312.00</td>
</tr>
<tr>
<td>Misipawistik CN</td>
<td>$16,016.00</td>
<td>$10,656.00</td>
</tr>
<tr>
<td>Mathias Colomb CN</td>
<td>$9,472.00</td>
<td>$10,464.00</td>
</tr>
<tr>
<td>Mosakahiken CN</td>
<td>$10,976.00</td>
<td>$8,032.00</td>
</tr>
<tr>
<td>Opaskwayak CN</td>
<td>$12,192.00</td>
<td>$9,280.00</td>
</tr>
<tr>
<td>Unorganized Territory</td>
<td>$23,967.00</td>
<td>$25,380.00</td>
</tr>
<tr>
<td>NOR-MAN Total</td>
<td>$23,320.00</td>
<td>$20,187.00</td>
</tr>
<tr>
<td>Manitoba Total</td>
<td>$24,194.00</td>
<td>$20,469.00</td>
</tr>
</tbody>
</table>

Source: Statistics Canada, 2006 Community Profile

---

Earnings

refers to total income received by persons 15 years and older who received wages and salaries, net income from non-farm unincorporated business and/or professional practice, and/or net farm self-employment income during the calendar year, who reported non-zero earnings

(Statistics Canada)
When comparing the 2006 Average Earnings by Community with the 2001 values for all NOR-MAN communities with the exception of Chemawawin CN and Misipawistik CN, our average earnings by community have decreased.

Average Earnings For Full Time Employment

Figure 4.24 highlights the average earnings for full time employment by community. As is clearly shown, the residents of our smaller communities are again at a disadvantage due to the lack of economic opportunities in their communities.

When reviewing the average earnings for full time employment from the 2006 census, 5,805 NOR-MAN residents who worked full time for a full year had average earnings of $44,493.00 (excluding Pukatawagan / Mathias Colomb Cree Nation. Pukatawagan / Mathias Colomb Cree Nation had 125 individuals with earnings for full time employment).

2001 Average Earnings by community are:

- Flin Flon - $31,964
- Grand Rapids - $27,859
- Snow Lake - $35,580
- The Pas - $29,854
- Chemawawin CN - $15,017
- Misipawistik CN - $17,722
- Mathias Colomb CN - $18,610
- Mosakahiken CN - $13,321
- OCN - $18,610
- Unorganized - $34,683

The NOR-MAN average earnings for full time employment is higher than the Manitoba average of $36,692.00.

Full Time Employment
refers to having worked for 49 to 52 weeks in 2005, mostly full time and reported earnings

(Statistics Canada)
When comparing the 2006 Worked Full Time - Average Earnings by Community with the 2001 census values, all NOR-MAN communities with the exception of Grand Rapids experienced an increase in their worked full time average earning.

When comparing average earnings to the worked full time average earnings by community, there is an increase in average earnings in all NOR-MAN communities. However, our larger communities have the higher worked full time average earnings.

**Median Household Income**

Based on the 2006 census data, the NOR-MAN region had 7,935 private households which is a decrease from the 2001 census data of 8,415 private households. These households can be described as one of the following “types”:

- **Couples (married or common law) with children** - 29% or 2,290 households (Manitoba rate is 28%)
• **Couples** (married or common law) **without children** - 27% or 2,160 households (Manitoba rate is 28%)

• **One-person households** - 25% or 2,015 households (Manitoba rate is 29%)

• **Other households** - 19% or 1,470 households (Manitoba rate is 16%)

Figure 4.25 shows the median household incomes by family type for the NOR-MAN region (excluding the community of Pukatawagan / Mathias Colomb Cree Nation) compares to provincial incomes.

When reviewing the median household incomes at a community level, a very different picture appears. Some important facts are:

• **Snow Lake** has the highest median household income at **$75,515.00**.

• **Mosakahiken Cree Nation** has the lowest median household income at **$27,989.00** and the lowest one-person median household income at **$11,232.00**.
• The larger NOR-MAN communities have higher median household incomes for each income type.

• The unorganized territory of the NOR-MAN region is a combination of the smaller Northern Affairs communities, as well as the “lake area residents”. The unorganized territory has the second highest median income in the NOR-MAN region. This is due to the inclusion of the “lake area residents” and provides a good example of why we look at various data sources to help paint the picture of each of our communities.

Median Family Income

Next, we will review the median family incomes by family structure for the NOR-MAN region. Median family income provides the best indication of income levels in a community. The reason being that a few extremely high or extremely low incomes can skew the average income. Median household income reflects the dollar value at which point half of the families have higher incomes and half have lower incomes.

Based on the 2006 census data, the NOR-MAN region had 5,975 families living in the region, these families can be described as one of the following types”

- 61% or 3,665 married-couple families
- 16% or 960 common-law families
- 23% or 1,345 lone-parent families, of which:
  - 78% or 1,050 are female lone-parent families
  - 22% or 290 are male lone-parent families

Figure 4.26 shows the median family incomes by family type for the NOR-MAN region (excluding the community of Pukatawagan / Mathias Colomb Cree Nation) compared to provincial incomes.
NOR-MAN married-couple families have a higher median family income at $74,717.00 than the provincial rate of $67,013.00. For all other family types the NOR-MAN income values are lower than the provincial values.

Also when comparing the 2006 Median Family Income with the 2001 data, the NOR-MAN common-law couple families was the only category that experienced an decrease in family income from $68,527.00 in 2001 to $50,016.00 in 2006.

When reviewing the median family incomes at a community level, some facts should be noted:

- Snow Lake has the highest median family income at $84,008.00.

- Mathias Colomb Cree Nation has the lowest median family income at $23,296.00 and the lowest lone-parent median family income at $15,072.00.
- The larger NOR-MAN communities are reporting higher median family incomes for each income type.

- Lone-parent family incomes vary by community and when compared to couple family incomes: Cranberry Portage has the largest difference of just over six times less at $11,764.00 compared to a couple family at $72,215.00; Pukatawagan/Mathias Colomb CN has a difference of about two and a half time less at $15,072.00 compared to $38,336.00 and Mosakahiken CN has a difference of just less than two times at $16,704.00 compared to $32,960.00.

### Dependency Ratio

Understanding the population dependency ratio is important because the higher the rate, the more socially and/or economically dependent are the non-working group on the working age group.

Figure 4.27 shows the dependency ratio over three points in time.

#### Population Dependency Ratio per 100 Working-Age Individuals

<table>
<thead>
<tr>
<th>Year</th>
<th>Manitoba</th>
<th>NOR-MAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>56.5</td>
<td>55.7</td>
</tr>
<tr>
<td>2001</td>
<td>54.4</td>
<td>54.6</td>
</tr>
<tr>
<td>2006</td>
<td>51.6</td>
<td>54.3</td>
</tr>
</tbody>
</table>

Figure 4.27: Population Dependency Ratio
Source: Statistics Manitoba Health Information Management, RHA Profile Document
NOR-MAN’s dependency ratio is slightly higher than Manitoba as a whole. However, both NOR-MAN and Manitoba have experienced a decline in the rates since 1996.

In 2006, there were 54.3 individuals of non-working age for every 100 people of working age in the NOR-MAN region compared to a Manitoba ratio of 51.6/100.

When reviewing the 2006 dependency ratio at a district level, we can see variations:

- District I - 45.1/100 and this ratio has experienced a decline from a high of 54.6/100 in 2001.

- District II - 51.6/100 and this ratio has increased compared to the 2001 value of 51.2/100

- District III - 74.8/100 and this ratio has experienced a decline from a high of 79.7/100 in 2001.

Language

One of the cornerstones of our health plan is a commitment to deliver services in a manner that respects the cultural diversity and language(s) spoken by NOR-MAN residents.

Table 4.17 presents data from the 2006 census that describes the languages used by individuals in the NOR-MAN RHA region.

<table>
<thead>
<tr>
<th>Languages</th>
<th>Male # (%)</th>
<th>Female # (%)</th>
<th>Totals # (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Only</td>
<td>8,765 (82)</td>
<td>8,795 (82)</td>
<td>17,560 (82)</td>
</tr>
<tr>
<td>French Only</td>
<td>150 (1)</td>
<td>95 (1)</td>
<td>240 (1)</td>
</tr>
<tr>
<td>Both English &amp; French</td>
<td>15 (0)</td>
<td>10 (0)</td>
<td>25 (0)</td>
</tr>
<tr>
<td>Other Languages</td>
<td>1795 (17)</td>
<td>1,810 (17)</td>
<td>3,605 (17)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>10,725</td>
<td>10,710</td>
<td>21,430</td>
</tr>
</tbody>
</table>

Table 4.17: Language(s) First Learned and Still Understood
Source: Statistics Canada, 2006 Community Profile – Division No. 21
As seen, 82% of NOR-MAN residents speak only English, while 17% speak a language other than English or French and 1% speak only French. The percentage of NOR-MAN residents speaking English at home is the same as for all Manitobans at 74%.

When comparing to our 2001 census data for language(s) first learned and still understood, the percentage of “other languages” for both males and females has increased from 17% to 21%

### Aboriginal Language(s)

Within the NOR-MAN region, **Cree is the Aboriginal language most frequently spoken by NOR-MAN residents** and according to Statistics Canada, 2006 Aboriginal Population Profile 28.4% of the Aboriginal identity population stated they have knowledge of Aboriginal language(s) compared to a Manitoba Provincial percentage of 25.2%.

When reviewing the data for Aboriginal identity population whose mother tongue is an Aboriginal language, the 2006 NOR-MAN rate is 26.5% compared to a provincial rate of 21.6%.

However, only 13% stated that an Aboriginal language was spoken at home. This is also a decrease from the 2001 reported rate of 29%.

During the last five years the NOR-MAN region has experienced a decrease in the use and understanding of Aboriginal Language(s).

A clearer picture of Aboriginal languages spoken in the NOR-MAN region is available by reviewing the Aboriginal language characteristics at the community level.

Figures 4.28 and 4.29 presents the 2006 Aboriginal Population Profile percentage for Aboriginal identity populations by NOR-MAN community
with respect to Aboriginal language(s) spoken at home and as mother tongue.

Aboriginal language(s) spoken at home varies greatly by community with Mosakahiken CN at 50.7% and Mathias Colomb CN at 46.2% having the highest rates of individuals speaking an Aboriginal language(s) at home.

Figure 4.35 shows that Aboriginal language(s) spoken as their mother tongue also vary greatly between communities.

Mosakahiken CN at 67.9%, Chemawawin CN at 62.9%, Mathias Colomb CN at 58.3% are reporting the highest rates in NOR-MAN region.
Summary

The NOR-MAN region covers a vast area of land spanning approximately 72,000 square kilometers in the central western part of the province. The people and the communities that make up the region display considerable diversity in origin, governance structure, economic base, service availability and interconnectedness.

The demographic information that has been reviewed includes age, gender, marital status, place of residence, education levels, income, labour force activities, dependency ratio and language. Each of these categories has been reviewed in order to begin to describe or paint the picture of the life circumstances, in each NOR-MAN community.

This brief demographic overview highlights some of the key characteristics of the NOR-MAN region that have a direct relationship and which ultimately impact on the health status of all NOR-MAN residents.

The NOR-MAN region is home to about 2.1% of the total Manitoba population. There are approximately 24,090 people living in the NOR-MAN region, of which:

- our region’s rural and remoteness – the number of small widely scattered communities impacts the health of our region
- NOR-MAN is showing a small yearly decrease in our population over the past five (5) years
- 50.0% of NOR-MAN residents claim Aboriginal identity (Manitoba rate is 15%)
- 13.1% of NOR-MAN residents are registered members of The Pas MMF Region
- Approximately 61% of the NOR-MAN population lives in the communities of Flin Flon, The Pas and OCN
• 58.2% of NOR-MAN residents live in an urban population area
• 41.8% of NOR-MAN residents live in a rural population area
• 49.8% of NOR-MAN residents are female
• 50.2% of NOR-MAN residents are male
• 25.8% of NOR-MAN residents are under the age of 15 (Manitoba rate is 19.3%)
• 46.9% of NOR-MAN residents are under the age of 30 (Manitoba rate is 39.9%)
• 8.7% of NOR-MAN residents are 65 years or older (Manitoba rate is 13.7%)
• Flin Flon and Snow Lake 65+ category rate is similar to the Manitoba rate
• The largest proportion of NOR-MAN males are the 15-19 year age group.
• The largest proportion of NOR-MAN females are the 5-9 year age group
• NOR-MAN’s population is projected to decrease by \(-13.9\%\) by the year 2036 (Manitoba +40.0% increase)
• By 2036, there will be a significant decrease in the number of people who are in the age category of 20 - 54 years and an increase in the 55 years and older age category
• 46% of NOR-MAN residents are married, 38% are single, 7% are divorced, 6% are widowed and 3% are separated
• NOR-MAN’s unemployment rate is almost double the provincial unemployment rate
• When comparing NOR-MAN income sources to Manitoba as a whole, our total earnings percentage of income is higher at 80% vs. 75%.
• There are 5,975 families living in the region, of which 61% are married-couple families, 16% are common-law families, and 23% are lone-parent families.

• This means that 64% of NOR-MAN residents are living in the same residence as they were five years earlier.

• 82% of NOR-MAN residents speak only English, while 17% speak a language other than English or French, and 1% speak only French.

• There has been a decrease in the use and understanding of Aboriginal language(s) since our last report.

Some of the factors hindering our ability to live a healthier lifestyle includes:

• our lower education levels

• our higher than average unemployment rates

• our lower than average incomes in the smaller NOR-MAN communities

• our inequality in income levels between the low and high wage earners

• our lone parent family income levels are significantly lower than our couple families income levels

• our population dependency ratios vary greatly between our districts

For the NOR-MAN Regional Health Authority, it is necessary to continue to monitor the demographics of our region, as they are the foundation for the development of quality health care programs and services.
Chapter 5

How healthy are the people of the NOR-MAN Region?

This chapter includes facts about the general health of people who live in the NOR-MAN region.

We will explore whether or not NOR-MAN residents have better or poorer health status in comparison with the rest of the province and other Regional Health Authority regions. It will also look at trending information since our last Community Health Assessment (CHA) report and if our health status is improving or worsening over time.

The specific health indicators that will be reviewed are in the following five (5) key areas:

1. Mortality
2. Illness Burden / Chronic Conditions
3. Well Being
4. Functional Health
5. Mental Health
Mortality

Mortality is made up of a number of indicators that measure death outcomes in the NOR-MAN region. The indicators to be reviewed are:

- Total Mortality Rates
- Premature Mortality Rates (PMR)
- Life Expectancy
- Potential Years of Life Lost (PYLL)
- Infant Mortality Rates
- Suicide Rates
- Leading Causes of Death
- Leading Causes of Cancer Death
- Injury Mortality Rates

Mortality information helps to identify opportunities for interventions to improve the health of NOR-MAN residents, particularly where deaths are premature or preventable.

Total Mortality Rates

Total Mortality Rate for the NOR-MAN region compared to the provincial rate for the periods of 1996-2000 and 2001-2005 is shown in Figure 5.1.

Our mortality rates have risen slightly, and we are statistically different (higher) than the Manitoba average in both time periods.

Figure 5.1: Total Mortality Rates by RHA
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
Premature Mortality Rates

The literature suggests that **Premature Mortality Rate (PMR)** is the best single measure to reflect the health status of a region’s population. PMR is difficult to interpret - it might be helpful to remember that the higher a PMR value, the poorer the health status of that population. PMR results are adjusted to account for the age and sex composition of each region.

Populations having a high PMR value are more likely to have their residents report poor overall health, larger number of chronic diseases, and more illness.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Manitoba Rate (1)</th>
<th>NOR-MAN Rate (1, 2)</th>
<th>District I</th>
<th>District II (1,2)</th>
<th>District III (1,2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996 – 2000</td>
<td>3.48/1,000</td>
<td>4.55/1,000</td>
<td>3.16/1,000</td>
<td>5.15/1,000</td>
<td>6.45/1,000</td>
</tr>
<tr>
<td>2001 – 2005</td>
<td>3.29/1,000</td>
<td>4.40/1,000</td>
<td>3.44/1,000</td>
<td>4.42/1,000</td>
<td>6.51/1,000</td>
</tr>
</tbody>
</table>

Table 5.1: Premature Mortality Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

Table 5.1 compares PMR rates at the provincial, regional and district levels. For our region, our PMR rate continues to be statistically different (higher) than the provincial rate.

However, during the second time period, we did experience a decrease but it was not statistically significant.

Of special note is that District I has a lower PMR rate than the provincial rate, but has experienced a small increase in the second time period. Both District II and District III are statistically different (higher) than the provincial PMR rates.

When reviewing the PMR from the last CHA report, the NOR-MAN region continues to experience a decline in our rate from **5.45/1,000** in 1990-1994 to **4.62/1,000** in 1995-1999 to our current rate of **4.40/1,000**.
Life Expectancy (at birth)

Life Expectancy is widely used as a basic measure of the health of a population.

The Life Expectancy for males in the NOR-MAN region is 73.4 years of age, and 77.6 years of age for females, which unfortunately has declined slightly. Table 5.2 shows that although NOR-MAN averages for both males and females are statistically lower than the Manitoba provincial rate, NOR-MAN males have experienced an increase in their Life Expectancy.

![Table 5.2: Life Expectancy Chart](source)

<table>
<thead>
<tr>
<th>Year</th>
<th>Manitoba Males</th>
<th>NOR-MAN Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991 – 1995</td>
<td>75.4 years</td>
<td>70.6 years</td>
</tr>
<tr>
<td>1996 – 2000</td>
<td>75.9 years</td>
<td>72.9 years (1)</td>
</tr>
<tr>
<td>2001 – 2005</td>
<td>76.3 years (1)</td>
<td>73.4 years (2)</td>
</tr>
</tbody>
</table>

![Table 5.3: Life Expectancy Chart by NOR-MAN District](source)

<table>
<thead>
<tr>
<th>District</th>
<th>NRHA Males</th>
<th>NOR-MAN Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>District I</td>
<td>75.9 years</td>
<td>79.7 years</td>
</tr>
<tr>
<td>District II</td>
<td>73.1 years (1,2)</td>
<td>77.2 years (1,2)</td>
</tr>
<tr>
<td>District III</td>
<td>69.6 years (2)</td>
<td>74.4 years (1,2)</td>
</tr>
</tbody>
</table>

When reviewing Life Expectancy at a district level, differences can easily be seen. Table 5.3 shows the 2001-2005 district level data. District II and III are statistically different (lower) than the Manitoba rate which clearly highlights that higher life expectancy rates are found in our larger more developed communities.
Potential Years of Life Lost

Potential Years of Life Lost (PYLL) is similar to PMR but gives greater weight to the death of a young person. PYLL adds up the number of years “lost” when a person dies before the age of 75.

Between 1996-2000 and 2001-2005, the NOR-MAN region experienced a decrease in PYLL from 80.8/1,000 to 72.0/1,000 due to deaths from all causes. For Manitoba as a whole, the decrease was from 54.8/1,000 to 50.9/1,000.

When reviewing the PYLL data at a district level there are a number of differences between our districts:

- District I experienced a decrease from 65.0/1,000 to 40.6/1,000
- District II experienced a decrease from 72.9/1,000 to 59.1/1,000
- District III experienced an increase from 125.8/1,000 to 134.8/1,000

The top causes for Potential Years of Life Lost for the period of 2002 – 2006 remain in the same order as reported in the last CHA report. Current rates in the NOR-MAN region for both males and females are:

1. deaths from unintentional injuries - NOR-MAN males at 19.6/1,000 compared to a provincial rate of 10.6/1,000 and NOR-MAN females at 7.2/1,000 compared to a provincial rate of 4.6/1,000

2. deaths from circulatory diseases - NOR-MAN males at 13.1/1,000 compared to a provincial rate of 12.6/1,000 and NOR-MAN females at 8.2/1,000 compared to a provincial rate of 5.1/1,000

3. deaths from cancer - NOR-MAN males at 12.6/1,000 compared to a provincial rate of 14.2/1,000 and NOR-MAN females at 4.6/1,000 compared to a provincial rate of 5.1/1,000
15.6/1,000 compared to a provincial rate of 13.8/1,000

4. **deaths from suicide** - NOR-MAN males at 5.7/1,000 compared to a provincial rate of 6.5/1,000 and NOR-MAN females at 2.1/1,000 compared to a provincial rate of 2.3/1,000

5. **deaths from respiratory diseases** - NOR-MAN males at 3.1/1,000 compared to a provincial rate of 2.1/1,000 and NOR-MAN females at 2.2/1,000 compared to a provincial rate of 1.6/1,000

**Infant Mortality**

Infant mortality (death) rates are commonly used as indicators of health of a population. Research has shown that infant mortality is strongly related to socioeconomic status, meaning as area-level decreases, infant mortality rates increase.

**Infant Mortality Rates by RHA**

Crude rates per 1,000 infants, all infants included

<table>
<thead>
<tr>
<th>Region</th>
<th>2001-2005</th>
<th>Manitoba Avg 2001-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Eastman</td>
<td>7.06</td>
<td>6.71</td>
</tr>
<tr>
<td>Central</td>
<td>7.06</td>
<td>7.06</td>
</tr>
<tr>
<td>Assiniboine</td>
<td>7.06</td>
<td>7.06</td>
</tr>
<tr>
<td>Brandon</td>
<td>7.06</td>
<td>7.06</td>
</tr>
<tr>
<td>Winnipeg</td>
<td>7.06</td>
<td>7.06</td>
</tr>
<tr>
<td>Interlake</td>
<td>7.06</td>
<td>7.06</td>
</tr>
<tr>
<td>North Eastman</td>
<td>7.06</td>
<td>7.06</td>
</tr>
<tr>
<td>Parkland</td>
<td>7.06</td>
<td>7.06</td>
</tr>
<tr>
<td>Churchill (s)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nor-Man</td>
<td>6.33</td>
<td>6.33</td>
</tr>
<tr>
<td>Burntwood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North</td>
<td>7.06</td>
<td>7.06</td>
</tr>
<tr>
<td>Manitoba</td>
<td>6.71</td>
<td>6.71</td>
</tr>
</tbody>
</table>

'S' indicates data suppressed due to small numbers

Figure 5.2: Infant Mortality Rates by RHA

Source: Manitoba Centre for Health Policy, Child Health Atlas Update, November 2008
When reviewing Figure 5.2, the NOR-MAN region experienced an increase in our infant mortality rates from a crude rate of 6.33/1,000 for all infants born between 1996 to 2000 to a crude rate of 10.17/1,000 for all infants born between 2001 to 2005. Even though we experienced an increase over time and our rate continues to be higher than the Manitoba rate, it is not statistically significant.

NOR-MAN was one of three regions to experience an increase in infant mortality rates and our main cause of death in both time periods is due to congenital anomalies (medical conditions at birth) at a rate of 26% and 38%.

**Suicide Rates**

Between 2000 and 2006, suicides and assaults were amongst the leading causes of death for Manitobans under the age of 54. Compared to the earlier time period of 1993-1999, suicide deaths have increased for those under the age of 54 years, but have decreased for older Manitobans.

According to the Manitoba Provincial Injury Data Report, the largest decrease between the two time period (1993/99 to 2000/06) was observed in those over 85 years of age, and the largest increase between the two time periods was observed in those 15 to 24 years.

When reviewing regional level data over two time periods (1996/00 to 2001/05) as shown in Figure 5.3,

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**Suicide**

is the act of intentionally killing oneself

Rate is reported as a two-year prevalence of suicide as a percentage of the population age 10 and older

(Manitoba Centre for Health Policy)

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**Figure 5.3: Suicide Rates by RHA**

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
NOR-MAN continues to experience higher rates at **0.17/1,000** and **0.23/1,000** than the provincial rates of **0.14/1,000** and **0.16/1,000**.

We experienced an increase, but not a statistical increase, in our suicide rates in the second time period. According to data presented in the MCHP 2004 *Patterns of Regional Mental Illness Disorders Diagnoses and Service Use in Manitoba: A Population-Based Study*, the Manitoba males age and sex-adjusted suicide rate at **2.01/10,000** were three times higher when compared to the female rate of **0.63/10,000**. This report also identified that the most common suicide method for males was **hanging** at **37.4%** and for females the most common suicide method was **poisoning** at **50.9%**.

The *Manitoba Provincial Injury Data Update* report for the period of 2000-2006 reported that the NOR-MAN region lost **1,161 years due to deaths from suicide**. Suicide was our second highest Potential Years of Life Lost (PYLL) following motor vehicle/traffic deaths. NOR-MAN males reported **758** years of life lost, while NOR-MAN females reported **403** years of life lost.

When all the risk factors available are considered together in a regression analysis, the key factors predicting **suicide** are:

- Being male
- Having been diagnosed with a mental illness in the previous year
- Being young
- Having poor health

The key factors predicting either **suicide or attempted suicide** are:

- Living in Northern Manitoba or rural South (compared to living in Winnipeg or Brandon)
- Being female
- Being young
- Having been diagnosed with a mental illness in the previous year
- Living in a low income area

In Manitoba, suicide rates are higher for residents in lower income areas.

Suicide and suicide attempts were identified as a concern during our consultation activities.
Leading Causes of Death

The top two (2) leading causes of death in the NOR-MAN region and in the Province of Manitoba have remained the same for the periods of 1992-1996, 1997-2001 and 2002-2006.

When reviewing Figure 5.4, you will see that during the period of 2002-2006, the percentage rate for the top three leading cause of death is due to Diseases of the Circulatory System at 26.3% for NOR-MAN and 33.0% for Manitoba. The second leading cause of death is due to Neoplasms (Cancers) at 24.7% for the NOR-MAN and 27.0% for Manitoba. The third leading cause of death for the NOR-MAN region is due to Endocrine, Nutritional & Metabolism Conditions at a rate of 9.8% for NOR-MAN and 5.0% for Manitoba.

Approximately 51% of all female and male deaths in the NOR-MAN region can be attributed to either diseases of the circulatory systems or to neoplasms (cancer). The only difference between NOR-MAN males and females is the top cause of death. Figure 5.5 shows the NOR-MAN percentages for each of the top five leading causes.
of death by sex.

The leading cause of death in the NOR-MAN region for females is Diseases of the Circulatory System which accounts for 28.2% of all female deaths. The leading cause of death for males is from Cancer at 26.6% during the time period of 2002-2006.

**Leading Causes of Cancer Deaths**

The second leading cause of death in the NOR-MAN region is Neoplasms (cancers) which accounts for 23% of all female deaths and 27% of all males deaths for the period of 2002-2006.

The 2000-2005 Cancer death by region and cancer type is currently only available for the “North”. The “North” is comprised of the three northern Regional Health Authorities of NOR-MAN, Burntwood and Churchill. During the time period of 2000-2005, the top three leading causes of male cancer deaths in the “North” were lung
cancer (71 deaths), colorectal cancer (25 deaths) and prostate cancer (24 deaths).

While, the top three leading causes of female cancer deaths in the “North” were lung cancer (50 deaths), colorectal cancer (25 deaths) and breast cancer (18 deaths).

When comparing the “North” cancer deaths by sex as shown in Tables 5.4 and 5.5 with the province as a whole, we clearly see that northern males have higher rates of both lung and prostate cancer. While, northern females have higher rates of lung, and breast cancer than the provincial rates.

**2000 – 2005 Top 5 Cancer Mortalities - Males and Females**

<table>
<thead>
<tr>
<th>Male Cause of Cancer Death</th>
<th>North</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>31.7%</td>
<td>28.9%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>10.7%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Prostate</td>
<td>11.2%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>2.2%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Bladder</td>
<td>1.3%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Other</td>
<td>42.9%</td>
<td>42.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female Cause of Cancer Death</th>
<th>North</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>28.7%</td>
<td>25.6%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>10.3%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Breast</td>
<td>14.4%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>6.9%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Ovary</td>
<td>2.3%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Other</td>
<td>37.4%</td>
<td>42.0%</td>
</tr>
</tbody>
</table>

The NOR-MAN region has a high level of both smokers and former smokers:
- **Current smokers rate — 27.2%**
- **Former smokers rate — 45.2%**

(Canadian Community Health Survey Cycles 1.1 (2001), 2.1 (2003), and 3.1 (2005))
Endocrine, Nutritional and Metabolic Disease

The third leading cause of death in the NOR-MAN region for both males at 8.8% and females at 10.8% is due to diseases of the endocrine system. The endocrine system comprises the following eight glands: pituitary, thyroid, adrenal gland, testes, pineal, thymus, pancreas and ovary glands. Our main concern with the death rate due to the endocrine system is the link to diabetes mellitus as our rates continue to increase.

The NOR-MAN region has seen an increase in the number of deaths due to diseases of the endocrine system. Our rates have risen from a low of 3.3% in 1992/99, to 6.1% in 1997/00 to a current high of 9.8% in 2002/06.

When reviewing our increases by sex, we see similar increases for both sexes. NOR-MAN males have increased from a low of 3.2% in 1992/99, 4.9% in 1997/00, to our current high of 8.8% in 2002/06. For NOR-MAN females during the same time period, our increases were 3.4% to 7.9% to the current high of 10.8%. Of note, is the fact that NOR-MAN females in each time period have higher rates than NOR-MAN males.

Injury Mortality Rates

Between 2000 and 2006, injury was the fourth leading cause of death in Manitoba. While for the North, injury has remained the third leading cause of death. Northern residents appear to be more likely to die as a result of injuries than were all other Manitobans.

Leading Causes of Injury Deaths

The leading causes of injury deaths in NOR-MAN are different from the leading causes of injury deaths for Manitoba. The leading causes of injury deaths in Manitoba from 2000 – 2006 compared to 1993-1999 were:
During the 2000 - 2006 period, Manitoba experienced an increase in injury deaths due to increases in suicide, falls, poisoning and assaults compared to 1993 - 1999 rates.

During the 2000 - 2006 period, the only increase in injury deaths experienced by NOR-MAN residents was due to assaults.

1. **Suicide** at a rate of 12.1/100,000 (11.4)
2. **Falls** at a rate of 10.6/100,000 (7.6)
3. **Motor Vehicle / Traffic** at a rate of 8.6/100,000 (9.9)
4. **Poisoning** at a rate of 3.8/100,000 (1.5)
5. **Assaults** at a rate of 3.4/100,000 (2.3)

While, the leading causes of injury deaths in NOR-MAN for the same time period were:

1. **Motor Vehicle / Traffic** at a rate of 16.7/100,000 (18.0)
2. **Suicide** at a rate of 16.1/100,000 (16.8)
3. **Assaults** at a rate of 6.9/100,000 (4.1)
4. **Falls** at a rate of 5.8/100,000 (6.4)
5. **Drowning** at a rate of 5.8/100,000 (8.7)

Table 5.6 shows injury death rates by sex. The NOR-MAN injury death rate by sex shows that females in the NOR-MAN region are less likely to die due to an injury compared to NOR-MAN males. NOR-MAN males were more likely to die from suicide and NOR-MAN females were more likely to die from motor vehicle / traffic injuries.

<table>
<thead>
<tr>
<th>Cause of Injury Death 2000 - 2006</th>
<th>NOR-MAN Male</th>
<th>NOR-MAN Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor Vehicle / Traffic</td>
<td>19.3/100,000</td>
<td>14.0/100,000</td>
</tr>
<tr>
<td>Suicide</td>
<td>22.7/100,000</td>
<td>9.3/100,000</td>
</tr>
<tr>
<td>Assaults</td>
<td>13.6/100,000</td>
<td>0.0/100,000</td>
</tr>
<tr>
<td>Fall</td>
<td>4.5/100,000</td>
<td>7.0/100,000</td>
</tr>
<tr>
<td>Drowning</td>
<td>10.2/100,000</td>
<td>1.2/100,000</td>
</tr>
</tbody>
</table>

Table 5.6: Leading Cause of Injury Deaths
Source: Manitoba Health, Manitoba Provincial Injury Data Report, 2009
Illness Burden / Chronic Diseases

Many health conditions decrease the quality of life of our NOR-MAN residents. Illness burden/chronic diseases are an important measure of the health status of our population. Characteristics that are used to define chronic disease include multiple risk factors, long-lasting, uncertain cause, and functional impairment. The top burden of illness/chronic diseases within the NOR-MAN region include:

- Hypertension
- Ischemic Heart Disease (IHD)
- Heart Attacks (AMI)
- Stroke
- Diabetes
- Cancer
- Arthritis
- Respiratory
- Osteoporosis
- Injury Hospitalization

As we review each of the listed illnesses/chronic diseases, we need to be clear on the following two concepts: “Incidence rate” and “Prevalence levels”

It is important to remember that it is difficult to estimate the “incidence” of many chronic diseases, therefore “prevalence” is usually reported.

Hypertension

Figure 5.6 shows that NOR-MAN residents age 25 and older have a statistically different (higher) hypertension prevalence rate of 25.7% compared to the provincial hypertension rate of 23.7%
During the reporting period of 2005-2006. Of note, is the fact that both Manitoba and NOR-MAN’s hypertension rate change over time was statistically significant (higher).

Hypertension Treatment Prevalence
Age and sex-adjusted percentage residents 19 years and older

Figure 5.7 highlights the district level hypertension rates. Of note for the time period of 2000-2006 is the change over time for all three districts is statistically significant (higher).

Hypertension or high blood pressure, is a condition wherein one’s systolic blood pressure is equal to or greater than 140mm HG and/or diastolic pressure is equal to or greater than 90mm Hg.

(American Public Health Association, 1988)

Hypertension prevalence increases with age, and women are generally at higher risk.
The implications of hypertension are great, placing an individual at risk for a variety of health problems, including coronary heart disease, stroke, congestive heart failure, kidney failure, and peripheral vascular disease.

Many of the risk factors for hypertension are lifestyle related and for the most part can be modified. The major changes required by NOR-MAN residents with hypertension or high blood pressure are weight reduction, increased physical activity, reduced sodium intake, and reduced alcohol consumption. In short, major changes to one’s lifestyle is required. Research also shows that to eliminate tobacco use and to reduce the intake of saturated fats and cholesterol are necessary since all of these lifestyle choices compound the risk for coronary heart disease and stroke.

**Ischemic Heart Disease (IHD) Prevalence**

According to the Women’s Health Profile Report, males are more likely to suffer from IHD than women. During the period of 2002/03 - 2003/04, the difference between Manitoba males at 7.0% and females at 4.0% is showing a statistically significant difference between males and females. The NOR-MAN region shows a similar trend with males at 7.1% and females at 4.3%. Based on this data, women do suffer from IHD, the difference being that they are normally affected at later ages.

Figure 5.8 shows our rate of IHD occurring in 2001/02 to 2005/06 has decreased from 9.0% to 8.5% over the two time periods, this is the same trend being shown at the provincial level. However, the provincial rate has seen a statistically significant decrease over time.
When reviewing IHD prevalence data at the district level, as shown in Figure 5.9 a number of differences between our districts are clearly shown.

- District I has an IHD prevalence rate below the provincial average for both time periods and experienced a small decrease in the second time period.
- District II has experienced a small decrease in the second time period.
- District III IHD rates are statistically different (higher) than the provincial rate for both time periods.

**Stroke**

Stroke data is comprised of a combination of hospitalizations and/or deaths due to strokes experienced by NOR-MAN residents age 40 and older in each of two five year time periods. (This is not a percentage, as an individual may suffer more than one stroke in the five year period).

NOR-MAN residents are experiencing more strokes in each of the two time periods than all
Although the rate of strokes occurring in the NOR-MAN region is higher than the provincial rate in both time periods, we have experienced a decrease from 4.9/1,000 to 3.7/1,000, which is statistically different (lower). This is the same trend being shown at the provincial level (4.1/1,000 and 3.1/1,000).

When reviewing data at a district level as shown in Figure 5.11, the following differences are of note:

- District I has a rate lower than the provincial rate in both time periods
- District II has seen a statistically significant decrease over time during the second time period
- District III has experienced an increase in their stroke rate from the first time period to the second time period and now our increase is statistically different (higher) than the provincial rate
Heart Attacks / Acute Myocardial Infarction (AMI)

Acute Myocardial Infarctions (AMI), more commonly called “heart attacks,” are a combination of both hospitalizations (over three days in length) and/or deaths due to heart attacks experienced by NOR-MAN residents age 40 and older in each of two time periods. (This is not a percentage, as an individual may suffer more than one heart attack in a five year period).

Figure 5.12 shows that NOR-MAN residents are experiencing more heart attacks than all Manitobans in both time periods.

The promising news for NOR-MAN residents is that our rates have decreased from 5.9/1,000 in 1996/97 - 2000/01 to 5.2/1,000 in 2001/02 - 2005/06.

Acute Myocardial Infarction (AMI)

Also known as a heart attack occurs when the heart muscle experiences sudden (acute) deprivation of circulating blood. The interruptions of blood are usually caused by narrowing of the coronary arteries leading to a blood clot. The clogging is usually initiated by cholesterol accumulating on the inner wall of the blood vessels that distribute blood to the heart muscle.

AMI rates are reported over a five year period.

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
the first time period to a rate of 5.2/1,000 in the second time period. The province also experienced a decrease but the decrease was a statistically significant change over time.

When reviewing the data at a district level, as shown in Figure 5.13, it is important to note the following differences:

- District I has experienced a small decrease in rates in the second time and continues to have lower rates than the provincial rate in both time periods.
- District II has experienced a decrease from their statistically different (higher) rate of 7.8/1,000 in the first time period to a rate of 5.7/1,000.
- District III has experienced an increase and this increase is statistically different (higher) at a rate of 8.6/1,000 compared to the provincial rate of 4.6/1,000.

**Diabetes**

Diabetes continues to be a growing problem in the NOR-MAN region. Figure 5.14 shows the percentage of individuals aged 19 and over who, over a three-year period, had a diagnosis of diabetes.

NOR-MAN has a statistically different (higher) percentage of residents diagnosed with diabetes in each of the two time periods compared to all Manitobans. Also of note, is that the change over
time for both NOR-MAN and the province is statistically significant—our rate continues to increase.

Manitoba women have the highest reported diabetes prevalence rates in Canada

**Diabetes**

Diabetes mellitus is a chronic condition in which the pancreas no longer produces enough insulin (Type 1) or when cells stop responding to the insulin that is produced (Type 2) so that the glucose in the blood cannot be absorbed into the cells of the body.

Diabetes Treatment prevalence means having had two or more physician visits or one hospitalization in either or both of the three year time periods.

Figure 5.14: Diabetes Rate
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Figure 5.15 shows diabetes treatment prevalence rates at the NOR-MAN district level. However, when district level data is reviewed the following differences are of note:

**Diabetes Treatment Prevalence**

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
• all three districts have diabetes rates higher than the provincial rate

• District II and III have experienced a statistically different (higher) diabetes treatment prevalence with the highest rates occurring in District III.

• our diabetes treatment prevalence rate is getting worse faster than the Manitoba time trend rate for both District II and III.

Within the NOR-MAN region, there is a strong belief that the NOR-MAN cases of diabetes are significantly underestimated. It is generally accepted that for every person known to have diabetes, another person with diabetes remains undiagnosed. Some of the reasons for this belief are those individuals receiving their health care from provincial or federal nursing stations - may not be seen by a doctor, or “shadow-billing” may not always be completed. Additionally, persons from Saskatchewan, who use resources in the NOR-MAN region are not included in NOR-MAN totals.

Type 2 Diabetes is known as a “lifestyle” disease and can be delayed or prevented. Considering the consequences of elevated blood glucose (sugar) levels, diabetics are at risk for a host of related ailments, including a number of eye diseases, diseases of the small blood vessels, as well as premature arteriosclerosis, kidney disease and neuritis (any disease of the peripheral nervous system which interferes with sensation, the nerve control of muscles, or both). Many of these complications are preventable or controllable if detected early and properly treated. To this end, the NRHA Diabetes Education Resource Program (DER) has been working towards both the reduction and prevention of diabetes within the NOR-MAN region. The NRHA DER Program continues to target both individuals with diabetes and individuals at risk of developing diabetes.
One of the major concerns for the NRHA with respect to diabetes is the fact that at present, approximately 59.5% of the NOR-MAN population are under forty years old and have not yet reached the age when incidence and prevalence rates increase dramatically.

**Cancer Incidence**

Cancer incidence is the measure of new cancer cases. According to CancerCare Manitoba’s Manitoba Cancer Registry, during the periods from 2000/02 and 2003/05, the NOR-MAN incidence of “All Cancers” are higher than the provincial rate.

As shown in Figure 5.16, the NOR-MAN “All Cancer” incidence rate for males in time period one is \(666.8/100,000\) compared to a provincial rate of \(558.6/100,000\) and is \(541.2/100,000\) compared to a provincial rate of \(527.4/100,000\) in the second time period.

Cancer is a group of disease in which abnormal cells in some organ or tissue begins to grow in an uncontrolled manner. Cancer incidence rates refer to the number of new cancer cases.

Since our last CHA report NOR-MAN Males Cancer Incidence rates have fluctuated from:
- 1996-2000 at \(536.2/100,000\)
- 2000-2002 at \(666.8/100,000\)
- 2003-2006 at \(541.2/100,000\)
434.3/100,000 and is 461.8/100,000 compared to a provincial rate of 427.1/100,000 in the second time period.

**Cancer Incidence Rates - Females**
Annual age-standardized rate per 100,000 residents

![Graph showing cancer incidence rates for females](image)

Since our last CHA report
NOR-MAN Female
Cancer Incidence rates have fluctuated from:
- 1996-2000 at 441.7/100,000
- 2000-2002 at 507.2/100,000
- 2003-2005 at 461.82/100,000

The cancer incidence rates for both males and females at the NOR-MAN and the provincial level have experienced a decrease between the two time periods.

Table 5.7 compares specific cancer incidence rates for NOR-MAN and Manitoba males and females:

<table>
<thead>
<tr>
<th></th>
<th>NOR-MAN 2000/2002 (per 100,000)</th>
<th>Manitoba 2000/2002 (per 100,000)</th>
<th>NOR-MAN 2003/2005 (per 100,000)</th>
<th>Manitoba 2003/2005 (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Breast</td>
<td>146</td>
<td>123</td>
<td>114</td>
<td>122</td>
</tr>
<tr>
<td>Cervical</td>
<td>7</td>
<td>9</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Colorectal</td>
<td>87</td>
<td>88</td>
<td>82</td>
<td>55</td>
</tr>
<tr>
<td>Lung</td>
<td>131</td>
<td>74</td>
<td>87</td>
<td>60</td>
</tr>
<tr>
<td>Prostate</td>
<td>184</td>
<td>148</td>
<td>148</td>
<td></td>
</tr>
<tr>
<td>Melanoma</td>
<td>11</td>
<td>suppressed</td>
<td>13</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 5.7: Cancer Incidence Rate per 100,000
Source: Manitoba Health, NRHA Profile Document, 2008/09
After reviewing the top six cancer types by sex, we see both good and bad news for NOR-MAN residents:

- **Breast** - NOR-MAN’s rate decreased to below the provincial rate in the second time period
- **Cervical** - NOR-MAN’s rate increased to a rate higher than the provincial rate in the second time period
- **Colorectal** - NOR-MAN’s rate decreased to below the provincial rate in the second time period for and females - males saw a small decrease but are still higher than the provincial rate
- **Lung** - both NOR-MAN male and female rates are higher than the province during the second time period - it appears that our female lung cancer rate is increasing faster
- **Prostate** - NOR-MAN’s rate decreased to below the provincial rate in the second time period
- **Melanoma** - NOR-MAN’s rate showed a small increase for males and a larger increase for females in the second time period. NOR-MAN females have a lower rate than the province as a whole. NOR-MAN male rates are higher than NOR-MAN female rates in both time periods. The rates for NOR-MAN females is increasing faster than the male rate.

**Cancer Prevalence**

When reviewing our cancer prevalence rates (all individuals who have been diagnosed with cancer and who are living as of December 31, 2005) in the NOR-MAN region, we have experienced a fluctuation in our rates over time for males and females when compared to the provincial rate.

Figure 5.18 shows that NOR-MAN males have a
prevalence rate of $5,145/100,000$ compared to the provincial male rate of $4,811/100,000$ in 2005.

Figure 5.18: Cancer Prevalence—Males
Source: Manitoba Health, NRHA Profile Document, 2008/09

Figure 5.19 shows that NOR-MAN females have a prevalence rate of $7,074/100,000$ compared to the female provincial rate of $3,678/100,000$.

Figure 5.19: Cancer Prevalence—Females
Source: Manitoba Health, NRHA Profile Document, 2008/09

When reviewing a number of different cancer types for NOR-MAN individuals with respect to cancer specific prevalence rates over a six year time period, the following highlights are of note:
- Breast Cancer - experienced a small decline in 2005 and is higher than Manitoba
- Cervical Cancer - experienced a small decline in 2005 and is higher than Manitoba
- Colorectal Cancer - has remained stable over the five years for both NOR-MAN males and females, and during 2005 both male and female rates were higher than Manitoba
- Lung Cancer - has fluctuated over the years for both males and females and continues to be higher than Manitoba
- Prostate Cancer - experienced a small decline in 2005 and is higher than Manitoba
- Melanoma Cancers - the NOR-MAN male rate has remained stable over the last three years and the female rate has remained stable for the last five years - NOR-MAN males have a lower rate and our female rate is higher than Manitoba

Arthritis

When reviewing our arthritis treatment prevalence rates for 1999/20-2000/01 and 2004/05-2005/06, NOR-MAN is statistically different (higher) than the provincial rate in time period two. During time period one, our rate was 25.9% compared to 20.9% for Manitoba as a whole. The good news is that during the second time period our rate experienced a slight decrease to 24.9% compared to the provincial rate of 20.2%.

For our region, district level data provides us with important information:

- District I is statistically different (higher) than the Manitoba in both time periods and the change over time is statistically significant - higher
- District II is statistically different (higher) than Manitoba in both time periods

Arthritis is one of the most prevalent chronic conditions in Canada, and a leading cause of long-term disability, pain, and increased health care utilization.

Osteoarthritis (OA):
is caused by the breakdown of cartilage at a joint, often resulting from overuse or an injury

Rheumatoid Arthritis (RA):
is an autoimmune disease that causes chronic inflammation in the lining of the joints
• District III has a rate similar to the Manitoba rate

**Total Respiratory Morbidity (TRM)**

Total respiratory morbidity (TRM) refers to the number of people who have been diagnosed with one of the following respiratory disease; such as asthma, acute bronchitis, chronic bronchitis, emphysema or chronic airway obstruction.

When reviewing our regional data, for 2000/01 and 2005/06 NOR-MAN’s rates are statistically different (lower) in both time periods compared to the Manitoba rate. Period one rates are 11.3% compared to 12.4%, and period two rates are 9.7% compared to 11.6%. Both the NOR-MAN and provincial rates in the second time period saw a statistically significant change over time - a decrease.

**Osteoporosis**

Osteoporosis leads to decreasing bone strength and increased risk of broken bones, particularly of the hip, spine and wrist.

When reviewing Osteoporosis prevalence rate for 1998/99-2000/01 and 2003/04-2005/06 we have experienced an increase in our rates. During the second time period our rate of 14.6% was statistically different (higher) than the provincial rate of 12.7%.

Also, both the NOR-MAN region and Manitoba as a whole experienced a statistically significant change over time - rates are now higher. Of note, as a new indicator the rate is likely an under-estimate of the true burden of osteoporosis because it only includes clinically diagnosed cases.

Figure 5.20 shows osteoporosis rates by NOR-MAN districts, it is important to note that all three of our districts have experienced a statistically
significant change over time - an increase.

Osteoporosis Prevalence Rates by District
Age & sex-adjusted of residents age 50 and older

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District I (t)</td>
<td>8.2%</td>
<td>12.4%</td>
</tr>
<tr>
<td>District II (t)</td>
<td>8.4%</td>
<td>15.3%</td>
</tr>
<tr>
<td>District III (2,t)</td>
<td>12.5%</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

Figure 5.20: Osteoporosis Prevalence Rates by NOR-MAN District
Source: Manitoba Health, NRHA Profile Document, 2008/09

Injury Hospitalization

Research shows that 90% of all injuries are predictable and preventable and safety prevention is broader than the absence of injuries. Safety needs to be everyone’s business.

Research also indicates that injury hospitalizations are strongly related to a person’s socioeconomic status - injuries increase as a community’s income decreases.

Figure 5.21 shows that injury hospitalizations have decreased for both the NOR-MAN region and the province as a whole and our decrease has been statistically significant.

Although, the NOR-MAN rate in both time periods is just shy of double the provincial rate.

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

District III’s Osteoporosis rate is statistically different (higher) at 17.5% than the provincial rate

Figure 5.21: Injury Hospitalization Rates by RHA
Source: Manitoba Centre for Health Policy, NRHA Profile Document, 2008/09
Table 5.8 highlights our top five injury hospitalization causes for two time periods.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male  Female</td>
<td>Male  Female</td>
<td>Male  Female</td>
</tr>
<tr>
<td>Falls</td>
<td>637.1/100,000</td>
<td>459.0/100,000</td>
</tr>
<tr>
<td>Assaults</td>
<td>324.8/100,000</td>
<td>267.9/100,000</td>
</tr>
<tr>
<td>Self Inflicted</td>
<td>107.9/100,000</td>
<td>79.5/100,000</td>
</tr>
<tr>
<td>Motor Vehicle / Traffic</td>
<td>153.3/100,000</td>
<td>110.1/100,000</td>
</tr>
<tr>
<td>Struck By/Against</td>
<td>212.4/100,000</td>
<td>112.4/100,000</td>
</tr>
</tbody>
</table>

Table 5.8: Leading Cause of Injury Hospitalizations: NOR-MAN
Source: Manitoba Health, Manitoba Provincial Injury Data Report, 2009

Figure 5.22 highlights our district level injury hospitalization data.

**Injury Hospitalization Rates by District**

<table>
<thead>
<tr>
<th>District</th>
<th>1996/97 - 2000/01</th>
<th>2001/02 - 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (1)</td>
<td>13.4</td>
<td>9.8</td>
</tr>
<tr>
<td>II (1,2)</td>
<td>17.5</td>
<td>13.0</td>
</tr>
<tr>
<td>III (1,2)</td>
<td>29.1</td>
<td>29.6</td>
</tr>
</tbody>
</table>

Figure 5.22 Injury Hospitalization Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

When reviewing our district level data, a number of differences need to be highlighted.

- During the first time period all three NOR-MAN districts had a statistically different (higher) rate than the provincial rate.
- The good news for the NOR-MAN region is that both District I and II saw a statistically significant decrease over time.
• Unfortunately, during the second time period both District II and III continue to be statistically different (higher) than the provincial rate.

When reviewing injury hospitalization data from the Child Health Atlas for children age 0 to 9 years, the NOR-MAN rate is statistically different (higher) at 160.55/10,000 than the provincial rate of 68.5/10,000 during the time period of 1996/97 – 2000/01.

The good news story is that although our rate is still statistically different (higher) than the provincial rate, we have experienced a statistically significant change over time—a decline to 114.45/10,000.

When reviewing injury hospitalization rates, it is important to remember that injury rates tend to increase as children age, with the highest rates of hospitalization being for children age 15—19 years.

Well Being

A person’s well being is subjective. The results of the following indicator are based on self-reported information from the Canadian Community Health Surveys (CCHS) based on self-rated health. When reviewing any CCHS data, remember that the survey do not occur on First Nation communities.

Self-Rated Health

Figure 5.23 shows the percentage of NOR-MAN residents participating in the CCHS reporting excellent and very good self-rated health at a rate of 56.9% compared to the provincial rate of 60.7%.

The response rate of 17.3% for NOR-MAN residents reporting excellent health is statistically different (lower) than the Manitoba rate of 21.9%.
District level data for those individuals reporting excellent or very good self-rated health are as follows:

- District I reported a rate of 56.3%
- District II reported a rate of 59.3%
- District III data was suppressed.

**Functional Health**

Functional health is a useful indicator because it helps to see the number of residents who may have ongoing health problems that affect the quality of their lives based on the two key indicators:

- Perfect Physical Functioning
- General Mental Health Scale

**Physical Functioning**

The physical functioning scale asks participants to rate their basic physical functioning on a scale of 0 to 100 (0 meaning unable to bathe or dress your self or walk one block; with 100 meaning capable of vigorous activity).
Figure 5.24 shows the perfect physical functioning for NOR-MAN residents at a rate of **57.9%** compared to the provincial rate of **55.6%**. More NOR-MAN residents report having perfect physical health than Manitoba as a whole.

**General Mental Health Scale**

Figure 5.25 shows the general mental health scale responses for NOR-MAN residents in three categories; high, medium and low self-rated general mental health.

14.5% of NOR-MAN males compared to 23.8% of NOR-MAN females reported low general mental health - the difference between males and females is significant.

62.1% of NOR-MAN males and 53.8% of NOR-MAN females reported perfect physical functioning.
More NOR-MAN residents reported better overall mental health at a rate of 47.7% compared to the provincial rate of 40.1%. In fact, the NOR-MAN rate for “high” is statistically different (higher) than the provincial rate. Also of note, is that the NOR-MAN region’s rate for “low” at 19.2% is statistically different (lower) than the provincial rate of 25.4%.

Mental Illness

The 2004 “Patterns of Regional Mental Illness Disorder Diagnoses and Service Use in Manitoba: A Population-Based Study,” released by the Manitoba Centre for Health Policy states that mental illness has a staggering impact on Manitoba’s health care system. Between 1997 - 2002, 37% of Manitobans had at least one mental health diagnosis. The study found that one (1) in ten (10) visits to physicians and one (1) in ten (10) hospitalizations are related to issues of mental illness. The study stated that 24% of all Manitobans were diagnosed with one or more of the following cumulative disorders:

- Depression
- Anxiety Disorders
- Substance Abuse
- Schizophrenia
- Personality Disorders

Cumulative Disorders

Is an overall indicator of mental illness, defined as a proportion of the population who receive treatment for any of the following: depression, anxiety disorders, substance abuse, personality disorders and/or schizophrenia. Cumulative Disorders rates are reported over a five year period.

(Manitoba Centre for Health Policy)

Figure 5.26 shows the difference between the NOR-MAN and the provincial prevalence rates of cumulative disorders.

Prevalence of Cumulative Disorders

Age and sex-adjusted percent of residents age 10 and older with disorder

Figure 5.26: Treatment Prevalence of Cumulative Mental Health
Source: Manitoba Centre for Health Policy, Manitoba RHA Indicator Atlas, 2009

Mental health issues were identified as a major health concern during all our consultations.
Of note, is the NOR-MAN rate during the last time period is lower than the provincial prevalence rate. Also, the provincial rate has seen a statistically significant change over time - an increase.

When reviewing our district level cumulative disorders prevalence data for the second time, the following differences are of note:

- District I rate was 19.9% which has experienced a small increase, but is statistically different (lower) than the provincial rate
- District II rate was 26.9% which has experienced a small decrease
- District III rate was 22.6% which experienced a small increase.

**Depression**

Depression is a relatively common mental disorder that causes substantial suffering and disruption in the lives of those affected and those around. Many individuals suffer varying degrees of depression.

Figure 5.27 shows that the NOR-MAN prevalence rate for depression in both time periods is statistically different (lower) than the provincial rate.

![Figure 5.27: Treatment Prevalence of Depression](image)

Source: Manitoba Centre for Health Policy, Manitoba RHA Indicator Atlas, 2009

According to the Youth Health Survey 45% of NOR-MAN youth who responded that they have felt so sad in the past 12 months that they stopped doing some of their usual activities for a while.
When reviewing NOR-MAN’s treatment prevalence of depression rates by sex, females have over double the rate of males

NOR-MAN males = 10.16%
NOR-MAN females = 22.72%

(MCHP, Mental Illness Report, 2004)

When reviewing our district level depression data for the second time period, the following differences are of note:

- District I prevalence rate was 13.6% which is statistically different (lower) than the provincial rate, but has experienced a small increase in rate.
- District II prevalence rate was 17.4% which showed a small decrease
- District III prevalence rate was 12.9% which is statistically different (lower) than the provincial rate

**Anxiety Disorders**

Everyone experiences anxiety from time to time as a result of a situation that we perceive as threatening, such as waiting for the results of a lab test. But when anxiety becomes persistent and interferes with the ability to cope and disrupts daily life, the person may have an anxiety disorder.

**Anxiety**

is excessive feelings of apprehension or fear

Rates are the proportion of residents age 10 and over with either one or more hospitalizations or three or more physician visits over a five year period

(Manitoba Centre for Health Policy)

Figure 5.28 shows that the NOR-MAN prevalence rate for anxiety disorders in both time periods is statistically different (higher) than the provincial rate.

We have observed an increase in our prevalence rate over time but this change is not statistically significant.

However, the provincial prevalence rate has experienced a statistically significant increase.

Figure 5.28: Treatment Prevalence of Anxiety Disorders

Source: Manitoba Centre for Health Policy, Manitoba RHA Indicator Atlas, 2009
When reviewing our district level anxiety disorders data for the second time period, the following difference are of note:

- District I prevalence rate was 5.6% which is statistically different (lower) than the provincial rate.
- District II prevalence rate was 12.8% which is statistically different (higher) than the provincial rate.
- District III prevalence rate was 5.3% which is statistically different (lower) than the provincial rate.

Substance Abuse

Substance Abuse is defined by the presence of ICD-9-CM codes for alcohol psychoses, drug psychoses, alcohol dependence, drug dependence and nondependent abuse of drugs from both physician claims and hospital abstracts.

Figure 5.29 shows that the NOR-MAN prevalence rate for substance abuse in both time periods is statistically different (higher) than the provincial rate.

When reviewing NOR-MAN’s treatment prevalence of anxiety disorders rates by sex, females have over double the rate of males

NOR-MAN males = 6.1%
NOR-MAN females = 12.5%

(MCHP, Mental Illness Report, 2004)

Substance Abuse

Is the excess use of and reliance on a drug, alcohol, or other chemicals that lead to severe negative effects on the individual’s health and well being or the welfare of others

Rates are the proportion of residents age 10 and over with either one or more hospitalizations or physician visits over a five year period

(Manitoba Centre for Health Policy)

When reviewing NOR-MAN’s treatment prevalence of Substance abuse rates by sex, females have a higher rate than males

NOR-MAN males = 0.8%
NOR-MAN females = 1.1%

(MCHP, Mental Illness Report, 2004)
When reviewing our district level substance abuse data all of our districts are statistically different (higher) than the provincial rate. The following differences are of note:

- District I prevalence rate was 6.2%
- District II prevalence rate was 7.2%
- District III prevalence rate was 10.6%.

### Personality Disorders

When reviewing personality disorders data, NOR-MAN rates are statistically different (lower) at a rate of 0.5% and 0.5% than the provincial rate at 0.9% and 0.9% in both time periods (1996/97-2000/01 and 2001/02-2005/06). At the district level, both Districts I and II are statistically different (lower) than the provincial rate.

When reviewing the MHCP 2004 report *Patterns of Regional Mental Illness Disorder Diagnoses and Service Use in Manitoba: A Population Based Study*, NOR-MAN’s treatment prevalence of personality disorder rates vary by sex. Females have a slightly higher rate at 0.5% compared to males at 0.4%.

### Schizophrenia

When reviewing schizophrenia data, NOR-MAN rates are statistically different (lower) at a rate of 0.8% and 0.8% than the provincial rate at 1.1% and 1.1% in both time periods (1996/97-2000/01 and 2001/02-2005/06). At the district level, both Districts I and II are statistically different (lower) than the provincial rate.

When reviewing the MCHP 2004 report *Patterns of Regional Mental Illness Disorder Diagnoses and Service Use in Manitoba: A Population Based Study*, NOR-MAN’s treatment prevalence of schizophrenia rates vary by sex. Females have a higher rate at 1.1% compared to males at 0.8%.
Dementia

When reviewing dementia data, NOR-MAN’s rates are similar to the provincial rates in both time periods at 9.1% and 9.2% compared to 10.0% and 10.8%.

When reviewing our district level data as shown in Figure 5.30, the only data highlight is that District I rates are statistically different (lower) than the provincial rate in both time periods.

The only available sex differences data on dementia is from the MCHP 2004 report Patterns of Regional Mental Illness Disorder Diagnoses and Service Use in Manitoba: A Population Based Study. Based on this report, NOR-MAN female treatment prevalence rates for dementia are higher at rate of 7.9% compared to NOR-MAN males at 7.4%. Also of note, from this report is that NOR-MAN females at 7.9% are statistically different (lower) than the provincial rate of 11.6% in 1997/98 - 2001/02.

Adolescents/Teenagers on SSRIs

The rate for Manitoba adolescents with a SSRI prescription experienced a statistically

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**Selective Serotonin Reuptake Inhibitors (SSRI)**

is a medication used to treat a mood disorder by helping to increase the level of available serotonin in the brain.

Rates are the proportion of children age 10 to 19 years who have had at least one SSRI prescription in a one year period.

(Manitoba Centre for Health Policy)
significantly decrease between 2002/03 and 2005/06, from 17.1/1,000 to 14.5/1,000. The NOR-MAN rate also decreased slightly to 9.3/1,000 but this decrease was not statistically significant.

For both time periods, the NOR-MAN rates are lower than the provincial rates. In the first time period (2002/03), NOR-MAN rates are lower at 11.4/1,000 compared to the provincial rate of 17.1/1,000. During the second time period (2005/06), the provincial rate change over time was a statistically significant decrease to 14.5/1,000.

When reviewing data at the district level, both District I at 8.3/1,000 and District III at 6.6/1,000 experienced a decrease in their rate, and District II at 11.6/1,000 experienced an increase.

Adolescents/Teenagers on Antidepressants

The rate for Manitoba adolescents with a prescription for an antidepressant experienced a significantly significant decrease between 2000/01 and 2005/06, from 13.0/1,000 to 10.5/1,000. Of note for both time periods, the NOR-MAN rates are lower than the provincial rates.

When reviewing antidepressant data, NOR-MAN rates are statistically different (lower) at 8.0/1,000 compared to the provincial rate of 13.0/1,000 during the first time period (2000/01).

During the second time period, the NOR-MAN rate decreased slightly to 7.01/1,000 but this decrease is not statistically significant.

When reviewing data at the district level both District I at 8.0/1,000 and District II at 8.9%/1,000 experienced a decrease in the rate of antidepressant use, while District III at 4.2/1,000 experienced an increase in their rate of antidepressant use.
Summary

The Health Status indicators that we have reviewed are mortality, life expectancy, potential years of life lost, illness burden/chronic disease, well-being, functional health and mental health. Review of each of these indicators, helps to identify opportunities for interventions, to improve the health of NOR-MAN residents, particularly where deaths are either premature or preventable.

Health Status indicators are measured using counts, crude rates, age-adjusted rates, rate ratios and rate differences. Crude rates are true summary rates and reflect the burden of health care needs. Adjusted rates are modified to account for differences in groups and tell us whether things are getting better or worse in comparison to other Manitobans.

This brief Health Status overview highlights some of the key characteristics of NOR-MAN residents that have a direct relationship and which ultimately impact on their lives and the type of services they require.

Some of our Health Status highlights are:

- NOR-MAN has a statistically higher mortality rate than the province and our rate has experienced a slight increase

- NOR-MAN region continues to experience a decline in our Premature Mortality Rates (MPR) rate from 5.5/1,000 in 1990-1994 to 4.6/1,000 in 1995-1999 to our current rate of 4.4/1,000.

- Males are living longer lives (73.4 years) - Although we die approximately three (3) years earlier that the average Manitoba male (76.3 years)

- Females experienced a small decrease in life expectancy during the 2001 to 2005 time
period (77.6 years) - we die approximately four (4) years earlier than the average Manitoba female (81.8 years)

- District I residents are living longer lives than both District II and III residents
- We have experienced a decrease in our Potential Years of Life Loss (PYLL)
- The top cause of Personal Years of Life Lost (PYLL) in the NOR-MAN region continues to be due to deaths from unintentional injuries.
- NOR-MAN infant mortality rates increased in the most recent time period, but this increase was not statistically significant, we need to continue to monitor
- NOR-MAN continues to experience higher rates of suicide than the provincial rate, with the largest increase overtime being in the 15 - 24 year age group
- Suicide rate in Manitoba are three (3) times higher for males
- Leading causes of death in the NOR-MAN region is the same as Manitoba as a whole and are due to Diseases of the Circulatory System at 26.3% followed by Neoplasms (cancer) at 24.7%. These two causes account for 51% of our deaths
- The leading cause of death for NOR-MAN females is Diseases of the Circulatory System and Cancer for NOR-MAN males
- Lung cancer is the leading cause of cancer death for both males and females, which is similar for Manitoba as a whole.
- NOR-MAN has seen an increase in our deaths due to Endocrine, Nutritional and Metabolic Disease from 3.3% in 1992/99 to 9.8% in 2002/06
• The leading cause of injury death in the NOR-MAN region is due to motor vehicle / traffic injuries - Manitoba’s leading cause is suicide

• Main cause of injury deaths for NOR-MAN males were due to suicides and motor vehicle /traffic injuries

• Main cause of injury deaths for NOR-MAN females were due to motor vehicle/traffic injuries and suicide

• Hypertension rates for NOR-MAN residents age 25 and older are statistically higher than the provincial rate and our increase over time was statistically significant

• Ischemic Heart Disease (IHD) rates in the NOR-MAN region have decreased, as have the provincial rates

• NOR-MAN District II and III residents are experiencing more strokes than all Manitobans - the good news is that we have experienced a decrease in rates over time

• NOR-MAN residents have experienced more Acute Myocardial Infarctions (AMI) - heart attacks than all Manitobans - the good news is our rates have decreased since the last CHA

• Diabetes continues to be a growing problem in the NOR-MAN region with statistically significantly higher rates than the Manitoba average and our rates continue to trend upward from 6.3% in 1986/87 to 13.0% in the current reporting period

• NOR-MAN experienced a decrease in our Lower Limb Amputations rates among residents with diabetes from 3.3% to 1.9% and this change over time is statistical significant

• NOR-MAN cancer incidence rates have decreased over time
• NOR-MAN males have a higher incidence rate for both colorectal and lung cancer than all Manitoba males

• NOR-MAN females have a higher incidence rate for both cervical and lung cancer than all Manitoba females

• Melanoma incidence rates for NOR-MAN residents has increased over time - the female rate is increasing faster than males

• The cancer prevalence rate for both NOR-MAN males and females is higher than the Manitoba rate

• NOR-MAN residents have been diagnosed with arthritis more often than other Manitobans - although our rates have decreased over time

• NOR-MAN residents Total Respiratory Morbidity (TMR) rates are statistically lower than the provincial rate

• NOR-MAN has a statistically higher rate of Osteoporosis than other Manitobans, and our change over time was statistically significant

• NOR-MAN experienced a statistically significant decrease in our injury hospitalization rate, - our rate is still almost double the provincial rate

• The top injury hospitalization for both NOR-MAN males and females were hospitalized most often for injuries from falls

• Overall, NOR-MAN 56.9% of NOR-MAN residents rated their self-rated health as either excellent or very good compared to the province at 60.7% (CCHS data)

• More NOR-MAN residents (57.9%) reported having perfect physical functioning than Manitobans as a whole (55.6%) (CCHS data)

Cancer was identified as a major health concern during all our consultations

Lack of recreational opportunities was identified as a concern during our consultations
• More NOR-MAN residents (47.7%) reported having better overall mental health than Manitobans as a whole (40.8%) (CCHS data)

• NOR-MAN’s Cumulative Mental Disorders rate is lower than the provincial rate

• NOR-MAN’s Depression, Personality Disorders and Schizophrenia rates are statistically lower than the provincial rate

• NOR-MAN’s Anxiety Disorders and Substance Abuse rates are statistically higher than the provincial rate

• NOR-MAN’s Dementia rates are similar to provincial rate

• NOR-MAN selective serotonin reuptake inhibitors (SSRI) and teen antidepressant rates have experienced a significant decrease, and our rates are lower than the provincial rate

As the above highlights have clearly shown, the NOR-MAN region has both good and bad news that needs to be addressed with respect to the various Health Status indicators reviewed.

For the NOR-MAN Regional Health Authority, it is necessary to continue to monitor each of these Health Status indicators, as they are the basis for the development of quality health care intervention programs and services.
Chapter 6

What makes people of the NOR-MAN region healthy?

In this chapter, we will be looking at the overall health of our region and our communities and not just the health of any one individual. This is called using a population health approach, meaning looking at health in the broad terms. It means looking for the answers to questions such as:

- What are the most important factors affecting the health of Canadians/Manitobans/NOR-MAN residents?
- Why are some people healthier than others?
- What can be done to improve the health of all Canadians/Manitobans/NOR-MAN residents?

In short, population health is a way of thinking about health and taking action to improve the health of the public, by looking to reduce barriers and increase opportunities for people to become healthier. A population health approach addresses a range of risk factors for the entire population, rather than only people who are at risk or have a high risk of becoming ill. **This approach is based on the fact that a small reduction in risk in a large proportion of a population will have a greater effect than a large change in a small group within a population.**

A population health approach focuses on strategies that address prevention, protection and promotion that will achieve greater health for our whole population.
NOR-MAN Health Determinants

The health of NOR-MAN residents is affected by many factors that together contribute to the overall health of our region and/or communities and not just the health of any one individual.

Adequate income, meaningful work, learning opportunities and support networks are all prerequisites for good health. Research findings indicate that the rich are healthier than the poor, the well educated are healthier than the less educated, and the employed are healthier than the unemployed. NOR-MAN residents with low incomes, low education and low employment rates are at greater risk - they generally have poorer health status.

When we review health status, it is important to look at the factors or determinants that have the greatest impact on our health. This section of our report will provide an overview on a number of the determinants that influence our health. We will be reviewing seven (7) of the Determinants of Health in this chapter. The determinants we will review include:

1. Income
2. Education
3. Employment
4. Living Conditions
5. Healthy Child Development
6. Personal Health Practices and Coping Skills
7. Environmental Factors
**Income**

Income and income distribution are key factors that affect the health status of our population. Household income provides information about the resources that are available to meet daily needs and affect choices that are made. Lifestyle choices such as eating habits, housing, and physical activity are all related to the amount of money an individual or family has to spend.

A higher income leads to better health not only because of the ability to purchase adequate food, housing or other necessities, but also because it means having more choices and a feeling of control over one’s life.

**Income Inequality: Low Income Cutoffs**

Low income cutoffs (LICO) are used to distinguish “low income” family units from “other” family units. A family unit is considered “low income” when its income is below the “cutoff” for its family size and its community.

LICO is important because it provides the threshold below which a family will likely devote a larger share of its income to the necessities of food, shelter and clothing than an average family.

**Income Inequality: Low Income**

Table 6.1 shows the low income percentages for the 2006 census year compared to 2001 and 1996 by household type.

<table>
<thead>
<tr>
<th></th>
<th>1996</th>
<th>2001</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOR-MAN</td>
<td>MB</td>
<td>NOR-MAN</td>
<td>MB</td>
</tr>
<tr>
<td>Unattached Individuals</td>
<td>30%</td>
<td>45%</td>
<td>29%</td>
</tr>
<tr>
<td>Private households</td>
<td>18%</td>
<td>21%</td>
<td>15%</td>
</tr>
<tr>
<td>Economic households</td>
<td>15%</td>
<td>16%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Table 6.1: Income Inequality: Low Income
Source: Manitoba Health, NRHA Profile Document, 2008/09
The NOR-MAN region, in all three time periods shows that we have a higher number of families experiencing more income inequality than the province as a whole.

<table>
<thead>
<tr>
<th>District I</th>
<th>District II</th>
<th>District III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unattached Individuals</td>
<td>20%</td>
<td>33%</td>
</tr>
<tr>
<td>Private households</td>
<td>13%</td>
<td>16%</td>
</tr>
<tr>
<td>Economic households</td>
<td>10%</td>
<td>13%</td>
</tr>
</tbody>
</table>

Table 6.2: Income Inequality: Income Status (LICO) by NOR-MAN Districts for 2006
Source: Manitoba Health, NRHA Profile Document, 2008/09

When reviewing 2006 Low Income percentages by NOR-MAN districts as show in Table 6.2, the following highlights are to be noted:

- District I percentages are lower than the NOR-MAN percentages for all three categories - District I families are experiencing more inequality than NOR-MAN as a whole
- District II percentages are higher than the NOR-MAN percentages for all three categories
- District III’s unattached individuals are experiencing more inequality than NOR-MAN as a whole, however percentages for both private households and economic families are higher than the NOR-MAN percentage - this maybe due to the make-up of the District III and the large differences between communities

Income Inequality: Median Household Income

Figure 6.1 compares 2006 census values to the 2001 and 1996 values for median household incomes for both NOR-MAN and Manitoba.

Unattached individual - are individuals 15 years of age and older, who are members of a private household, and who are not members of an economic family. Persons living alone are included in this category.

Private households - are persons or groups of people who occupy the same dwelling

Economic households - are groups of two or more people who live in the same dwelling and are related to each other by blood, marriage, common-law or adoption

(Statistics Canada)
Table 6.3 shows the median household income by NOR-MAN districts for the time periods of 2001 and 2006.

<table>
<thead>
<tr>
<th></th>
<th>District I</th>
<th>District II</th>
<th>District III</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$52,584.00</td>
<td>$43,274.00</td>
<td>$32,875.00</td>
</tr>
<tr>
<td>2006</td>
<td>$57,887.00</td>
<td>$47,172.00</td>
<td>$40,518.00</td>
</tr>
</tbody>
</table>

When reviewing median household income values by NOR-MAN districts the following highlights are to be noted:

- District I median household income values are **higher** than both the NOR-MAN and provincial values in both time periods
- District II median household income values are **lower** than both the NOR-MAN and provincial values in both time periods
- District III median household income values are **lower** than both the NOR-MAN and provincial values in both time periods

**Income Inequality: Average Household Income**

Figure 6.2 compares 2006 census values compared to the 2001 and 1996 values for average household incomes in both NOR-MAN and Manitoba.
Table 6.4 shows the average household income by NOR-MAN districts.

<table>
<thead>
<tr>
<th>District I</th>
<th>District II</th>
<th>District III</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$56,646.00</td>
<td>$51,208.00</td>
</tr>
<tr>
<td>2006</td>
<td>$63,825.00</td>
<td>$59,129.00</td>
</tr>
</tbody>
</table>

Table 6.4: Income Inequality: Average Household Income by NOR-MAN Districts
Source: Manitoba Health, NRHA Profile Document, 2008/09

When reviewing average household income values by NOR-MAN districts, the following highlights are to be noted:

- District I average household income values are **higher** than both the NOR-MAN and provincial values in both time periods
- District II average household income values are **lower** than the 2001 NOR-MAN average and both the 2006 NOR-MAN and provincial values
- District III average household income values are **lower** than both the NOR-MAN and provincial values in both time periods
Income Inequality: Median Income of Individuals - Males

Figure 6.3 compares the 2006 census values to the 2001 and 1996 median individual incomes for males at both the NOR-MAN and provincial levels.

![Median Income of Individuals - Males](image)

When reviewing median individual - male income values for NOR-MAN districts as shown in Table 6.5, the following highlights are to be noted:

<table>
<thead>
<tr>
<th>Year</th>
<th>District I</th>
<th>District II</th>
<th>District III</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$42,487.00</td>
<td>$26,057.00</td>
<td>$14,376.00</td>
</tr>
<tr>
<td>2006</td>
<td>$44,449.00</td>
<td>$28,327.00</td>
<td>$17,585.00</td>
</tr>
</tbody>
</table>

Table 6.5: Income Inequality: Median Income - Males by NOR-MAN Districts
Source: Manitoba Health, NRHA Profile Document, 2008/09

- District I median individual - male income values are higher than both the NOR-MAN and provincial values in both time periods
- District II median individual - male income values are lower than both the NOR-MAN and provincial values in both time periods
- District III median individual - male income values are lower than both the NOR-MAN and provincial values in both time periods

Poverty was identified as a concern during our consultations
Income Inequality: Median Income of Individuals - Females

Figure 6.4 compares 2006 census values to the 2001 and 1996 median individual incomes for females at both the NOR-MAN and provincial levels.

When reviewing median individual - female income values by NOR-MAN districts as shown in Table 6.6, the following highlights are to be noted:

<table>
<thead>
<tr>
<th>Year</th>
<th>District I</th>
<th>District II</th>
<th>District III</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$14,833.00</td>
<td>$15,750.00</td>
<td>$11,885.00</td>
</tr>
<tr>
<td>2006</td>
<td>$17,892.00</td>
<td>$20,303.00</td>
<td>$16,144.00</td>
</tr>
</tbody>
</table>

Table 6.6: Income Inequality: Median Income – Females by NOR-MAN Districts
Source: Manitoba Health, NRHA Profile Document, 2008/09

- District I median individual - female income values are higher than the NOR-MAN values in the first time period and lower than the provincial values in both time periods
- District II median individual - female income values are higher than the NOR-MAN values in both time periods and higher than the provincial values in the second time period
• District III median individual - female income values are lower than both the NOR-MAN and provincial values in both time periods

Employment

Labour Force Participation

During 2006, 66.6% of NOR-MAN residents aged 15 years and over were employed in the labour force. Chapter four (4) provides a in-depth description of labour force participation.

Occupations

According to 2006 Statistics Canada census data, there are some slight differences when comparing the top six occupations in NOR-MAN to the top six provincial occupations for males and females combined. Figure 6.5 shows the differences.

![Top Six Occupation Comparisons](image)

### Top Six Occupation Comparisons

<table>
<thead>
<tr>
<th>Occupation Type</th>
<th>Manitoba</th>
<th>NOR-MAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sales</td>
<td>24.6%</td>
<td>28.1%</td>
</tr>
<tr>
<td>Trades, Transportation, Equipment</td>
<td>15.0%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Business, Finance &amp; Administrative</td>
<td>17.3%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Social Science, Education, Government Services &amp; Religion</td>
<td>8.8%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Management</td>
<td>8.5%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Health</td>
<td>13.4%</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Figure 6.5: Top Six Occupation Comparisons
Source: Statistics Canada, 2006 Community Profile

Sales is the largest occupation type for both NOR-MAN residents at 28.1% and Manitoba residents as a whole at 24.6%.
When reviewing the comparisons of NOR-MAN males top three occupation types to Manitoba males as shown in Figure 6.6, we see that NOR-MAN males have a higher rate of participation in the top three occupation categories listed.

The main occupation category for both NOR-MAN and all provincial males is in the trades, transport and equipment operators and related occupations. NOR-MAN’s rate is slightly higher at a 29.6% compared to 26.9% for all provincial males. Sales occupations are the next highest at 20.6% for NOR-MAN and 19.6% for the province as a whole.

When reviewing the comparisons of NOR-MAN females top four occupation types to Manitoba females as shown in Figure 6.7, we see that NOR-MAN females have a lower rate of participation in the business, finance and administration category. The main occupation category for both NOR-MAN and all provincial females is in the sales occupations. NOR-MAN has a slightly higher percentage at a 36.6% compared to 30.3% for all provincial females.
Unemployment Rates

NOR-MAN has the fourth highest overall rate of unemployment in Manitoba. Both NOR-MAN males at 11.5% and females at 10.0% appear to be more likely to be unemployed than were all Manitoba males at 5.5% and females at 5.4%.

However, limitations of using the unemployment rate to gauge the health of NOR-MAN residents is questionable as it does not comprehensively portray unemployment in Manitoba, nor does it accurately portray differences in male and female unemployment rates according to the “Women’s Health Profile” report for the following reasons:

1. women are more likely than men to have left the labour force because of care giving responsibilities

2. it excludes workers who have been discouraged and are not actively searching for work

3. it excludes involuntary part-time workers

Unfortunately, most of the smaller NOR-MAN communities have a limited economic base and a large number of residents no longer are actively looking for work.
As the NOR-MAN population ages, economic issues will cause even bigger problems due to the fact that 25.8% of NOR-MAN residents are under the age of 15 and currently are not a part of the workforce.

Youth Unemployment Rates

When reviewing youth (age 15 to 24 years) unemployment stats, NOR-MAN males and females are more likely to be unemployed than were all Manitoba youth in all three time periods.

Figure 6.8 shows that the NOR-MAN male unemployment rate is currently at its highest, with a rate of 25.3% compared to the provincial rate which is at its lowest rate at 11.7% over the three time periods.

Figure 6.9 shows that the NOR-MAN female unemployment rate has increased in both the 2001 and the 2006 time periods to a high of 20.0% in 2001. The NOR-MAN female rate is currently higher at 18.3% compared to the provincial female rate of 10.5%.
The unemployment rate indicates who is not working and therefore may not have access to employee health benefits. There is strong evidence that unemployed individuals have a disproportion share of health problems such as depression and reduced life expectancy.

**Education**

Education is an important determinant of health. Individuals with little schooling are more likely to have low paying jobs, have periods of unemployment or are on welfare, and have a higher probability of being functionally illiterate.

Higher levels of education improves people’s ability to access and understand information to help keep them healthy. Education is an important characteristic to consider in health planning as it helps to determine appropriate and effective communication mechanisms with the people we serve.

**School Attainment**

As reported in Chapter 4 of this report, the NOR-MAN region has a higher percentage of residents...
with less than a high school or only a high school diploma in all ages compared to the provincial rates.

Research shows that people with little school or who have no certificate or degree are more likely to get low paying jobs and to have periods of unemployment or living on welfare.

School Changes

Frequent school moves are associated with grade retention, which is in turn associated with higher rates of subsequent school failure and high school withdrawal. Students who move frequently are more likely to have been doing poorly even before they began moving because frequent school changes are markers for other social factors, such as lone-parent families and low social-economic status, which are associated with poor school performance.

During the period of 1997/98 to 2000/01, 82% of NOR-MAN grade three students experienced no school changes compared to the provincial rate of 79%. However, when reviewing the 2002/03 to 2005/06 data the NOR-MAN region experienced a decrease in the number of grade three students who had not changed schools at a rate of 76% compared to the provincial rate of 80%.

When reviewing the school changes data at the district level as shown in Figure 6.10, the following differences are to be noted.

- District I during the second time period experienced a decrease that was statistically different at 64% than the provincial rate at 80% and this change over time is statistically significantly lower.
- District II was the only NOR-MAN district that experienced an increase in the number of
students not changing schools from 81% to 85% in the second time period

- District III experienced a small decrease from 83% to 75% during the second time period

### School Changes by NOR-MAN District

<table>
<thead>
<tr>
<th>District</th>
<th>1997/98 - 2000/01</th>
<th>2002/03 - 2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>District I</td>
<td>82.0%</td>
<td>64.0%</td>
</tr>
<tr>
<td>District II</td>
<td>81.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>District III</td>
<td>83.0%</td>
<td>75.0%</td>
</tr>
</tbody>
</table>

Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

### Living Conditions

#### Marital Status

Marital status is one way of looking at the social supports that individuals may enjoy. Social supports are known to be an important health determinant and the literature on health and aging suggests that lack of social supports is one risk factor associated with personal care home placement.

As reported, in Chapter Four (4), approximately 16% of NOR-MAN residents have experienced a major stress event in their life through divorce, being widowed or being separated. NOR-MAN rates for being divorced is 7.0%, being widowed 6.0% and separated is 3.0%.
Living Alone

In some circumstances, living alone is also considered a major stress event. According to the 2006 census data, a total of 2,015 NOR-MAN residents were living alone. That means that approximately 25.5% of our population lives in a one-person household, lower than the provincial average of 28.6%. Living alone is an important factor that not only influences a person’s quality of life, but also the types of health care programs and services that they may potentially require.

Lone Parent Families

According to the 2006 census data, the NOR-MAN region has a total of 5,975 families living in the region. Of those families, 23% or 1,345 of those families are lone parent families. Of those 1,345 lone parent families in the NOR-MAN region, 78% or 1,050 are headed by women compared to Manitoba as a whole at 81%. and 22% or 290 are headed by males compared to Manitoba as a whole at 19%.

Housing Affordability

When housing is unaffordable, individuals and families often face a number of hardships; such as food insecurity, possible malnutrition and inability to fully participate in active recreation and social programs for children due to costs. Shelter expenses include payments for electricity, oil, gas, wood or other fuels, water and other municipal services, monthly mortgage payments, property taxes, condominium fees and rent.

Of note, band housing was not included in the calculations that shows housing affordability for both owners and renters in the NOR-MAN region compared to Manitoba overall, based on spending 30% or more of total household income on shelter costs.

Lone Parent

refers to a mother or a father, with no spouse or common-law partner present, living in a dwelling with one or more children

(Statistics Canada)

Housing Affordability

refers to the percentage of the population spending 30% or more of total household income on shelter costs - shelter expenses include payment for electricity, oil, coal, wood or other fuels, water and municipal services, monthly mortgage payments, property taxes and rent

(Statistics Canada)

The 2001 Census reported a higher number of Lone Parent families with 1,395 or 22% compared to 2006

Lone parent families’ median family income for the NOR-MAN region is $23,636.00 an increase from the 2001 value of $ 18,703.00
As shown in Figure 6.11, NOR-MAN has a lower percentage of NOR-MAN tenants (renters) at 25% during 2006 spending 30% or more of their total household income on shelter costs compared to the provincial rate of 35%. Also, we see that our rate over the three census years has remained similar, while, the provincial rate has been decreasing.

When reviewing Figure 6.12, we see that District I has experienced an increase in the number of tenants (renters) who are spending 30% or more of their total income on shelter costs. District II and III experienced decreases.

When reviewing Figure 6.13, we see that although our homeowners are spending fewer dollar at 9% in 2006 compared to the provincial rate at 11%, our costs overtime have increased for NOR-MAN homeowners from a low of 7% in 1996 to a high of 9% in 2006.

When reviewing Figure 6.14, we see that both Districts I and II have experienced an increase in the number of homeowners who are spending 30% or more of their total income on shelter costs.
Housing Characteristics

Housing is at the center of a person’s well-being and the quality of the dwelling has impacts on our residents. Housing affects physical and mental health and influences an individual’s educational achievement, the ability to make healthy social connections and success in the job market.

When reviewing the data in Figure 6.15, we see that all of our First Nation communities are reporting overcrowding in their homes, ranging from 14.7% for Misipawistik CN to a high of 27.3% for Mosakahiken CN.

According to the First Nation Children’s Environmental Health report—through the Eyes of a Child, First Nation people tend to live in a lower standard of home whether they live on-reserve or off-reserve. There are problems with overcrowding, a lack of maintenance on rental homes and poorly designed houses that
contribute to the health concerns related to housing.

Figure 6.16 highlights the percentage of housing in each NOR-MAN community that requires major repairs. Again as with the issue of crowding, our First Nation communities have reported the highest rates with both Mosakahiken CN at 57.6% and Mathias Colomb CN at 57.1% having over half of their homes requiring major repairs. Mold and mildew has been identified as one of the major repairs required.

The overall percentage of NOR-MAN homes requiring major repairs is 19.5% compared to a provincial rate of 10.3%.

Healthy Child Development

It is vital to recognize that the health and well-being of the children in the NOR-MAN region are important determinants of the health. Early childhood experiences have a lifelong effect on their health and well-being in the future.
Studies show that what happens to a child in the first six years of their life determines how well they do throughout their lifespan. The key indicators that measures healthy child development are:

- Birth Counts
- Birth Weights
- Teen Birth Rates
- Immunization Rates
- Breastfeeding
- School Readiness

**Birth Counts**

Our last Community Health Assessment reported that there were 2600 NOR-MAN births between 1996/97 and 2001/02. During the period of 2003/04 to 2007/08, there were a total of 2126 NOR-MAN births reported. This is a decrease of 474 births since the last CHA report.

**Birth Weights**

**Preterm Birth**

Is a any live birth where the gestational age was less than 37 weeks.

(Manitoba Centre for Health Policy)

For the period of 2002/03 to 2006/07 the NOR-MAN percentage of live birth under 37 weeks gestation was 6.5% which is statistically different (lower) than the provincial rate of 8.0% for the same time period.

However, when reviewing the data on a yearly basis in Figure 6.17, the NOR-MAN region has seen a steady increase in the number of babies being born earlier than 37 weeks gestation. Our rate for the time period of 2006/07 is the first time...
in five years that the NOR-MAN rate has been higher at 9.1% than the provincial rate at 8.2%.

When reviewing NOR-MAN district level data, for the period of 2002/03 - 2006/07, we discovered the following results:

- District I with a rate of 5.3% is significantly different (lower) than the provincial rate of 8.0%
- District II with a rate of 5.3% is significantly different (lower) than the provincial rate of 8.0%
- District III with a rate of 8.6% is higher than the provincial rate of 8.0%

**Teen Birth Rates**

Teen pregnancy is an important health indicator as teen mothers are less likely to complete high school and more likely to be unemployed than women who delay having children. The teen pregnancy rate indicates the number of teens and their children who may experience difficult living conditions and indirectly may provide information on accidental or unplanned pregnancies.

**Teen Birth Rates**

refers to the percentage of females aged 12 to 19 years who gave birth

(Manitoba Centre for Health Policy)
In the NOR-MAN region during the period of 1996/97 to 2001/02, and 2001/02 to 2005/06, NOR-MAN teens are two times more likely to give birth than Manitoba teens as a whole.

Figure 6.18 shows that the NOR-MAN birth rates for teens aged 15 to 19 years in both time periods are statistically different (higher) than the provincial rate. The good news for the NOR-MAN region is our rate has started to decrease.

When reviewing teen births at the NOR-MAN district level, as shown in Figure 6.19, a number of differences between our districts are clearly shown:

- District I has experienced a decrease in their teen birth rate
- District II teen birth rates are statistically different (higher) than the Manitoba rates of 36.2% and 30.2% in both time periods. However both NOR-MAN and the province have seen a decrease overtime
- District III teen birth rates are statistically different (higher) than the Manitoba rates in both time periods, but the rates have started to decrease

Teen mothers are often at higher risks of problems associated with improper or inadequate prenatal care, especially in lower socio-economic populations. Teen mothers have a higher chance of suffering pregnancy complications,
are less likely to ever complete a high school education, and earn about half the lifetime income of women who gave birth in their twenties.

Low Birth Weights

Low-birth weight babies, those who weight less than 2500 grams (5 pounds 8 ounces) at birth, are much more prone to illness and infant death than are babies of normal birth weight. Many low weight births and the consequent health problems are preventable. Factors associated with low birth weight include smoking, poor diet during pregnancy, low weight prior to pregnancy, poverty and pregnancy at very early or late ages.

When reviewing low birth weight rates over a five year period from 2002/03 to 2006/07, the NOR-MAN rate is lower at 4.7% compared to Manitoba at 5.3%. When looking at yearly percentages over the five year time period, NOR-MAN rates were 1.9%, 3.7%, 5.4%, 4.2% and 7.9% and Manitoba rates were 5.0%, 5.4%, 5.5%, 5.3% and 5.5%.

When reviewing low birth weight rates at a NOR-MAN district level, the following differences are of note:

- District I at 4.8% is lower than the provincial rate of 5.5% in the second time period
- District II at 3.9% is lower than the provincial rate of 5.5% in the second time period
- District III has a rate slightly lower than the provincial rate at 5.4% in the second time period

High Birth Weights (HBW)

High birth weight babies, those who weigh more than 4000 grams (8 pounds 12 ounces) are at greater risk of birth complications as well as later health problems. We are concerned because of

Low Birth Weight

refers to the number of live births in which the birth weight is greater than or equal to 500 grams, but less than 2500 grams (5 pounds 8 ounces)

(Manitoba Centre for Health Policy)

High Birth Weight

refers to the number of live births in which the birth weight is greater than 4000 grams (8 pounds 12 ounces)

(Manitoba Centre for Health Policy)
their potential health problems later in life.

When reviewing high birth weight data, the NOR-MAN rates for the periods 2002/03 to 2006/07 are higher at 19.9% compared to the Manitoba rate of 16.5%.

When looking at high birth weight rates over a five year period from 2002/03 to 2006/07, both the NOR-MAN region and Manitoba as a whole have experienced decreases in their rates - NOR-MAN rates were 19.4%, 23.8%, 18.2%, 20.5% and 17.6% and Manitoba rates were 16.8%, 17.1%, 16.7%, 15.8% and 16.1%.

When reviewing high birth weight rates at the NOR-MAN district level, as shown in Figure 6.20 a number of differences between our districts are clearly shown:

Since our last CHA report our; high birth weight rates have decreased from a rate of 22.8% for the period of 2001/02 compared to 17.6% in 2006/07

- District I is experiencing more high weight births at a rate of 17.4% than the province as a whole at 16.5%

- District II has the highest rate at 22.8% of high birth weight babies being born in the NOR-MAN region, also their rate is statistically different (higher) than the Manitoba rate at 16.5%
• District III high weight birth rate of 18.1% is statistically different (higher) than the Manitoba rate at 16.5%

Childhood Immunization Rates

Immunization is a primary preventive care intervention to start or increase resistance against infectious disease. According to the Canadian Coalition for Immunization Awareness & Promotion, 100 years ago infectious diseases were the leading cause of death worldwide. In Canada, they now cause less than 5% of all deaths.

Immunization protects individuals and communities by preventing the spread of disease.

As more people are immunized, the disease risk for everyone is reduced. Immunization has probably saved more lives in Canada in the last 50 years than any other health intervention.

**Immunization is the single most cost-effective health investment, making it a cornerstone in the effort to promote health.**

In the NOR-MAN region, immunization coverage for children includes; Measles, Mumps and Rubella (MMR), Diphtheria, Pertussis, Tetanus, Polio and Hemophilus Influenza B (DaPTP/Hib) and Hepatitis B.

**Childhood Immunizations Rates - Age 1 Year**

Figure 6.21 shows the rates for complete childhood immunizations for one year olds born in two different time periods. As shown, the NOR-MAN region was statistically different (lower) than the provincial rate in both time periods. The good news for NOR-MAN is that our rate has
experienced an increase in completion rates in the second time period.

When reviewing NOR-MAN district level data on completed childhood immunizations for one year olds born in two different time periods, as shown in Figure 6.22, the following highlights are of note:

- District I has higher rates at 91.1% and 90.7% of completed immunizations in both time periods than the province as a whole with rates of 84.6% and 82.5%

- District II has experienced a statistically different (lower) rate at 74.8% of completed immunizations in the second time period than the province as a whole at 82.5%

- District III has experienced a statistically different (lower) rates at 57.7% and 70.1% of completed immunizations than the province as a whole at 84.6% and 82.5% in both time periods - also District III’s change over time is a statistically significantly increase

Generally, immunization rates are lower in areas that have the poorest overall health status.
Childhood Immunizations Rates - Age 2 Years

Figure 6.23 shows the rates for complete childhood immunizations for two year olds in two time periods. As shown, the NOR-MAN region was statistically different (lower) than the provincial rate in the first time period. The bad news for NOR-MAN is that our rate during the second time period has experienced a slight decrease.

When reviewing NOR-MAN district level data on completed childhood immunizations for two year olds born in two different times periods is shown in Figure 6.24, with the following highlights:

- District I has a statistically different (higher) rate at 84.2% of completed immunizations in the earlier time period than the province as a whole at 72.3%, also the change over time was statistically significantly lower - less infants born in the later time period were immunized.

- District II’s change over time was statistically significantly lower

- District III has experienced a statistically different (lower) rate at 49.0% of completed immunizations than the province in the first time periods with a rate of 72.3% and the change over time is statistically significant - the good
news is that District III has experienced an increase in their completion rates, more infants in the later time period are being immunized

**Childhood Immunizations Rates - Age 7 Years**

Figure 6.25 shows the rates for complete childhood immunizations for seven year olds born in two different time periods. As shown, the NOR-MAN region was statistically different (higher) with a rate of 86.0% than the provincial rate of 76.4% in the later time period. Also, the change over time for both NOR-MAN and Manitoba is statistically significantly higher.

![Completed Childhood Immunizations - Age 7 Years](image)

When reviewing NOR-MAN district level data on completed childhood immunizations for seven year olds, as shown in Figure 6.26, the following highlights are of note:

- District I rates are higher than the provincial rate in both time periods with rates of 82.8% and 86.4% compared to provincial rates of 74.2% and 76.1%
• District II change over time was statistically significantly higher - District II experienced a increase in completion rates in the later time period with a rate of 84.5% compared to the provincial rate of 76.4%

• District III has experienced a statistically different (lower) rate at 57.7% of completed immunizations than the province in the earlier time period at 74.2%. The good news is that we have experienced a statistically significant increase in our rates over time and we our now statistically different (higher) at 88.8% compared to the provincial rate of 76.4%.

**Completed Childhood Immunizations - Age 7 Years**

**by NOR-MAN District**

Sex-adjusted percent of children who completed immunization schedules

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District I</td>
<td>82.8%</td>
<td>86.4%</td>
</tr>
<tr>
<td>District II (2,t)</td>
<td>75.3%</td>
<td>84.5%</td>
</tr>
<tr>
<td>District III (1,2,t)</td>
<td>57.7%</td>
<td>88.8%</td>
</tr>
</tbody>
</table>

Figure 6.26: Completed Childhood Immunizations - Age 7 Years by NOR-MAN District
Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

For the NOR-MAN region, it is important to have a high rate of immunization coverage to reduce the susceptibility of our population to such diseases as: diphtheria, polio, measles, mumps and rubella.
Breastfeeding Initiation

Research over the years has shown there are many known benefits to breastfeeding. Breastfeeding provides the infants with optimum nutrition, protection against infectious diseases and provides the best opportunity for maternal-child bonding.

When reviewing the NOR-MAN breastfeeding initiation rates from 1996/97 to 2000/01 and from 2001/02 to 2005/06 we have statistically different (lower) rates at 67.0% and 69.6% compared to provincial rates of 80.6% and 81.6%.

When reviewing NOR-MAN District level data as shown in Figure 6.27, we discovered the following differences between districts:

- District I rates are similar to provincial rates in both time periods
- District II rates are statistically different (lower) than the provincial rates in both time periods, also the change over time was statistically significantly (higher) - an increase
- District III rates are statistically different (lower) than the provincial rate in both time periods

![Breastfeeding Initiation Rates by NOR-MAN District](image_url)
Readiness for School

The first five years of a child’s life are very important in preparing them for future success in school and life. A child’s readiness for school is influenced by their early years, as well as family and community factors that shape a child’s early years. Early Development Instrument (EDI) results are a reflection of the strengths and needs of a child’s community.

To ensure that Manitoba children get the best start in life is one of the key reasons for the use of the Early Development Instrument (EDI). The EDI is an annual questionnaire measuring kindergarten children’s “readiness for school” across several areas of child development. The EDI measures the following:

1. **physical health and well-being** - children are healthy, independent, rested each day
2. **social competence** - children play and get along with others, share, show self-confidence
3. **emotional maturity** - children are able to concentrate on tasks, help others, show patience, are not often aggressive nor angry
4. **language and thinking skills** - children are interested in reading and writing, can count and recognize numbers and shapes
5. **communication skills and general knowledge** - children can tell a story, communicate with adults and other children

Figure 6.28 shows NOR-MAN rates compared to provincial rates for each of the five areas of development for those “not ready” for school.

Figure 6.29 shows NOR-MAN rates compared to provincial rates for those “very ready” for school.
When reviewing the results for the “Not Ready” for school, the area that scores above the 10% cut-off (are in need of further development) are language and thinking skills, emotional maturity, social competence and physical health and well-being. On a positive note, NOR-MAN results have improved in all categories during 2005-2006.

When reviewing the results for the “Very Ready” for school the areas that scored below the 30% cut-off (are in need of further development) are emotional maturity and physical health & well-being. Also, our results for every category but emotional maturity improved during 2005-2006.
Personal Health Practices

The next several indicators reflect personal health practices and lifestyle choices. These are sometimes referred to as non-medical determinants of health. Improvement in our health will be achieved through the efforts of NOR-MAN residents who make choices that lead to improvements in their health status. As individuals become more aware of how their personal health practices can impact their health, changes are slowly being made and maintained.

There is room for improvement, as will be highlighted by the review of the following personal health practices, most of which are currently affecting the health of NOR-MAN residents:

- Smoking - tobacco use
- Alcohol Consumption - binge drinking
- Nutrition - fruits & vegetable consumption
- Body Mass Index (BMI)
- Physical Activity
- Cervical Screening
- Mammography Screening
- Influenza Immunizations
- Pneumococcal Immunization
- H1N1 Immunizations
- Sexually Transmitted Infections

Smoking – Tobacco Use

Smoking remains the major preventable cause of death in Canada. Smoking is estimated to be responsible for the death of 50% of all smokers as a result of smoking related illnesses. The leading form of tobacco use is cigarette smoking, which damages the lungs and increases the risks of developing cancer, especially lung cancer, as well as chronic obstructive pulmonary disease, and asthma.

Smoking

Is the act of inhaling tobacco smoke from cigarettes, pipes or cigars - tobacco smoke contains nicotine, an addictive substance that cause some individuals to become addicted to smoking

(Statistics Canada)
Other risks of smoking are associated with coronary heart disease, other cancer (of the larynx, pharynx, oral cavity, esophagus, pancreas and bladder), stroke, emphysema and other health problems such as respiratory infections and stomach ulcers.

Figure 6.30 shows data from the Canadian Community Health Survey (Cycle 1.1, 2.1 and 3.1 combined) a total of 27.2% of NOR-MAN residents age 12 and over are current smokers compared to the Manitoba current smoking rate of 22.7%.

Based on Youth Health Survey (grades 6 - 12) data 44% of NOR-MAN boys and 29% of girls reported being a smoker, either occasional or daily with Grades 6 - 8 = 14% Grade 9 - 12 = 37%.

When reviewing the data for former smokers, NOR-MAN is home to a larger number of former smokers at 45.2% than the province as a whole at 39.3%.

When reviewing the data for non-smokers, NOR-MAN has a lower rate at 27.6% of non-smokers living in the region compared to the provincial rate of 38.0%.

When reviewing the differences between males and females for the various smoking types as shown in Table 6.7, we see differences:

CCHS data limitations is that surveying does not occur in First Nation Reserve Communities.

The gap in life-expectancy between smokers and non-smokers has widened over the past several decades.
• NOR-MAN males report a significant difference (higher) in their rate of former smokers at 49.4% compared to NOR-MAN females at 41.1%

• NOR-MAN females report a significant difference (higher) in their rate of non-smokers at 32.4% compared to NOR-MAN males at 22.6%

<table>
<thead>
<tr>
<th>Smoking Types</th>
<th>NOR-MAN Males</th>
<th>NOR-MAN Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Smoker</td>
<td>28.0%</td>
<td>26.5%</td>
</tr>
<tr>
<td>Former Smoker</td>
<td>49.4%</td>
<td>41.1%</td>
</tr>
<tr>
<td>Non-Smoker</td>
<td>22.6%</td>
<td>32.4%</td>
</tr>
</tbody>
</table>

Table 6.7: Tobacco Smoking Rates by Sex
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

When reviewing district level data as shown in Figure 6.31, a number of differences need to be noted:

• District I has the lowest rate of current smokers at 22.1% and the highest rate of former smokers at 49.2%

• District III has the highest rate of current smokers at 54.5% in the NOR-MAN region

When researching the topic of smoking, a number of different reports have been reviewed. The most important of the report highlights include:

• The Manitoba First Nations Regional Longitudinal Health Survey (RHS) Report, 2002/03 indicates that Manitoba First Nations people reported a smoking rate of 42% for youth and 63% for adults

Smoking, especially youth smoking was identified as a concern during our consultations

Quitting smoking brings health benefits at any age

![Figure 6.31: Tobacco Smoking Rates by NOR-MAN District](source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009)
• The 2007 Manitoba First Nation Youth Tobacco Survey indicates that 23% of participants reported that they were smokers.

• The Canadian Tobacco Use Monitoring Survey indicated that 20% of youth aged 15 - 19 in Manitoba and 15% of youth aged 15 - 19 in Canada were current smokers in 2007.

The NRHA Youth Health Survey (YHS) report provides smoking data which is based on a census of NOR-MAN youth attending school in grades six (6) through twelve (12). Data for this report was collected during the 2007/08 and early 2008/09 school years. The following smoking highlights include:

• 22% of males and 29% of females in grades 6 - 12 reported being current smokers.

• 19% of males smokers and 19% of female smokers have plans to quit smoking sometime in the next year.

• 10% of students smoke in grade six, 15% of students smoke in grade nine, but the smoking rate increases to 37% by grade twelve.

Alcohol Consumption / Binge Drinking

Alcohol abuse has been linked to both heart disease and stroke and is the primary contributor to cirrhosis of the liver. Alcohol-related behavior places one at risk for chronic drinking, binge drinking, and drinking and driving.

Binge drinking is linked to motor vehicle accidents, Fetal Alcohol Spectrum Disorders and other health issues, family problems, crime and violence.

Figure 6.32 shows CCHS binging drinking rates for both NOR-MAN and the province as a whole. For both, having had five or more drinks on one occasion.

Binge Drinking

Is having five or more alcoholic drinks on one occasion

One drink is defined as one bottle or can of beer or a glass of draft, one glass of wine or a wine cooler, or one drink or cocktail with 1.5 ounces of liquor

(Manitoba Centre for Health Policy)
occasion once or more per month and less than once a month, the NOR-MAN region is reporting higher rates at **22.9%** (once per month or more) and **24.7%** (less than once per month) compared to provincial rates of **17.5%** and **20.4%**.

### Binge Drinking by RHA

<table>
<thead>
<tr>
<th></th>
<th>Had 5 or more drinks on one occasion, once per month or more</th>
<th>Had 5 or more drinks on one occasion, less than once per month</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba</td>
<td>17.5%</td>
<td>20.4%</td>
<td>62.1%</td>
</tr>
<tr>
<td>NOR-MAN</td>
<td>22.9%</td>
<td>24.7%</td>
<td>52.4%</td>
</tr>
</tbody>
</table>

When reviewing district level binge drinking rates for both five or more drinks on one occasion once or more per month; and five or more drinks on one occasion less than once per month the following difference are of note:

- District I reported the highest rates of once per month or more at **24.4%** and less than once per month at **24.5%**, District I rates are higher than the provincial rates at **17.5%** and **20.4%**

- District II reported rates of once per month or more at **20.5%** and less than once per month at **24.9%** - District II rates are higher than the provincial rates at **17.5%** and **20.4%**

- District III reported results were suppressed - reminder that CCHS surveys are not conducted on First Nation communities.

### Figure 6.32: Binge Drinking Rates

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

According to the Youth Health Survey, 22% of NOR-MAN students reported having five or more drinks on one occasion once per month or more at a rate of **32%**, grade 10 at **41%**, grade 11 at **47%** and grade 12 at **49%**

NOR-MAN males report a significant difference (higher) rate of having had five or more drinks on one occasion once per month or more at a rate of **32.6%** compared to females at **13.4%**
Nutrition

Adequate nutrition is essential for good health and is especially important for the healthy development of children and young adults. The Canada’s Food Guide to Healthy Eating recommends children should eat four to six servings of fruits and vegetables daily and teenagers and adults should eat eight to ten servings of fruits and vegetables daily as part of a healthy diet.

According to Canadian Community Health Survey (Cycle 1.2, 2.1 and 3.10) as shown in Figure 6.33, the percentage of the NOR-MAN residents age 12 and over that reported consuming four or less fruits and vegetables per day is 64.1% compared to Manitoba as a whole at 66.1%. NOR-MAN residents have a higher rate of consumption of five or more fruits and vegetables at 35.9% compared to a provincial rate of 33.5%.

Average Daily Consumption of Fruits and Vegetables by RHA

Age- and sex-adjusted percent of weighted sample aged 12+ from combined CCHS cycles 1.1 (2001) and 2.1 (2003)

<table>
<thead>
<tr>
<th>RHA</th>
<th>0-4 Times / Day</th>
<th>5+ Times / Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba</td>
<td>66.6%</td>
<td>33.5%</td>
</tr>
<tr>
<td>NOR-MAN</td>
<td>64.1%</td>
<td>35.9%</td>
</tr>
</tbody>
</table>

Figure 6.33: Average Daily Consumption of Fruits and Vegetables
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

When comparing the consumption rates between NOR-MAN males and females as shown in Table 6.8, we see differences:
• Majority of NOR-MAN males and females reported eating zero to four (0-4) servings of fruits and vegetables per day

• More NOR-MAN females are eating five plus (5+) servings of fruits and vegetables at 42.0% compared to NOR-MAN males at 29.7%

<table>
<thead>
<tr>
<th>Average Daily Consumption of Fruits and Vegetables</th>
<th>NOR-MAN Males</th>
<th>NOR-MAN Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4 servings</td>
<td>70.3%</td>
<td>58.0%</td>
</tr>
<tr>
<td>5+ servings</td>
<td>29.7%</td>
<td>42.0%</td>
</tr>
</tbody>
</table>

Table 6.8: Average Daily Consumption of Fruits and Vegetables by Sex
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

According to the Child Health Atlas, 68% of Manitoba children aged 12 to 19 years consume less than the recommended number of serving of fruits and vegetables daily and only 31.8% of Manitoba children are consuming five or more fruits and vegetables per day. For NOR-MAN children, 30.3% are eating more than five fruits and vegetables daily.

Poor diet has been linked to coronary heart disease, some types of cancers (colorectal, breast and prostate), stroke, and type 2 diabetes. A well-balanced and low fat diet can also help limit the risks associated with excessive weight, high blood pressure and high blood cholesterol.

**Body Mass Index (BMI)**

The Body Mass Index (BMI) is a common method used to determine if an individual’s weight is in a healthy range based on his or her height. The BMI criteria is derived from a report produced by the World Health Organization (WHO) in 1998.

According to the BMI criteria, individuals are considered to have a BMI score that is:

- Based on CCHS data close to 6 in 10 adults report excess body weight
Based on data from the Manitoba First Nations RHS, 52% of children, 41% of youth, and 75% of adults reported being overweight or obese.

CCHS data limitations is that surveying does not occur in First Nation Reserve Communities.

Based on NRHA Youth Health Survey data, 32% of males and 25% of females reported being overweight - 62% of males and 70% of females reported being in the healthy weight category.

According to the Child Health Atlas, 31.3% of NOR-MAN children aged 12 to 19 years reported being either overweight or obese compared to a provincial rate of 23.7%.

Table 6.9 shows the differences between NOR-MAN males and females by BMI indexes:
• NOR-MAN females reported a statistically different (higher) rate at 43.0% of individuals who are normal/underweight compared to a NOR-MAN male rate of 31.1%

• NOR-MAN males reported a statistically different (higher) rate at 40.8% of individuals who are overweight compared to a NOR-MAN female rate of 28.4%

Canadian research based on CCHS data has found that overweight and obesity rates are strongly related to nutritional intake and leisure time activities. Specifically, children and teens who consume five or more fruits and vegetables per day are much less likely to be overweight or obese than those who consume fewer fruits and vegetables. Also, the likelihood of being overweight or obese increases in children and teens as their time spent watching TV, playing video games or using computers rises.

**Physical Activity**

Regular physical activity contributes to a longer and healthier life. The health benefits of physical activity are numerous. Regular physical activity can help prevent or limit the risks for such diseases as coronary heart disease, hypertension, type 2 diabetes, osteoporosis, obesity, depression, colon cancer, stroke and back injuries.
Figure 6.35 shows the total activity levels for NOR-MAN residents as reported in the Canadian Community Health Survey (Cycle 1.1, 2.1 and 3.3). NOR-MAN residents reported being more active at 33.3% than the provincial rate of 29.5%. NOR-MAN residents also reported being more moderately active at 37.5% compared to the provincial rate of 34.0%.

**Total Activity Level (Work + Leisure + Travel) by RHA**

Age- and sex-adjusted percent of weighted sample aged 15-75 who were physically active, from combined CCHS cycles 1.1 (2001), 2.1 (2003), and 3.1 (2005)

<table>
<thead>
<tr>
<th></th>
<th>Manitoba</th>
<th>NOR-MAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>29.5%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Moderate</td>
<td>34.0%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Inactive</td>
<td>36.6%</td>
<td>29.2%</td>
</tr>
</tbody>
</table>

When comparing the physical activity levels between NOR-MAN males and females as shown in Table 6.10 the following differences are of note:

- NOR-MAN males reported a statistically different (higher) rate at 41.3% of males who report being active compared to NOR-MAN female with a rate of 25.2%

<table>
<thead>
<tr>
<th>Total Physical Activity</th>
<th>NOR-MAN Males</th>
<th>NOR-MAN Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>41.3%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Moderate</td>
<td>37.0%</td>
<td>38.0%</td>
</tr>
<tr>
<td>Inactive</td>
<td>21.7%</td>
<td>36.8%</td>
</tr>
</tbody>
</table>

Table 6.10: Total Physical Activity Levels by Sex

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Based on data from the Manitoba First Nations RHS 95% of adults reported they were engaged in at least one type of physical activity and 23% of youth reported being involved in some physical activity at least four (4) to six(6) times a week.

Lack of recreational opportunities was identified as a concern during our consultations.

Based on the results of the NOR-MAN Youth Health Survey 56% of NOR-MAN students are active, 28% are moderately active, and 16% were inactive.

2009/2010 NRHA Community Health Assessment

Chapter 6 - What makes people of the NOR-MAN region healthy?

Page 6 - 42
compared to NOR-MAN males with a rate of 21.7%.

Cervical Screening

Cervical screening is an important tool in the early detection of cervical cancer, leading to early diagnosis and treatment, which results in reducing deaths due to cervical cancer. Cervical cancer is completely treatable if detected early by a Pap test, which screens for the Human Papillomavirus (HPV).

The NOR-MAN region currently has the third lowest rate of cervical screening. We are ahead of the Burntwood and Churchill RHA regions.

Figure 6.36 shows the cervical screening rates for the NOR-MAN region compared to the provincial rate as a whole. The NOR-MAN rate in both time periods are statistically different (lower) at 54.5% and 51.6% compared to 70.1% and 69.3%. Unfortunately, both the NOR-MAN and provincial rates experienced decreases. Less women are receiving PAP tests.

Cervical Screening (PAP)

refers to the Papanicolaou (PAP) test, used primarily for cervical cancer screening, is based on the examination of cells collected from the cervix to reveal pre-malignant (before cancer) and malignant (cancer) changes, as well as, changes due to non-cancerous conditions, conditions such as inflammation from infections

is the proportion of women 18 - 69 years old who received at least one PAP test in a three-year period

(Manitoba Centre for Health Policy)

Papanicolaou Test Rates by RHA

Age-adjusted percent of women aged 18-69 with one or more PAP smears in a three-year period

<table>
<thead>
<tr>
<th>Year</th>
<th>NOR-MAN (1,2)</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04-2005/06</td>
<td>51.6%</td>
<td>69.3%</td>
</tr>
<tr>
<td>1998/99-2000/01</td>
<td>54.5%</td>
<td>70.1%</td>
</tr>
</tbody>
</table>

Figure 6.36: Papanicolaou Test Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

The NOR-MAN rate is getting worse faster compared to the Manitoba time trend

Cervical Screening rates do not include PAP tests completed by NRHA Primary Health Care staff
When reviewing the cervical screening rates at the district level as shown in Figure 6.37, the following differences are of note:

- District I during the first time period had a rate of 63.1% which is statistically different (lower) than the provincial rate of 70.1%, and the change over time was a statistically significant increase.

- District II during the first and second time period had rates of 57.3% and 57.7% which are statistically different (lower) than the provincial rates of 70.1% and 69.3% respectively, and the change over time was a statistically significant increase.

- District III during the first and second time period had rates of 54.4% and 50.9% which are statistically different (lower) than the provincial rates of 70.1% and 69.3% respectively, and the change over time was a statistically significant decrease.

Of note, is the fact that the district with the lowest cervical screening rates is comprised of a number of communities for which the NRHA does not have jurisdiction for health service delivery.
Mammography Screening

Mammography screening among women 50 to 69 years of age may be helpful in the early detection of breast cancer.

Figure 6.38 shows that the NOR-MAN region has seen an increase in our mammography screening rates in the second time period at a rate of 60.5% compared to the provincial rate of 61.7%.

Mammography Rates by RHA

Age-adjusted percent of women aged 50-69 receiving at least one mammogram in two years

<table>
<thead>
<tr>
<th>Year</th>
<th>NOR-MAN</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004/05 - 2005/06</td>
<td>61.4%</td>
<td>61.7%</td>
</tr>
<tr>
<td>1999/00 - 2000/01</td>
<td>58.8%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

Figure 6.38: Mammography Screening Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

When reviewing mammography screening rates at the NOR-MAN district levels as shown in Figure 6.39, the following differences are of note:

- District I experienced a small increase in rates in the second time period from a rate of 63.1% to 66.7%
- District II experienced a small increase in rates in the second time period from a rate of 57.3% to 57.7%
- District III experienced a small decline in the second time period from a rate of 54.4% to 50.9%
Influenza Immunization (Flu shots)

Is the most effective way to prevent influenza and its complications for high-risk populations

is the proportion of residents 65 years or older who received a vaccination for influenza in a given year

(Manitoba Centre for Health Policy)

Adult Influenza Immunizations

Influenza is a viral illness, which usually appears between the months of November to April and is spread from person to person by coughing or sneezing. Although most people recover completely from influenza, there can be serious complication that can result in death. Research has shown that a yearly influenza vaccination is the best way to be protected.

Adult Influenza Immunization Rates by RHA

Age- & sex-adjusted percent of residents aged 65+ who received a flu shot

Figure 6.40 shows the population aged 65 and over, which have been immunized for influenza over two time periods. NOR-MAN’s rate at 50.9% during the first time period was lower than the provincial rate at 54.5%.

During the second time period both NOR-MAN and the
provincial rate experienced a statistically significant increase over time to rates of 64.5% and 66.4%.

When reviewing adult influenza immunization rates at the NOR-MAN district levels as shown in Figure 6.41 the following differences are of note:

- District I experienced an increase in rates in the second time period from a rate of 50.6% to 68.3%
- District II experienced an increase in rates in the second time period from a rate of 55.9% to 64.6%
- District III experienced an increase in the second time period from a rate of 39.6% to 54.7%

![Adult Influenza Immunization Rates by NOR-MAN District](image)

Figure 6.41: Adult Influenza Immunization Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

All three NOR-MAN districts’ reported statistically significant increases over time.

### Adult Pneumococcal Immunizations

Pneumonia is an inflammation of the lungs caused by a bacterial, viral, or fungal infection. Bacterial pneumonia in adults is commonly caused by a bacterium called Streptococcus Pneumonia.
Adult pneumococcal immunization rates have continued to increase in the NOR-MAN region, from a low of 0.3% in 1999 to 39.5% in 2000/01, to the current rate of 64.2% in 2005/06 for NOR-MAN residents age 65 years and older. Our rate in the time period of 2000/01 of 39.5% was statistically different (higher) than the provincial rate of 23.6%.

Figure 6.42 shows that both the NOR-MAN region and the province as a whole experienced a statistically significant increase in their rates between the first and second time period.

When reviewing adult pneumococcal immunization rates at the NOR-MAN district levels as shown in Figure 6.43 the following differences are of note:

- District I experienced an increase in rates in the second time period from a rate of 41.7% to 64.0% - the rate in period one was statistically different (higher) than the provincial rate

- District II experienced an increase in rates in the second time period from a rate of 45.9% to
62.1% - the rate in period one was statistically different (higher) than the provincial rate

- District III experienced an increase in the second time period from a rate of 40.6% to 53.6% - the rate in period one was statistically different (higher) than the provincial rate

**Pneumococcal Immunization Rates by NOR-MAN District**

Age- & sex-adjusted percent of residents aged 65+ who received a pneumococcal vaccination after April 2000

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District I (1,t)</td>
<td>41.7%</td>
<td>64.0%</td>
</tr>
<tr>
<td>District II (1,t)</td>
<td>46.0%</td>
<td>62.1%</td>
</tr>
<tr>
<td>District III (1,t)</td>
<td>40.6%</td>
<td>53.5%</td>
</tr>
</tbody>
</table>

Figure 6.43: Adult Pneumococcal Immunization Rates by NOR-MAN District

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

**H1N1 Influenza Pandemic**

The primary goal of the health sector during an Influenza Pandemic response is to maintain a coordinated approach in response with minimal disruption to health services, society in general, while reducing morbidity (illness) and mortality (death) associated with the pandemic.

The novel H1N1 pandemic influenza virus first appeared in Mexico in the spring of 2009 and spread world-wide. On June 11, 2009, the World Health Organization declared the novel H1N1 influenza virus to be a pandemic. Manitoba’s first confirmed case was reported on May 5, 2009 and the first death linked to the H1N1 was reported on June 16, 2009.
The first wave of the pandemic flu peaked in mid-June and continued through the summer, with the second wave starting in October. The second wave has been relatively mild for Manitobans, and northern RHA’s experienced fewer cases in the second wave than the first.

The majority of NOR-MAN residents were affected during the first wave, which left NOR-MAN residents less susceptible to the second wave. The recommended course of action was the administration of one (1) dose of pH1N1 Vaccine to all residents through immunizations clinic in all NOR-MAN communities. Table 6.11 shows our H1N1 vaccination totals by community for the period September 1, 2009 to January 31, 2010.

<table>
<thead>
<tr>
<th>Community</th>
<th>Total # Vaccinated</th>
<th>% of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>R.M. of Kelsey</td>
<td>930</td>
<td>37%</td>
</tr>
<tr>
<td>Snow Lake</td>
<td>457</td>
<td>52%</td>
</tr>
<tr>
<td>Flin Flon</td>
<td>2,603</td>
<td>44%</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td>52</td>
<td>8%</td>
</tr>
<tr>
<td>The Pas</td>
<td>3,455</td>
<td>48%</td>
</tr>
<tr>
<td>Channing</td>
<td>75</td>
<td>57%</td>
</tr>
<tr>
<td>Cormorant</td>
<td>309</td>
<td>78%</td>
</tr>
<tr>
<td>Easterville</td>
<td>88</td>
<td>15%</td>
</tr>
<tr>
<td>Moose Lake</td>
<td>59</td>
<td>8%</td>
</tr>
<tr>
<td>Pukatawagan</td>
<td>205</td>
<td>56%</td>
</tr>
<tr>
<td>Sherridon</td>
<td>63</td>
<td>67%</td>
</tr>
<tr>
<td>OCN</td>
<td>1,053</td>
<td>61%</td>
</tr>
<tr>
<td>Misipawistik CN</td>
<td>29</td>
<td>6%</td>
</tr>
<tr>
<td>Chemawawin CN</td>
<td>132</td>
<td>19%</td>
</tr>
<tr>
<td>Mosakahiken CN</td>
<td>44</td>
<td>9%</td>
</tr>
<tr>
<td>Mathias Colomb CN</td>
<td>752</td>
<td>59%</td>
</tr>
<tr>
<td><strong>NRHA Totals</strong></td>
<td><strong>10,306</strong></td>
<td><strong>42%</strong></td>
</tr>
</tbody>
</table>

Table 6.11: H1N1 NOR-MAN Vaccine Report, 01/09/2009 to 31/01/2010
Source: Manitoba Health, Health Information Management
Sexually Transmitted Infections (STI)

Sexually transmitted infections are a growing problem at the regional, provincial and federal levels. These rises in STI is being attributed to people not consistently using safer sex methods.

Gonorrhea

According to Health Canada after 20 years of constant decline in Canada, the rates of infection for gonorrhea have risen more than 40% over the last five years. Poor safer sex practices and drug-resistant strains of the disease are causing this increase.

When reviewing gonorrhea rates at a regional level for the period of 2002 to 2005, NOR-MAN has the second highest rate for females at 1.1/1000 compared to the provincial rate of 0.5/1,000. The NOR-MAN males rate is the same as the provincial rate at 0.6/1000. NOR-MAN males have the fourth highest rate of gonorrhea in the province.

Figure 6.44 shows the five year trend for NOR-MAN males compared to females, whose rates are showing similar growth trends. NOR-MAN males report higher rates of gonorrhea than females.

Figure 6.44: NOR-MAN Gonorrhea Rates
Source: Manitoba Health, NRHA Profile Document, 2008/09
Chlamydia

is a bacterial infection that is transmitted through oral, genital or anal sex and can be transmitted from mother to child during childbirth. Chlamydia cases are those reported via positive lab test (Health Canada).

Chlamydia

Chlamydia is the most common bacterial sexually transmitted infection (STI) in Canada. When left untreated, it can lead to painful health problems and sterility. Chlamydia is known as the “silent disease”, because more than 50% of infected males and 70% of infected females have no symptoms and are unaware of their condition.

According to Health Canada, after being in decline for many years, rates of Chlamydia infection have risen steadily since 1997. These rising rates are a sign that people are not using safer sex practices.

When reviewing Chlamydia rates at a regional level for the period of 2002 to 2005, NOR-MAN has the highest rate for females in the province at 6.6/1000 compared to the provincial rate of 2.9/1000. The NOR-MAN males rate at 2.4/1000 is higher than the provincial rate at 1.6/1000. NOR-MAN males have the third highest rate of Chlamydia in the province.

According to the Women’s Health Profile, First Nation Manitobans, especially young women experience higher rates of Chlamydia infections than do other Manitobans.

Figure 6.45 shows the five year trend for NOR-MAN males compared to females, whose rates are showing similar growth trends. NOR-MAN
females report higher rates of Chlamydia than males.

**HIV and AIDS**

Like other sexually transmitted infections, HIV is transmitted through unprotected sexual intercourse (vaginal, anal, oral); shared needles or equipment for injecting drugs; unsterilized needles for tattooing; skin piercing or acupuncture; pregnancy; delivery and breast feeding (from an HIV-infected mother to infant); and occupational exposure in health care settings.

HIV attacks the immune system, resulting in a chronic, progressive illness and leaving infected people vulnerable to opportunistic infections and cancers. The median time from infection to AIDS diagnosis now exceeds ten years.

Currently the reported HIV rates for NOR-MAN are very low. At the provincial level, the rates have decreased between 2005 and 2006 for both males and females. During 2006, at a provincial level, a total of 51 new male cases and 30 new female cases were reported. To be counted as a new case a positive lab test is required.

**Life Stress**

Stress affects many aspects of a person’s health and well-being and has been recognized as contributing problem with chronic illness and mental health. Life stress is a self-reported indicator that gives us an indication of how people feel they are able to cope with the stress in their lives.

Overall, 40.6% of NOR-MAN CCHS respondents reported low stress lives, 43.3% reported medium stress lives and only 16.0% reported high stress lives in comparison to provincial rates of 34.9%, 44.1% and 21.0%.
Environmental Factors

Second-Hand Smoke

Exposure to second-hand smoke can have damaging effects on a person’s health. Children are particularly vulnerable to the negative exposure.

With 34.4% of our region’s population being under the age of 19 years, along with our smoking rate at 27.2% within the NOR-MAN region, exposure to second hand smoke is a concern. According to data from the Canadian Community Health Survey (Cycle 1.1, 2.1, and 3.1), 40.5% of NOR-MAN residents age 12 - 19 years reported being exposed to second-hand smoke. Our exposure is statistically different (higher) that the provincial rate at 26.8%.

Second-Hand Smoke at Home

There appears to be a relationship between health status and exposure to second-hand smoke at home especially in areas with less healthy populations like the NOR-MAN region because of the higher proportion of non-smokers who are exposed to second-hand smoke.

When reviewing the differences between the various smoking types as shown in Table 6.12, NOR-MAN males report a lower rate of no exposure to second-hand smoke at home at 75.1% compared to NOR-MAN females at 77.9%

<table>
<thead>
<tr>
<th>Exposure to Smoke at Home</th>
<th>NOR-MAN Males</th>
<th>NOR-MAN Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>24.9%</td>
<td>22.1%</td>
</tr>
<tr>
<td>No</td>
<td>75.1%</td>
<td>77.9%</td>
</tr>
</tbody>
</table>

Table 6.12: Exposure to Second Hand Smoke
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
Flin Flon Soil Study

Manitoba Conservation conducted a study in 2006 measuring the levels of 33 heavy metals and other elements in the soil in Flin Flon and Creighton, Saskatchewan. Of the substances tested, 11 were found to be somewhat elevated relative to other control sites away from the Flin Flon area. In some locations in Flin Flon and Creighton, concentrations of arsenic, cadmium, copper, lead, mercury, selenium and/or thallium were found to be above the very protective quality guidelines set by the Canadian Council of Ministers of Environment (CCME).

Due to the history of emissions of these substances related to the Hudson Bay Mining & Smelting Co. Ltd. (HBM&S) smelter, Manitoba Conservation and Saskatchewan Ministry of Environment directed HBM&S to commission a comprehensive “Human Health Risk Assessment” to estimate any ongoing and future health risks of exposure to these metals and elements for the people of Flin Flon and Creighton.

This study, conducted by external consultants under the guidance of technical and community advisory groups, used an “exposure pathways” approach, measuring levels of contaminants in local soil, water, air, dust and food to estimate daily lifetime exposure to the contaminants under study for all age groups, and the potential to affect local community health. Potential exposure of children (who are the most vulnerable age group and also the group most likely to be exposed to soil through incidental ingestion) to the metals of most concern was measured directly through collection of urine and blood samples from a representative sample from volunteer families.

The final reports of the Flin Flon Soil Study, including the Human Health Risk Assessment and Exposure Study, are planned to be released in

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Risk Assessment

Is a scientific process that predicts the risks to humans, animals or plants if they are exposed to a contaminant such as a chemical or other pollutant in the environment

(Hudson Bay Mining & Smelting)

Community Health Status Assessment

Examines the overall health of a population

(Saskatchewan Health)

Human Health Risk Assessment (HHRA)

Examines the possible risks to human health from exposure to contaminants in the environment - will provide a comprehensive assessment of possible human exposure to metals in Flin Flon and Creighton

(Saskatchewan Health)
mid 2010, with an open house for interested members of the public. Detailed information regarding these studies can be found on the website: www.flinflonsoilsstudy.com

**Flin Flon / Creighton Community Health Status Assessment**

Due to the concerns regarding possible health risks related to contaminated soils in the Flin Flon area, the medical officers of health for NOR-MAN and Mamawetan Churchill River (MCR) Health Authority in Saskatchewan coordinated a “Community Health Status Assessment for Flin Flon and Creighton.” This assessment looked at all available statistics on overall death rates, causes of death and cancer incidence in Flin Flon and Creighton for a ten year period from 1996 to 2005.

This health status assessment found that while statistics were not available for every possible health condition, overall health status indicators for Flin Flon and Creighton were similar to or better than provincial and regional averages. This provides some reassurance that long term health and mortality has not likely been seriously impacted by metal exposures in the general Flin Flon / Creighton population, and that other positive determinants of health (such as education and income levels) are also important in these communities.

**Air Quality**

Manitoba Conservation has an ongoing program monitoring pollutant emissions and air quality in the Flin Flon area. Guidelines are followed to notify the public regarding any exceedances of acceptable air quality levels. National air quality and emission standards have been getting progressively stricter over recent years, and this is
one of the factors in the decision by HBM&S to close the copper smelter by July 2010.

**Drinking Water Quality and Sewage Treatment**

Drinking water quality and treatment standards are monitored by both local (city, municipal or band) and provincial (Manitoba Water Stewardship Drinking Water Officers) authorities, as well as the Environmental Health Officer for Cree Nation Tribal Health in the Swampy Cree Tribal Council communities. The Canadian Drinking Water Guidelines are followed for all communities.

Generally, drinking water quality is very good in all communities. Rarely, if there is an acute risk to the quality of drinking water (e.g. if there is a large water main break, or if water quality indicators such as turbidity change) then a “Boil Water Advisory” may be temporarily issued. This occurs only 2 or 3 times per year for short periods for specific communities in NOR-MAN.

Regarding longer-term water quality indictors (e.g. trihalomethanes, the by-products of chlorine treatment of surface water with organic material in it), Manitoba Water Stewardship has directed water treatment jurisdictions to submit plans for complying with the latest recommended levels.

Due to population growth and new housing developments in some of the outlying communities in NOR-MAN, sewage pipeline and treatment infrastructures have been stressed over the years. This has resulted in some temporary surface leaks of sewage in some communities. These leaks have been contained by local authorities under the direction of environment and health officials, and sewage treatment infrastructures have been expanded in some communities. Ongoing water and sewage...
infrastructure upkeep and renewal should remain a priority for all communities.

**Summary**

Health behaviors are lifestyle choices an individual makes that are influenced by social, economic, and environmental factors. Social environments that support healthy choices and lifestyles, as well as people’s knowledge, intentions, and health behaviors, are key influences on health.

This chapter has clearly given us the picture of what our current health status is and how the choices we make about the way we live impacts our health. Some of the basic determinants of health that are affecting our region are income disparity, lower education levels, higher unemployment rates and family structures. Some of the key findings for the NOR-MAN region include:

- The NOR-MAN region, in all three time periods shows that we have a higher number of families experiencing more income inequality than the province as a whole

- There is a large discrepancy between high and low income earners in the NOR-MAN region - District I families are experiencing more inequality than NOR-MAN as a whole

- NOR-MAN’s median household income value is higher than the provincial value in all three time periods

- NOR-MAN female medium income values are significantly lower at $18,232.00 than our male level of $31,376.00

- Our main male occupations are trades, transportation and equipment operators at

*Poverty was identified as a concern during our consultations*
29.6% followed by sales at 19.6% and unique to primary industry at 14.8%

- Our main female occupations are sales at 36.6% followed by business, finance and administration at 20.4% and social sciences, education, government and other services at 15.5% and health at 12.9%

- NOR-MAN has the fourth highest overall rate of unemployment in Manitoba. Both NOR-MAN males at 12% and females at 10% appear to be more likely to be unemployed than were all Manitoba males at 6% and females at 5%.

- As the NOR-MAN population ages, economic issues will cause even bigger problems due to the fact that 25.8% of NOR-MAN residents are under the age of 15 and currently are not a part of the workforce.

- When reviewing youth (age 15 to 24 years) unemployment stats, NOR-MAN males and females are more likely to be unemployed than were all Manitoba youth in all three time periods.

- The NOR-MAN region has a higher percentage of residents with less than a high school or only a high school diploma in all ages compared to the provincial rates.

- Approximately 16% of NOR-MAN residents have experienced a major stress event in their life through divorce, being widowed or being separated.

- 5,975 families live in the NOR-MAN region, of those families, 23% are lone parent families - of the lone parent families in the NOR-MAN region, 78% are headed by women.

- Most of our First Nation communities are reporting overcrowding in their homes.
Most of our First Nation communities are reporting mold and/or mildew as a major housing repair required.

There has been a decrease of 474 births over the five year time periods since our last CHA.

Our Preterm birth rate at 6.5% is statistically lower than the provincial rate.

NOR-MAN teens are two times more likely to give birth than the province as a whole - NOR-MAN teen birth rates have started to decrease.

When looking at low birth weight rates over a five year period both the NOR-MAN region and Manitoba have experienced increases in their rates.

We have higher high birth weight babies in our region.

Completed childhood immunizations have improved in the age one (1) and age seven (7) year old categories.

NOR-MAN breastfeeding initiation rates are statistically lower than the Manitoba rate.

NOR-MAN children deemed “Not Ready” for school require further development in language and thinking skills, emotional maturity, social competence and physical health and well-being.

We have more current smokers - we are concerned with the smoking rates of our youth and Aboriginal peoples.

We are home to a larger number of former smokers.

We have more reported occurrences of binge drinking - we are concerned with the rates of youth binge drinking.

Limited housing options was identified as a concern during our consultations.

Teen pregnancy was identified as a concern during our consultations.

Smoking, especially youth smoking was identified as a concern during our consultations.

Drugs and alcohol use was identified as a concern during our consultations.

Teen pregnancy was identified as a concern during our consultations.
• Our youth are reporting a high rate of illegal drug use and the rates increase by grade

• Approximately 70% of NOR-MAN residents do not consume five or more fruits and vegetables per day

• We are more likely to be either overweight or obese - this applies to both children and adults

• NOR-MAN residents reported being more active

• We have the third lowest rate of cervical screening in the province

• We continue to see an increase in our mammography screening rates - the Manitoba Mobile Breast Screening Program has had a significant impact

• Adult pneumococcal immunization rates have continued to increase in the NOR-MAN region

• From September 2009 to January 2010, 10,306 or 42% of NOR-MAN residents received their H1N1 vaccinations

• Gonorrhea rates are increasing in our region - males report a higher rate than females

• Chlamydia rates in NOR-MAN have risen steadily since 1997 - females have the highest rate of all females in Manitoba

• Our exposure to second hand smoke is statistically different (higher) that the provincial rate at 26.8%.

• According to Flin Flon / Creighton Community Health Status Assessment, the long term health and mortality has not likely been seriously impacted by metal exposures in the general Flin Flon / Creighton population
Generally, drinking water quality is very good in all NOR-MAN communities.

Water quality and contamination was identified as a concern during our consultations.

As the above highlights have clearly shown, the NOR-MAN region has both good and bad news that needs to be addressed with respect to the various determinants of health we reviewed.

For the NOR-MAN region it is necessary to continue to monitor each of the determinants of health, as they are the basis for the development of quality partnerships and community development programming.
Chapter 7

Where do NOR-MAN residents go for health services and are they receiving quality services?

Assessing our healthcare quality is a key step to improving our care and service delivery within the NOR-MAN region. The review of both quality and performance data is required to ensure ongoing quality improvement activities are taking place. By collecting, analyzing and reporting our healthcare data, it becomes possible to identify the areas where our performance needs improvement and where new solutions are required.

This chapter will explore two questions: First... Where do NOR-MAN residents go for Health Services? And second… Are they receiving quality services? The only way to answer these questions is by reviewing the following health system performance indicators:

1. **Accessibility** - is the ease with which an individual and/or community obtains the required or available services and supports in the most appropriate setting

2. **Continuity of Services** - refers to the provision of coordinated and seamless services

3. **Effectiveness** - refers to the extent to which interventions, whether a service, visit, procedure or diagnostic test, produces the intended results.

4. **Service Utilization** - refers to monitoring information on the who used our services, what services were used, when, where and how much
NOR-MAN Health Services

The NOR-MAN Regional Health Authority (NRHA) provides a range of services to approximately 30,000 – 32,500 people. In addition to the Manitoba-based population of 24,090 NOR-MAN residents, approximately 8,300 northeastern Saskatchewan residents use acute, ambulatory, diagnostic, emergency care and physician services in both Flin Flon and The Pas.

As we review our health service utilization rates for the NOR-MAN region, it is important to remember that the numbers reflect only Manitoba residents. Of note is that northeastern Saskatchewan residents accounted for 39% - 67% of Flin Flon General Hospital use during 2008/09. When reviewing the various utilization categories, Saskatchewan residents account for 39% of ER visits, 53% of hospital discharges, and 67% of newborns.

Consistent with our mandate, the NRHA delivers a wide range of services in eleven (11) core service areas through the following facilities:

- **Hospitals** - Flin Flon General Hospital, St. Anthony’s Hospital, Snow Lake Health Centre
- **Personal Care Homes** - St. Paul’s Residence, Northern Lights Manor, Flin Flon Personal Care Home
- **Addiction Centre** - Rosaire House
- **Primary Health Care** - The Pas, Primary Health Care - Flin Flon (two sites), Cranberry Portage Wellness Centre, Cormorant Health Care Centre, and the Sherridon Health Care Centre
Physician Services

Access to health care is a major concern of patients and the public worldwide. Within the NOR-MAN region, access is one of the top concerns identified by most communities during our consultation activities. NOR-MAN residents are concerned with both the number of physicians practicing in our region and the wait times required to access a physician. (Physician data from the MCHP Reports must be interpreted with caution due to physician shadow billing practices)

Use of Physicians

An ongoing relationship with a physician plays an important role in maintaining a person’s health and ensuring that they have access to all required health care services. The proportion of Manitoba residents visiting a physician at least once in a year was 83.2%, a value which has been relatively stable since 1995/96.

Figure 7.1 shows that 77.8% of NOR-MAN residents visited a physician in 2005/06 compared to our rate of 79.8% in 2000/01. Our rate is statistically different (lower) than the provincial visits rate of 83.2% in the second time period.

When reviewing district level data as shown in Figure 7.2, a number of differences are clearly visible:

- District I physician visit rates are similar to the Manitoba rate, but have experienced a small decrease

Figure 7.1: Use of Physicians by RHA
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
NRHA employs a Physician Recruiter and has established a Regional Physician Resource Committee who coordinates ongoing physician/retention efforts for the region.

- District II physician visit rates are similar to the Manitoba rate, but have experienced a small decrease.
- District III physician visit rates are statistically different (lower) in both time periods compared to the provincial rate, also the change over time is statistically significantly lower.

**Ambulatory Visits**

NOR-MAN residents place great importance on family physicians, due to our extremely low level of access to specialists within our region. Currently the majority of physicians working in the NOR-MAN region are either General Practitioners (GP) or Family Practitioners (FP).

Figure 7.3 shows the average number of ambulatory visits to all physicians by NOR-MAN residents. These average numbers include visits for any reason, to any type of physician (including GP/FPs and specialists). As shown both NOR-
MAN and Manitoba, residents are seeing physicians approximately five times per year.

When reviewing ambulatory visit rates at our district levels as shown in Figure 7.4, a number of differences are of note:

- **District I** experienced a change over time from **5.4** visits in 2000/01 to **5.0** visits in 2005/06 - this change over time was a statistically significant decrease

- **District II** physician visit rates at **5.6** visits per person in both time periods are statistically

![Ambulatory Visit Rates](image1)

![Ambulatory Visit Rate by District](image2)

**Figure 7.3: Ambulatory Visit Rates**
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

**Figure 7.4: Ambulatory Visits by NOR-MAN District**
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
different (higher) than the provincial rates of 5.0 and 5.1 visits

- District III physician visit rates for both time periods are statistically different (lower) at 3.8 and 3.3 visits compared to the provincial visit rates at 5.0 and 5.1, also District III experienced as statistically significant decrease.

**Location of Visits to General and Family Practitioners**

To understand how our residents access our services, the first step is to review where they go for physician visits. Figure 7.5 compares NOR-MAN GPs/FPs visit rates in two time periods with the provincial rates. For the NOR-MAN region, the majority of residents are seeing physicians in their home district at 80.9% in the first time period and 82.6% in the second time period, followed by elsewhere in the NOR-MAN region at 9.8% and 10.2%.

<table>
<thead>
<tr>
<th>Location</th>
<th>NOR-MAN, 2000/01</th>
<th>Manitoba, 2000/01</th>
<th>NOR-MAN, 2005/06</th>
<th>Manitoba, 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>% To Winnipeg</td>
<td>3.9%</td>
<td>6.1%</td>
<td>3.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>% To Other RHA</td>
<td>5.3%</td>
<td>3.9%</td>
<td>3.8%</td>
<td>4.1%</td>
</tr>
<tr>
<td>% Elsewhere in RHA</td>
<td>9.8%</td>
<td>4.2%</td>
<td>10.2%</td>
<td>4.4%</td>
</tr>
<tr>
<td>% In District</td>
<td>80.9%</td>
<td>85.8%</td>
<td>82.6%</td>
<td>85.6%</td>
</tr>
</tbody>
</table>

Figure 7.5: Location of Visits to GP/FPs
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

GPs/FPs Visit Locations

is the proportion of visits to GPs/FPs by location of the visit

Visit rate are reported in two one-year time periods

(Manitoba Centre for Health Policy)

NOR-MAN physician use in the region has increased slightly between the two time periods.
When reviewing NOR-MAN district level data over two time periods for location of physician visits as shown in Figures 7.6 & 7.7, differences are clearly seen:

- District I and II residents are seeing physicians in their own district the majority of the time, and have the lowest rate of visits to Winnipeg hospitals.

- District III residents are seeing physicians in other districts than their own at 70.4% - the majority of NOR-MAN physicians are found in The Pas and Flin Flon.

- District III has also experienced a decrease in physician visits to other RHAs and Winnipeg in the second time period.
Reasons for Physician Visits

Figure 7.8 shows the top reasons for visiting a physician in the north (NOR-MAN RHA, Burntwood RHA and Churchill RHA) in 2005/06. The top three reasons were for respiratory, injuries & poisonings, and musculoskeletal. The only similarity to Manitoba as a whole is that respiratory issues are the top reason in both.

Reasons for Physician Visits, North, 2005/06

Figure 7.8: Cause of Physician Visits
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

When comparing the reasons for physician visits to the leading causes of death in the North, the following differences are of note:

- **Respiratory** at 12.4% is the main reason for visiting a physician, but is ranked fifth (5th) as a cause of death.

- **Injury and poisonings** at 9.0% is ranked second (2nd) as a reason for visiting a physician but is ranked first (1st) as a cause of death.
Ambulatory Consultation Rates

As shown in Figure 7.9, the NOR-MAN region is statistically different (lower) than the Manitoba average for both time periods.

![Ambulatory Consultation Rates by RHA](chart)

Since our last CHA report NOR-MAN rates have increased from our past rates of:

- 0.18 in 1995/96
- 0.20 in 2000/01

When reviewing the average consultation rates at the district level for the period of 2005/06, a showed in Figure 7.10, a number of differences are seen:

- District I had the lowest ambulatory consultation averages at a rate of 0.17 and the rate in both time periods is statistically different (lower) than the provincial rate of 0.27.

- District II had the highest consultation average at 0.23 for...
the NOR-MAN region but, this average is still statistically different (lower) than the Manitoba average of 0.27 in both time periods.

- District III also has a statistically different (lower) rate than the Manitoba rate of 0.27 in both time periods.

**Ambulatory Visits to Specialist**

As shown in Figure 7.11, the NOR-MAN region is statistically different (lower) at 0.39 in the first time period and 0.49 in the second time period compared to the Manitoba average of 1.23 and 1.27 in the same time periods. The NOR-MAN region experienced an increase in the second time period and this change over time was statistically significant (increase).

When reviewing district level for the period of 2005/06 as shown in Figure 7.12, a number of differences are seen:

- District I had the lowest ambulatory visits to specialist averages with a rate of 0.43 and the rate in both time periods is statistically different (lower) than the provincial rate of
1.27 - also the change over time is statistically significant (higher)

- District II experienced a statistically significant increase over time from 0.41 to 0.50 - but this average is still statistically different (lower) than the Manitoba average of 0.27

- District III had the highest average specialists visit average in the NOR-MAN - but their rate continues to be statistically different (lower) than the Manitoba rate of 1.27

**Location of Visits to Specialists**

To understand how our residents access specialist services, the first step is to review where they go for specialists visits. Figure 7.13 compares NOR-MAN specialists visit rates in two time periods with the provincial rates. For the NOR-MAN region, the majority of NOR-MAN residents are seeing specialists in Winnipeg at 91.4% in the first time period and 83.4% in the second time period. Of interest is the fact that the NOR-MAN specialist visit location changed in the second time period. The NOR-MAN region experienced an increase in visits in both the “elsewhere in the
NOR-MAN region” from 1.5% to 4.9% and “in the district” from 4.0% to 9.3%

When reviewing district level data for the two time periods of 2000/01 and 2005/06, we discovered that most of our residents visits to specialists are occurring in Winnipeg, however:

- District I rates decreased from 94.5% to 88.9%
- District II rates decreased from 87.4% to 79.4%
- District III rates decreased from 94.9% to 84.1%

Physician Visits for those with Mental Illness

Mental Illness is ranked the eighth (8th) reason for physician visits in the north at a rate of 6.4%.

When reviewing our 2003/04 - 2007/08 physician visit rates for those with cumulative disorders, the NOR-MAN male rate is 1452/1,000 and the female rate is 2235/1,000. In short, NOR-MAN females
visit physicians more often for mental illness issues than do NOR-MAN males.

Continuity of Care

An ongoing relationship with a doctor is important in maintaining a person’s overall health. Individuals with a regular family physician (or specialist) may have improved health outcomes as a result of one physician managing their health care needs over an extended period of time. Because of this, we review continuity of care to provide us with a picture of how many NOR-MAN residents are seeing the same physician on a regular basis.

Figure 7.14 shows the continuity of care rates over two time periods for both NOR-MAN and Manitoba as a whole. During the second time period, 67.3% of NOR-MAN residents were seeing the same physicians at least 50% of the time, this was a decrease for the NOR-MAN region from 70.4%. NOR-MAN’s current rate is similar to the Manitoba rate of 67.7%.

![Continuity of Care Rates](image)

During the 2004/05 to 2005/06 time period, NOR-MAN had the fourth highest rate in the province of residents seeing the same physician for 50% of their ambulatory visits.

Figure 7.14: Continuity of Care Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
When reviewing continuity of care at the district level as shown in Figure 7.15, the following differences need to be highlighted:

- District I’s rate was statistically different (higher) in the first time period - during the second time period the district experienced a small decline in their rate to **72.2%** but remains **higher** than the provincial rate of **67.7%**

- District II has similar rates to the provincial rate in both time periods

- District III has experienced a statistically **significant decrease** in their rates from **69.8%** to **63.9%** - District III rates are now slightly **lower** than the provincial rates.

### Hospitals - Acute Care Facilities

Hospitals are an essential component of our health care system and provide a wide variety of services. Our hospitals provide two types of services to our residents - “in-patient care” and “out-patient visits.”

#### Hospital Bed Supply - Acute Care

Within the NOR-MAN region, there are eighty-four (84) acute care beds. These beds are located in the Flin Flon General Hospital (42 beds), St. Anthony’s General Hospital (40 beds) and Snow Lake Health Centre (2 beds).

Table 7.1 highlights the bed types available by the following NRHA Acute Care facilities: Flin Flon General Hospital which is located in District I, St. Anthony’s General Hospital which is located in

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**In-patient** is someone who is admitted to hospital, and spends at least one night in hospital.

**Out-patient** is someone who receives care on a visit but is not admitted to hospital.

(Manitoba Centre for Health Policy)
District II and the Snow Lake Health Centre which is located in District I.

<table>
<thead>
<tr>
<th></th>
<th>Obstetrical Beds</th>
<th>Adult Medical Beds</th>
<th>Pediatric Beds</th>
<th>Surgical Beds</th>
<th>Special Care Unit Beds</th>
<th>Palliative Care Bed</th>
<th>Psychiatric Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon General Hospital</td>
<td>6</td>
<td>18</td>
<td>7</td>
<td>8</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>St. Anthony’s General Hospital</td>
<td>8</td>
<td>12</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Snow Lake Health Centre</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 7.1: Bed Type by NOR-MAN Facility
Source: NOR-MAN Regional Health Authority, Bed Map Count, 2010

Use of Hospitals

It is important to know the proportion of our population that is being admitted to our acute care facilities. Figure 7.16 compares our rate of NOR-MAN inpatient hospital bed use to Manitoba as a whole. Of note, is the fact that NOR-MAN has a statistically different (higher) rate of residents being admitted to hospital in both time periods. During 2000/01, 11.1% of our residents compared to 7.5% of all Manitobans were admitted. During 2005/06 our rate declined to 10.4% compared to Manitoba at 7.0% which also was a decline.

![Figure 7.16: Use of Hospitals](source)

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
Figure 7.17 reviews NOR-MAN district level data for hospital use in two different time periods. The following highlights are of note:

- District I experienced a small decrease in their rates in the second time period - however, rates are higher at 8.6% and 8.2% than the provincial rates of 7.5% and 7.0%

- District II experienced a small decrease in their rates in the second time period - however, rates in both time periods are statistically different (higher) at 11.2% and 10.3% than the provincial rates of 7.5% and 7.0%

- District III experienced a small decrease in their rates in the second time period - however, rates in both time periods are statistically different (higher) at 15.6% and 14.4% than the provincial rates of 7.5% and 7.0%

![Use of Hospitals by District](image)

Use of Hospitals by District
Age & sex-adjusted percent of residents with at least one inpatient hospital stay per year

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District I</td>
<td>8.6%</td>
<td>8.2%</td>
</tr>
<tr>
<td>District II (1,2)</td>
<td>11.2%</td>
<td>10.3%</td>
</tr>
<tr>
<td>District III (1,2)</td>
<td>15.6%</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

Figure 7.17: Use of Hospitals by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
Hospital Separation - Where NRHA Resident went for Hospitalizations

Where our residents are hospitalized is important to understand. During the first time period (2000/01), the majority of NOR-MAN residents who required hospitalization were admitted to NRHA facilities at 68.6% compared to the Manitoba rate of 76.9% as shown in Figure 7.18. Of note, in the second time period the percentage of NOR-MAN residents being hospitalized in Winnipeg increased from 24.7% to 26.0%.

Separation Rates
Refers to the people discharged from the hospital
(Manitoba Centre for Health Policy)

Where RHA Residents Went for Hospital Separations

<table>
<thead>
<tr>
<th></th>
<th>NOR-MAN - 2000/01</th>
<th>Manitoba - 2000/01</th>
<th>NOR-MAN - 2005/06</th>
<th>Manitoba - 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Province Hospital</td>
<td>2.3%</td>
<td>1.8%</td>
<td>2.8%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Winnipeg Hospital</td>
<td>24.7%</td>
<td>15.7%</td>
<td>26.0%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Other RHA Hospital</td>
<td>4.4%</td>
<td>5.6%</td>
<td>3.3%</td>
<td>6.0%</td>
</tr>
<tr>
<td>RHA Hospital</td>
<td>68.6%</td>
<td>76.9%</td>
<td>68.0%</td>
<td>75.5%</td>
</tr>
</tbody>
</table>

Figure 7.18: Where RHA Residents Went for Hospital Separations
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Hospital Separation - Where NRHA Patients Come From

Where our hospitalized patients live impacts our fiscal operation because of the volume of Saskatchewan residents been hospitalized in NRHA facilities.

During the first time period (2000/01), the majority of NOR-MAN residents who required hospitalization were admitted to NRHA facilities.

Total days of care used by NOR-MAN residents in the province for 2000/01 was 29,678 days compared to 18,345 days in 2005/06.
Total days of care used in NRHA facilities in 2000/01 was \textbf{26,766} days compared to \textbf{16,712} days in 2005/06.

at \textbf{68.6\%} compared to the Manitoba rate of \textbf{76.9\%} as shown in Figure 7.19. Of note, in the second time period (2005/06), the percentage of “out of province” (Saskatchewan) residents being hospitalized in NRHA facilities has decreased from \textbf{22.0\%} to \textbf{21.6\%}.

![Figure 7.19: Where RHA Residents Came From: Separations]

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

### Short Stay Hospital Days

Figure 7.20 shows the rate per 1,000 residents who had short stay hospital days in two time periods.

The NOR-MAN rate in both time periods at \textbf{615.5/1,000} in 2000/01 and \textbf{537.7/1,000} in 2005/06 is statistically different (higher) than the provincial rates of \textbf{352.2/1,000} and \textbf{321.6/1,000}.

Both NOR-MAN and the province as a whole experienced a decline in their hospital short stays.

![Figure 7.20: Hospital Days Used in Short Stays by RHA]

Age- & sex-adjusted rate of hospital days used in stays of less than 14 days, per 1,000 residents

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
When reviewing our district level short stay hospitalizations as shown in Figure 7.21, the following differences are of note:

- District I in the second time period has a statistically different (higher) rate $451.1/1,000$ compared to the provincial rate of $321.6/1,000$.

- District II in both time periods has a statistically different (higher) rate at $647.9/1,000$ and $486.8/1,000$ than the province as a whole at $352.2/1,000$ and $321.6/1,000$ - also, our change over time (decrease) is statistically significant.

- District III has the highest rate of short stay hospitalizations in the NOR-MAN region at $958.0/1,000$ and $790.5/1,000$ - also, our rate in both time periods is statistically different (higher) than the provincial rate.

**Short Stay Hospital Days**

Is the number of hospital days used in short stays (less than 14 days). Per 1,000 area residents per year - if a resident had more than one short hospitalization in period, then the days used were summed.

(Manitoba Centre for Health Policy)

These results are consistent with the 2003 MCHP Atlas, though the values here are lower because this report used 14 days as the cut-off for “short stays”, and the 2003 Atlas used 30 days.

**Long Stay Hospital Days**

Is the number of hospital days used in long stays (less than 14 or more days). Per 1,000 area residents per year - if a resident had more than one long hospitalization in period, than the days used were summed.

(Manitoba Centre for Health Policy)

Figure 7.21: Hospital Days Used in Short Stays by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Figure 7.22 shows the rate per 1,000 residents who had long stay hospital days in two time periods.

NOR-MAN’s rate in 2000/01 at $1003.2/1,000$ was
When reviewing our district level long stay hospitalizations as shown in Figure 7.23, the following differences are of note:

- District I rates experienced a statistically significant decrease over time and are now lower than the provincial average.
- District II and III rates have decreased over time, although not statistically significant.

**Hospital Days Used in Long Stays by RHA**

*Age- and sex-adjusted rate of hospital days used in stays of 14 days or more, per 1,000 residents*

<table>
<thead>
<tr>
<th>Year</th>
<th>NOR-MAN (1,t)</th>
<th>Manitoba</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000/2001</td>
<td>1125.9</td>
<td>659.5</td>
</tr>
<tr>
<td>2005/2006</td>
<td>436.9</td>
<td>593.8</td>
</tr>
</tbody>
</table>

**Hospital Days Used in Long Stays by District**

*Age- and sex-adjusted rate of hospital days used in stays of 14 days or more, per 1,000 residents*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1125.9</td>
<td>436.9</td>
</tr>
<tr>
<td>II</td>
<td>605.9</td>
<td>453.1</td>
</tr>
<tr>
<td>III</td>
<td>1190.1</td>
<td>643.9</td>
</tr>
</tbody>
</table>

Figure 7.22: Hospital Days Used in Long Stays
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Figure 7.23: Hospital Days Used in Long Stays by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Long Term Care patients previously at the Flin Flon General Hospital’s 4th Floor were moved to Northern Lights Manor in February 2001.
Causes of Hospitalization

Overall, the leading causes of hospitalization have remained constant over time. Figure 7.24 shows the top ten (10) causes of hospitalization for the north as a whole (NOR-MAN RHA, Burntwood RHA, and Churchill RHA). Pregnancy and birth is our leading cause of hospitalizations in the north at 22.7%, followed by injuries & poisonings at 13.5% and respiratory at 10.0%

When comparing the reasons for hospitalizations to both causes of physician visits and deaths, those causes that are found in all three categories in the top (five) are:

- **Respiratory** - ranked first (1st) for physician visits at 12.4%, ranked fourth (4th) for causes of death at 8.7% and third (3rd) for hospitalizations at 10.0%
• **Injury and Poisonings** - ranked second (2nd) for physician visits at 9.0%, ranked third (3rd) for causes of death at 16.7% and second (2nd) for hospitalizations at 13.5%.

**Ambulatory Care Sensitive Conditions (ACSC) Hospitalizations**

Many chronic illnesses, including diabetes, asthma, angina, and high blood pressure, can be effectively managed in the community with appropriate medical screening, monitoring and follow-up. Combined with education and support for patients to manage their own conditions, such practice can potentially reduce the number of hospital stays by people with one or more chronic conditions. Optimizing management and treatment of ACSC in the community can potentially contribute to both improved health outcomes and more efficient resource utilization.

When reviewing hospitalizations for those with ACSC, the NOR-MAN rate at **20.7/1,000** in 2000/01 and **18.6/1,000** in 2005/06 is statistically different (higher) than the Manitoba rates at **11.3/1,000** and **9.5/1,000**. The good news for both NOR-MAN and Manitoba as a whole is the rate decreased, unfortunately NOR-MAN’s rate showed no significant change over time.

When reviewing district level data as shown in Table 7.2, the following differences are of note:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District I</td>
<td>12.1/1,000</td>
<td>13.1/1,000</td>
</tr>
<tr>
<td>District II (1,2)</td>
<td>20.5/1,000</td>
<td>16.6/1,000</td>
</tr>
<tr>
<td>District III (1,2)</td>
<td>36.6/1,000</td>
<td>31.0/1,000</td>
</tr>
</tbody>
</table>

Table 7.2: Ambulatory Care Sensitive Conditions by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

• District I in both time periods has the lowest rates in the NOR-MAN region - but rates are still higher than Manitoba

• District II and III have statistically higher rates
than Manitoba in both time periods - although, there has been a slight decrease

Hospital Separations for Mental Illness Disorders

Hospitalizations for mental illness is ranked seventh (7th) for the north at a rate of 5.1% when reviewing the causes of hospitalization.

When reviewing our 1997/98 - 2001/02 hospitalizations rates for those with cumulative disorders, the NOR-MAN male rate is higher at 42.5/1,000 compared to the provincial rate of 32.3/1,000. The female rate is also higher at 29.0/1,000 compared to the provincial rate of 24.5/1,000.

When comparing our rates with the 2003/04 - 2007/08 rates, rates have continued to increase for males at 51.4/1,000 and females at 61.7/1,000.

Figure 7.25 shows the district level data for hospital separation for those with mental illness disorders. Of note, is the differences between males and females. Females rates are lower than males in all three of our districts and this is the same trend for the province as a whole.

Of special note, is the rates difference between males and females in District II are statistically significant.

<table>
<thead>
<tr>
<th>District</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>District I</td>
<td>45.9</td>
<td>34.8</td>
</tr>
<tr>
<td>District II (d)</td>
<td>35.5</td>
<td>24.3</td>
</tr>
<tr>
<td>District III</td>
<td>55</td>
<td>34.6</td>
</tr>
</tbody>
</table>

Figure 7.25: Hospital Separations for Mental Illness Disorders - Cumulative Disorders, 1997/98 - 2001/02 Source: Manitoba Centre for Health Policy, Patterns of Regional Mental Illness Report, 2004
High Profile Procedures

Joint Replacement Surgery

According to the 2009 Indicators Report by Canadian Institute for Health Information (CIHI), joint replacement surgery can be very effective for relieving pain and improving function for people suffering from conditions such as osteoarthritis or injury. It is not a surprise that the number of hip and knee replacements performed is rising annually and is expected to continue to increase.

Knee Replacement Surgery

The knee is a critical joint. If arthritis or an injury affects the knee, the impact can be debilitating. NOR-MAN residents are receiving less knee replacement surgeries. In 1996/97 - 2000/2001 the NOR-MAN rate was 1.7/1,000, slightly lower than the Manitoba rate of 2.0/1,000. In 2001/02 - 2005/06 NOR-MAN rate is equal to the Manitoba rate of 2.8/1,000. For both the NOR-MAN region and Manitoba as a whole, the change over time was statistically significantly higher.

When reviewing NOR-MAN district level data as shown in Table 7.3, the following differences are of note:

- District I has slightly higher rates than both NOR-MAN and Manitoba in both time periods
- District II has slightly lower rates than both the NOR-MAN and Manitoba rates in both time periods
- District III has higher rates than both the NOR-MAN and Manitoba rates in both time periods

<table>
<thead>
<tr>
<th>Knee Replacement Surgery by District</th>
<th>1996/97 - 2000/01</th>
<th>2001/02 - 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>District I</td>
<td>1.9/1,000</td>
<td>2.9/1,000</td>
</tr>
<tr>
<td>District II</td>
<td>1.4/1,000</td>
<td>2.3/1,000</td>
</tr>
<tr>
<td>District III</td>
<td>2.1/1,000</td>
<td>3.9/1,000</td>
</tr>
</tbody>
</table>

Table 7.3: Knee Replacement Surgery by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
Hip Replacement Surgery

Total hip replacement is surgery to replace a damaged hip joint with a prosthetic one. This type of surgery can help people suffering from a variety of hip problems, resulting from either wear and tear from a lifetime of activity or from disease and injury.

NOR-MAN residents are receiving less hip replacement surgeries. In 1996/97 - 2000/2001, the NOR-MAN rate at **1.5/1,000** compared to the Manitoba rate of **1.7/1,000**. In 2001/02 - 2005/06, the NOR-MAN rate increased slightly to **1.9/1,000** compared to the a Manitoba rate of **2.2/1,000**. However, Manitoba’s increase over time was statistically significant.

<table>
<thead>
<tr>
<th>Hip Replacement Surgery by District</th>
<th>1996/97 - 2000/01</th>
<th>2001/02 - 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>District I</td>
<td>1.5/1,000</td>
<td>1.7/1,000</td>
</tr>
<tr>
<td>District II</td>
<td>1.4/1,000</td>
<td>1.8/1,000</td>
</tr>
<tr>
<td>District III</td>
<td>1.7/1,000</td>
<td>2.1/1,000</td>
</tr>
</tbody>
</table>

Table 7.4: Hip Replacement Surgery by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

When reviewing NOR-MAN district level data as shown in Table 7.4, the following differences are of note:

- **District I** has similar rates to both NOR-MAN and Manitoba in both time periods - experienced the lowest rate in NOR-MAN at **1.7/1,000** during the second time period
- **District II** has similar rates to both NOR-MAN and Manitoba in both time periods - experienced the lowest rate in NOR-MAN at **1.4/1,000** during the first time period
- **District III** has similar rates to both NOR-MAN and Manitoba in both time periods -
The NOR-MAN rates for:
- Deaths due to diseases of the circulatory system are 26.3%
- Hypertension rates are 25%
- IHD rates are at 8.8%
- AMI rates are at 5.2%

Patients receiving an Angioplasty have an easier and quicker recovery than bypass surgery.

The NOR-MAN rates for:
- Deaths due to diseases of the circulatory system are 26.3%
- Hypertension rates are 25%
- IHD rates are at 8.8%
- AMI rates are at 5.2%

experienced the highest rates in NOR-MAN at 2.1/1,000 during the second time period

Percutaneous Coronary Interventions (PCI) / Angioplasty and Stent Insertion

PCI is a new approach to care, which emphasizes the rapid re-opening of arteries (either by clot-busting medications or cardiac revascularization). These procedures are increasing peoples’ chances of survival after heart attacks. For PCI, there is no need to open a person’s chest, but it must be noted that it cannot be used to treat all coronary artery obstructions.

The procedure involves inserting a catheter into a coronary artery, then inflating a small balloon at the end of it to dilate the narrowed segment of the artery so blood flows to the heart muscle. Coronary stents - tiny cage-like tubes are often inserted at the same time to keep the artery open.

NOR-MAN residents have lower levels of PCI rates at 1.4/1,000 in 1996/97 - 2000/01 compared to the Manitoba rate of 1.6/1,000. In 2001/02 - 2005/06, our rate increased to 2.0/1,000 compared to a Manitoba rate of 2.3/1,000. For both the NOR-MAN region and Manitoba as a whole, the change over time was statistically significantly higher.

As shown in Table 7.5, NOR-MAN district rates differ:

<table>
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<tr>
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<tbody>
<tr>
<td>District I</td>
<td>1.8/1,000</td>
<td>1.6/1,000</td>
</tr>
<tr>
<td>District II (t)</td>
<td>0.9/1,000</td>
<td>2.4/1,000</td>
</tr>
<tr>
<td>District III</td>
<td>1.1/1,000</td>
<td>1.8/1,000</td>
</tr>
</tbody>
</table>

Table 7.5: Percutaneous Coronary Interventions by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009
• District I has slightly higher rates than both NOR-MAN and Manitoba in the first time period and experienced a decrease in the second time period.

• District II rates are lower than both the NOR-MAN and Manitoba rate in the first time period - District II experienced a statistically significant change over time (increase).

• District III in both time periods has the lowest rates compared to both NOR-MAN and Manitoba as a whole.

**Coronary Artery Bypass Surgery (CABG)**

Coronary Artery Bypass is performed on patients with significant narrowing or blockage of coronary arteries to replace narrowed and blocked segments, permitting increased blood flow to deliver oxygen and nutrients to the heart muscle, thereby improving circulation throughout the body.

There has also been some improvements in bypass surgery, including the introduction of a minimally invasive procedure allowing certain types of patients to be treated without opening their chests. Another new approach, the off-pump technique, means some patients can have bypass surgery without having their hearts stopped. Nevertheless, angioplasty has an easier and quicker recovery than bypass surgery and puts less demand on hospital resources, which makes it an attractive alternative for both patients and care providers. As a result, the rates of CABG are decreasing, whereas angioplasty rates increased steeply in recent years.

**NOR-MAN residents experienced higher CABG rates at 1.8/1,000 in 1996/97 - 2000/01 compared to a Manitoba rate of 1.7/1,000.** In 2001/02 - 2005/06,
our rate increased to \(2.0/1,000\) and Manitoba’s rate decreased to \(1.5/1,000\).

As shown in Table 7.6, NOR-MAN district rates differ:

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>District I</td>
<td>1.4/1,000</td>
<td>1.1/1,000</td>
</tr>
<tr>
<td>District II (2)</td>
<td>2.0/1,000</td>
<td>2.5/1,000</td>
</tr>
<tr>
<td>District III</td>
<td>2.6/1,000</td>
<td>2.9/1,000</td>
</tr>
</tbody>
</table>

Table 7.6: Coronary Artery Bypass Surgery Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

- District I has lower rates than both NOR-MAN and Manitoba in both time period and experienced a decrease in the second time period
- District II rates are higher than both the NOR-MAN and Manitoba rate in the first time period and experienced a statistically different (higher) rate in the second time period than the Manitoba
- District III rates are higher in both time periods compared to both NOR-MAN and Manitoba as a whole and our rates increased over time

**Cardiac Catheterization (Diagnostic Angiogram)**

Cardiac catheterization is the most accurate method for evaluating and defining ischemic heart disease and is used to identify the location and severity of coronary artery disease. During cardiac catheterization, a small catheter (a thin hallow tube with a diameter of 2-3 mm) is inserted through the skin into an artery in the groin or the arm. Guided with a fluoroscope (a special x-ray viewing instrument), the catheter is then advanced to the opening of the coronary arteries, the vessels supplying blood to the heart. The images that are produced are called angiograms.

NOR-MAN residents experienced higher rates of Cardiac Catheterization at \(6.3/1,000\) in 1998/99 - 2000/01 compared to a Manitoba rate of \(2.8/1,000\).
In 2003/04 - 2005/06 our rate increased to 7.9/1,000 compared to the Manitoba rate of 6.9/1,000.

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</thead>
<tbody>
<tr>
<td>District I</td>
<td>6.4/1,000</td>
<td>6.1/1,000</td>
</tr>
<tr>
<td>District II (2,t)</td>
<td>5.6/1,000</td>
<td>10.2/1,000</td>
</tr>
<tr>
<td>District III</td>
<td>7.7/1,000</td>
<td>7.1/1,000</td>
</tr>
</tbody>
</table>

Table 7.7: Cardiac Catheterization Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

As shown in Table 7.7, NOR-MAN district rates differ:

- District I has similar rates to both NOR-MAN and Manitoba in both time periods and experienced a small decrease in the second time period

- District II rates are lower than both the NOR-MAN and Manitoba rate in the first time period - during the second time period District II rate was statistically different (higher) than the Manitoba rate, also the change over time was a statistically significant increase

- District III rates are similar in both time periods to both NOR-MAN and Manitoba as a whole - District III experienced a small decrease in the second time period

Cataract Surgery

Cataracts occur when the lens of the eye becomes cloudy and normal vision is impaired. There are many causes of cataracts including, but not limited to, cortisone medication, trauma, diabetes, and aging. The symptoms include double or blurred vision and unusual sensitivity to light and glare. The clouded lens is removed in its entirety.
and replaced with an intraocular lens made of plastic, an operation that takes less than an hour. The results are a major improvement for the patient in their vision and quality of life.

NOR-MAN residents are having less cataract surgeries than Manitoba as a whole. NOR-MAN rates are lower in both time periods at \(22.2/1,000\) in 2000/01 compared to a Manitoba rate of \(27.7/1,000\) and \(26.4/1,000\) in 2005/06 compared to a Manitoba rate of \(28.4/1,000\). Although not significant, the NOR-MAN rate increased in the second time period.

### Cataract Surgery Rates by District

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>District I (1,t)</td>
<td>14.0/1,000</td>
<td>22.9/1,000</td>
</tr>
<tr>
<td>District II</td>
<td>29.0/1,000</td>
<td>29.5/1,000</td>
</tr>
<tr>
<td>District III</td>
<td>33.8/1,000</td>
<td>28.4/1,000</td>
</tr>
</tbody>
</table>

Table 7.8: Cataract Surgery Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Table 7.8 shows the following district level difference:

- District I has a statistically different (lower) rate at \(14.0/1,000\) compared to the Manitoba rate of \(27.7/1,000\) - the change over time was a statistically significant increase
- District II rates are slightly higher than the province as whole in both time periods
- District III rates are slightly higher in both time periods to both NOR-MAN and Manitoba as a whole - District III experienced a small decrease in the second time period and is similar to the provincial rate
Re-admission Rates AMI

Heart attacks (acute myocardial infarctions) can be deadly, but more than 90% of Canadian patients who are admitted to hospital for a heart attack survive. After patients are discharged, most either recover at home or in another health care facility. However, some patients return to hospital shortly after discharge because they experience further health problems, such as another heart attack, persisting chest pain, heart failure, or need extra care.

While not all unplanned readmissions are avoidable, they are often seen as a measure of quality of care received during the initial stay and after discharge from the hospital.

According to the 2009 Health Indicator Report, from Canadian Institute for Health Information in 2007-2008 in Canada, the annual risk-adjusted rate of unplanned readmission following discharge for a heart attack was 4.7%, down from 6.8% in 2003-2004, representing a 31% drop over the past five years.

Antidepressant Prescription Follow-up

Regular monitoring of persons who are prescribed antidepressants after the initial diagnosis of depression is essential to track that patients’ response to the medication and modify treatment if necessary. Often antidepressant medications do not begin to have a clinical effect for some time after initiating therapy, and persons diagnosed with a major depression may be at risk of suicide, which makes follow-up a critical part of treatment.

Figure 7.26 compares our antidepressant prescription follow-up rates with Manitoba as a whole. Our rates in both time periods are lower than the provincial rate. The good news for NOR-
MAN is that our rate has increased but has not reached a statistically significant level

Antidepressant Prescription Follow-up by District

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>District I</td>
<td>62.1%</td>
<td>62.6%</td>
</tr>
<tr>
<td>District II</td>
<td>47.3%</td>
<td>55.2%</td>
</tr>
<tr>
<td>District III</td>
<td>43.9%</td>
<td>37.9%</td>
</tr>
</tbody>
</table>

Figure 7.27: Antidepressant Prescription Follow-up by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

When reviewing NOR-MAN district level data as shown in Figure 7.27, the following differences are of note:

- District I remains similar to the Manitoba rate
- District II experienced an increase in their rates in the second time period
- District III has the lowest rates in the NOR-MAN region and their second time period rate was a decline in rates

Antidepressant use in the NOR-MAN region is statistically different (lower) at 3.9% (2000/01) and 5.4% (2005/06) than the provincial rates of 5.9% and 7.5% - the change over time for both NOR-MAN and the province was a statistically significant increase.
Diabetes Care: Eye Examinations

Individuals with diabetes are at a greater risk of damage to the retina than the general population. In the later stages of diabetes, individuals may develop diabetic retinopathy, which causes the swelling of blood vessels in the retina and leaking of fluid or the abnormal growth of new blood vessels on the surface of the retina. Diabetic retinopathy can develop without symptoms and, when left untreated may cause loss of vision or blindness. So regular eye examinations for diabetics help to diagnose retinopathy early and slow its progression.

When comparing NOR-MAN rates to provincial rates for diabetes care: eye exams as shown on Figure 7.28, the good news is more NOR-MAN diabetics are receiving eye exams. In both time periods the NOR-MAN rates are statistically different (higher) at 36.9% and 36.5% than the provincial rates of 32.5% and 33.5%.

Differences of note for district level data as shown in Figure 7.29 are:

- District I rates are higher than both the NOR-MAN and the provincial rate in both time periods, also our rate increased slightly in the second time period.

- District II rates are higher than the NOR-MAN rates in both time periods, however our rate statistically different (higher) than the provincial rate in the second time period.
• District III rates are the lowest in the NOR-MAN region, but the good news is that the change over time was statistically significant increase.

5-Year Cancer Survival Rates

When reviewing cancer survival rates, we are looking at a person’s probability of still being alive after five years of cancer diagnosis. NOR-MAN males are reporting an all cancer survival rate of 52% compared to a provincial rate of 58% and NOR-MAN females are reporting an all cancer survival rate of 57% compared to a provincial rate of 59%.

When we review the time trend data for males, our lowest survival rate was reported in 1985-1989 at 40% to our current high of 52% in 2000-2004. When reviewing the time trend data for females our lowest survival rate was reported in 1990-1984 at 52% and our highest survival rate was reported in 1985-1989 at 58%.

Table 7.9 compares the NOR-MAN male survival rates for colorectal, lung and prostate to the provincial rates for the period 2000-2004. As shown, the NOR-MAN rates differ from the provincial rates depending on the cancer type. The good news is that NOR-MAN males have a higher survival rate for both colorectal and lung cancer. Prostate cancer survival rates are of concern.

<table>
<thead>
<tr>
<th>Male Cancer Survival Rates - 2000/2004</th>
<th>Colorectal</th>
<th>Lung</th>
<th>Prostate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOR-MAN</td>
<td>61%</td>
<td>21%</td>
<td>77%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>59%</td>
<td>15%</td>
<td>94%</td>
</tr>
</tbody>
</table>

Table 7.9 Cancer Survival Rates - Males
Source: Manitoba Health, NRHA Profile Document, 2008/09
Table 7.10 compares the NOR-MAN female survival rates for colorectal, lung and breast to the provincial rates for the period 2000-2004. As shown, the NOR-MAN rates differ from the provincial rates depending on the cancer. The good news is that NOR-MAN females have a higher survival rate for colorectal cancer. Lung cancer survival rates are a concern.

| Female Cancer Survival Rates - 2000/2004 |
|-------------------------------|-----------------|----------------|
|                               | Breast | Colorectal | Lung   |
| NOR-MAN                       | 78%    | 64%        | 10%    |
| Manitoba                      | 86%    | 60%        | 22%    |

Table 7.10: Cancer Survival Rates - Females
Source: Manitoba Health, NRHA Profile Document, 2008/09

Caesarean Sections

Caesarean sections are usually performed to protect the health of the fetus or the mother. About 5% of Canadian women delivered via C-section in the 1960’s, nearly 20% in the late 1980 and today C-sections account for 25% of deliveries in Canada.

Increasing rates of C-sections are a concern because they can be associated with increased maternal illness and mortality, and they are also more costly.

When reviewing the data for NOR-MAN compared to the province as a whole, as shown in Figure 7.30, the following differences are of note. In both time periods, the NOR-MAN rates was statistically different (higher) at 23.6% and 24.5% than the provincial rates at 17.4% and 19.5%. Also of note, the provincial rate experienced a statistically significant increase.
According to the Women’s Health Profile during the period of 1998/99 to 2002/03 women from the NOR-MAN region were most likely to give birth by C-Section

When reviewing district level data as shown in Figure 7.31 we clearly see a difference between our districts:

- District I has statistically different (higher) rates in both time periods and our rates continue to increase
- District II has statistically different (higher) rates in both time periods
- District III has the lowest rates in the NOR-MAN region and their rate decreased in the second time period and is now lower than the provincial rate

Vaginal Births after C-Section

Is the percentage of women who have previously received a C-section, who gave birth via vaginal delivery in an acute care hospital, by location of hospital

Rate are reported in two five-year time periods

(Manitoba Centre for Health Policy)

Vaginal Birth After C-Section

When reviewing our vaginal births after a C-section, the NOR-MAN rate is statistically different (lower) at 14.9% compared to a provincial rate of 38.1% for the time period of 1996/97 - 2000/01.

When reviewing the data from the period of 2001/02 - 2005/06, the NOR-MAN females continue to experience low rates, but the good

Figure 7.31 Caesarean Section Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, Child Health Atlas Update, 2008
news is that the NOR-MAN rate experienced a statistically significant change over time - an increase to 26.8%, and the province experienced a statistically significant decrease over time to a rate of 34.9%.

<table>
<thead>
<tr>
<th>Vaginal Births After C-Section</th>
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<tbody>
<tr>
<td>District I</td>
</tr>
<tr>
<td>1996/97 - 2000/01</td>
</tr>
<tr>
<td>2001/02 - 2005/06</td>
</tr>
</tbody>
</table>

Table 7.11: Vaginal Births after Caesarean Section by NOR-MAN District
Source: Manitoba Centre for Health Policy, Child Health Atlas Update, 2008

When reviewing district level data for vaginal births after a C-section as shown in Table 7.11, the following differences are of note:

- District I data in the first time period was suppressed, and the rate for the second time period was lower than the NOR-MAN rate
- District II’s rate in the first time was statistically different (lower) at 13.8% than the provincial rate - during the second time period the rate increased but was still lower than both the NOR-MAN and the provincial rate
- District III’s rate was higher than the NOR-MAN rate in both time periods.

Hysterectomy

The hysterectomy rate has been declining since the early 1980’s. However, hysterectomy (complete or partial removal of the uterus) remains the second (2nd) most common surgery for Canadian women after Caesarean section.
Hysterectomy can be performed vaginally, laparoscopically or by making an incision through the abdomen. The choice of approach may depend on the experience of the surgeon, the reason for the surgery and the patient’s characteristics and preference.

Figure 7.32 highlights the differences between NOR-MAN and the province as a whole over a five year time period. NOR-MAN rates have fluctuated more than the provincial rates and the current overall five year rate for NOR-MAN is 4.5/1,000 compared to the provincial rate of 4.0/1,000.

Reviewing NOR-MAN district level data for the 2002/03-2006/07 time period, the overall five year rate for each district is:

- District I is 5.1/1,000 which is higher than both the NOR-MAN and the provincial overall rate.
- District II is 6.7/1,000 which is higher than both the NOR-MAN and the provincial rate overall, but should be used with caution because of small number of cases.
- District III is 4.2/1,000 and is similar to both the NOR-MAN and provincial overall rate.

Tonsillectomy/Adenoidectomy

Tonsillectomy and adenoidectomy are an example of a procedure that time has shown to be unnecessary in many cases. Because of the success with antibiotics, surgery is no longer the standard treatment for tonsillitis that it was years ago.
Figure 7.33 compares the differences between the NOR-MAN region and Manitoba as a whole. Of note, the NOR-MAN region change over time is statistically significantly lower.

When reviewing rates at the district level as shown in Figure 7.34, the following differences are of note:

- District I’s rate in the second time period is statistically different (lower) than the provincial rate and the change over time is a statistically significant decrease.

- District II’s rate is statistically different (higher) than the provincial rate in both time periods.

- District III’s rate in the second time period experienced a statistically significant decrease.

Figure 7.33: Tonsillectomy and Adenoidectomy Rates by RHA
Age- and sex-adjusted rates per 1,000 children aged 0-14

Figure 7.34: Tonsillectomy and Adenoidectomy Rates by NOR-MAN District
Age- and sex-adjusted rates per 1,000 children aged 0-14
Home Care

The Manitoba Home Care Program, established in 1974, is the oldest comprehensive, province-wide, universal home care program in Canada. Home Care services are provided to Manitobans of all ages assessed as having inadequate informal resources to return home from hospital or remain at home in the community. Home care services are provided free-of-charge. Clients receive reassessments at pre-determined intervals and these are the basis for discharge from the program or changes to the type or amount of services being delivered.

Within the NOR-MAN region, Home Care services are provided by our Primary Health Care Seniors/Home Care Team. It is a community-based program which provides home support to NOR-MAN residents who require either health services or assistance with daily living.

New Home Care Cases

Within the NOR-MAN region, the number of new cases has shown a small decrease from 1.3% in 1999/00 – 2000/01 to 1.2% in 2003/04 – 2004/05. In comparison, the number of new cases for the province as a whole has seen a statistically significant increase between the two time periods from 1.2% to 1.4%

Figure 7.35 shows the differences at the District level for new home care cases:

- District I rates remained the same
- District II experienced a small decline in the number of new home care cases between the two time periods
- District III rates are lower than both the NOR-MAN and provincial rates in both time periods
When reviewing the number of open home care cases, as shown in Figure 7.36, the NOR-MAN region in the first time period experienced a rate that was statistically different (higher) at 3.6% than the Manitoba as a whole at 2.7%. In the second time period our rate decreased to 3.4% which is now not statistically different than the Manitoba rate of 3.2%.

Open Home Care Cases

Is the percentage of the population (all ages) with an open home care case in a year.

Rate are shown as the annual average for a two-year period

(Manitoba Centre for Health Policy)
In Figure 7.37 district level difference are;

- District I’s rate in the first time period was statistically different (higher) than the provincial rate - also our rate experienced a small decline and is now similar to the Manitoba average

- District II’s rate has been stable over the two time periods and are similar to the provincial rates

- District III’s rate in the second time period was statistically different (lower) than the provincial rate

### Home Care Case Closing Rates

Within the NOR-MAN region, the case closing rates have remained constant at 1.3%. However, due to the statistically significant change over time at the provincial level, our rate in the second time period is now statistically different (lower) than the provincial rate.

When reviewing district level data as shown in Figure 7.38, the only item of note is for District III which had a statistically different (lower) rate at 0.5% than the provincial rate of 1.3% in the first time period.
Average Length of Stay

NOR-MAN home care patients received on average **248.6 days** of service compared to **219.7 days** for the province as a whole during the period of 1999/00 - 2000/01. During the time period of 2003/04 - 2004/05, NOR-MAN’s average length of home care case days decreased slightly to **234.7 days** of service compared to the provincial rate of **222.0 days** as shown in Figure 7.39.

When reviewing district level, as shown in Figure 7.40, the following differences are of note:

- District I and II have similar average lengths of stay for their home care clients, and these rates are higher than the provincial rate in both time periods
- District III has experienced a statistically significant decrease over time

![Average Length of Home Care Cases by RHA](image)

![Average Length of Home Care Cases by District](image)
Personal Care Homes (PCH)

Personal care homes (PCH), sometimes referred to as nursing homes, are residential facilities for persons with chronic illness or disability, predominately older adults. In Manitoba, personal care homes can be proprietary (for profit) or non-proprietary.

When someone’s needs can no longer be met at home, whether by family members, community supports, or home care services, a personal care home may be required. The NOR-MAN region provides residential long-term care for NOR-MAN residents and some northeastern Saskatchewan residents from the communities of Creighton and Denare Beach.

Bed Supply

Within the NOR-MAN region, we have both federal and provincial facilities operating. The NRHA is responsible for the four (4) provincially funded personal care homes providing 130 beds. OCN operates a 40 bed federally funded Personal Care Home.

When looking at bed supply numbers, the NOR-MAN region has a slightly higher rate of beds per 1,000 residents aged 75 and older at 147.8/1,000 aged 75 than the province as a whole at 121.1/1,000.

Admission to PCH

When reviewing our PHC admissions data during the periods of 2004/05 - 2005/06. Residents age 75 and older being admitted to our facilities was at 3%, this is slightly higher than the provincial admission rate.

For the NOR-MAN region, this was a small increase from the 2.6% of residents age 75 and
Levels of Care on Admission

Figure 7.41 shows the percentage of NOR-MAN residents’ seventy-five (75) years and older as compared to the provincial percentages for their level of care on admission to our PCH. The levels of care represent the differences of care required by the patient. Level I represents the lowest level of need and Level 4 represents the highest level of need. The good news for our region is that 75% of admissions fall within the level three and four categories. This is significantly higher than the Manitoba percentage of 56.4% for the same levels of care.

The majority of NOR-MAN residents are being admitted to our facilities in 2004/05 - 2005/06 were at the following care levels:

- **Care Level 1-2 = 25.0%**
  a increase from 19.1%, our admission levels are lower than the provincial percentages at 43.6%

- **Care Level 3 = 57.7%**
  a small decrease from 61.9%, our admission levels are higher than the provincial percentages at 45.5%

- **Care Level 4 = 17.3%**
  a decrease from 19.1%, our admission levels are higher than the provincial percentages at 10.9%
For the NRHA, it is important to know the service level required by our residents to ensure that they are able to maintain a good quality of life living in our facilities.

**Median Length of Stay by Care Levels on Admission**

The median length of stay (in years) of PCH residents, overall for Manitoba as a whole is 2.3 years.

Figure 7.42 shows both the 1999/00 - 2000/01 and the 2004/05 - 2005/06 median length of stay for both NOR-MAN and the province as a whole.

The following differences by levels of care rating on admission are highlighted:

- Care Level 1-2 = half of these residents are staying for 2.4 years a decrease from the first time period of 3.9 years
- Care Level 3 = half of these residents are staying for 2.1 years a decrease from the first time period of 2.6 years
• Care Level 4 = half of these residents are staying for 1.5 years a decrease from the first time period of 2.9 years

Median Wait Times for PCH Admissions

For the NOR-MAN region during the 2004/05 - 2005/06 time period, our median wait time was **2.9 weeks**, which is statistically different (lower) than the provincial wait time of **6.9 weeks**.

Families First Program Risk Factors

The early years comprise a significant period of brain development and sets the foundation for health and success in all aspects of life. The family environment is very influential in child development, making it essential to identify which situations, stressors, or behaviours are known to be associated with family difficulties. These situations, stressors or behaviours are called risk factors.

Healthy Child Manitoba, in partnership with the RHA’s, attempts to screen all families with newborns for risk factors associated with poor child outcomes, using the Families First Screening Form. This screening form is a brief measure of biological, social and demographic risk factors. The risk factors that will be reported on are:

- Alcohol use by mother during pregnancy
- Maternal smoking during pregnancy
- Maternal depression and anxiety disorders combined
- Income support or financial difficulties
- Mother with less than grade twelve (12)
- Parents experienced relationship distress
- With three or more risk factors

The screening process does not include families from First Nation reserves because of provincial / federal jurisdictions
Alcohol Use by Mother during Pregnancy

When reviewing the screening data of NOR-MAN mothers compared to the overall provincial results, our rates are a concern. Our overall result of 26.3% of our screened mother who consumed alcohol during their pregnancy is higher than the provincial rate of 12.9% during the period of 2003 - 2006.

When reviewing this data on a yearly basis, NOR-MAN reported the following rates by year: 22.3% (2003), 27.6% (2004), 26.9% (2005) and 27.4% (2006). As shown our rates of alcohol use by NOR-MAN mothers is increasing over time.

Smoking Use by Mother during Pregnancy

When reviewing the screening data of NOR-MAN mothers compared to the overall provincial results, our rates are a concern. Our overall result of 38.2% of our screened mother smoking during their pregnancy is higher than the provincial rate of 21.0% during the period of 2003 - 2006.

When reviewing this data on a yearly basis, NOR-MAN reported the following rates by year: 31.5% (2003), 40.7% (2004), 39.2% (2005) and 38.4% (2006). As shown our rates of smoking by NOR-MAN mothers has fluctuates.

Maternal Depression and Anxiety Disorder combined of Mothers with Newborns

Maternal depression, whether in the prenatal or postnatal period, is related to behavioral difficulties and cognitive deficits in infants and children.

When reviewing the screening data of NOR-MAN mothers compared to the overall provincial results, our overall result of 15.7% of our screened mother experiencing depression and anxiety
disorders combined during or after their pregnancy is again higher than the provincial rate of 14.1% during the period of 2003 - 2006.

When reviewing this data on a yearly basis, NOR-MAN reported the following rates by year: **14.4%** (2003), **16.4%** (2004), **15.8%** (2005) and **15.5%** (2006).

**Income Support or Financial Difficulties by Mothers with Newborns**

When reviewing the screening data of NOR-MAN mothers compared to the overall provincial results, our rates are a concern. Our overall result of **26.5%** of our screened mother experiencing financial difficulties during or after their pregnancy is again higher than the provincial rate of **17.7%** during the period of 2003 - 2006. Of note, NOR-MAN rate is statistically different (higher) than the provincial rate.

When reviewing this data on a yearly basis, NOR-MAN reported the following rates by year: **25.0%** (2003), **25.8%** (2004), **24.2%** (2005) and **29.5%** (2006). As shown our rates of NOR-MAN mothers having financial difficulties or requiring income support are on the rise.

When reviewing the single parenthood data, NOR-MAN single parenthood at a rate of **18.6%** during the time period of 2003 - 2006 have experienced a statistically significant change over time - an increase.

**Less than Grade 12 Education by Mothers with Newborns**

Maternal education is one of the strongest predictors of child outcomes across a number of different domains.
When reviewing the screening data of NOR-MAN mothers compared to the overall provincial results, our rates are of concern. With an overall result of 30.1% of our screened mother having less than a grade 12 education compared to the provincial rate of 21.6% during the period of 2003-2006. Of note, the NOR-MAN rate is statistically different (higher) than the provincial rate.

When reviewing this data on a yearly basis, NOR-MAN reported the following rates by year: 29.5% (2003), 32.2% (2004), 28.4% (2005) and 29.0% (2006). As shown our rates of NOR-MAN mothers with less than a grade 12 education has fluctuated.

Where Parents Experienced Relationship Distress

When reviewing the screening data of NOR-MAN mothers compared to the overall provincial results, our rates are of concern. With an overall result of 11.0% of our screened families experiencing relationship distress compared to the provincial rate of 3.9% during the period of 2003-2006. Of note, the NOR-MAN rate is statistically different (higher) than the provincial rate.

With Three or More Risk Factors

When reviewing the screening data of NOR-MAN mothers compared to the overall provincial results, our rates are of concern. Our overall result of 40.9% of our screened mother having three or more risk factors is higher than the provincial rate of 24.4% during the period of 2003-2006. Of note, the NOR-MAN rate is statistically significantly higher than the provincial rate.

When reviewing this data on a yearly basis, NOR-MAN reported the following rates by year: 36.9% (2003), 41.2% (2004), 42.8% (2005) and 40.8%
As shown, our rates of NOR-MAN mothers with three or more risk factors fluctuates.

**Screening For and Use of Families First Programs**

The screening process involves our Infant/Child Primary Health Care Nurses gathering information from the post-partum referrals and through an open-ended interview usually held within the week following the birth. The purpose of the universal screening process is two fold. First, the screening process is used to direct families to appropriate resources such as child care, parenting program, financial assistance, or home visiting programs. Secondly, the information is used for tracking risk factors for planning services and for policy development.

The NOR-MAN region screened the following number of families with newborns:

- 2003 - 98.0% compared to a provincial rate of 97.3%
- 2004 - 97.0% compared to a provincial rate of 97.3%
- 2005 - 99.0% compared to a provincial rate of 94.7%
- 2006 - 99.5% compared to a provincial rate of 93.9%

**Number of Families Screened for Family First Programs**

The number of NOR-MAN families who met the criteria for enrollment in the Families First program by year are:

- 2003 - 34.9% (65 families)
- 2004 - 44.0% (103 families)
- 2005 - 40.3% (77 families)
- 2006 - 34.9% (65 families)
Of those families who were screened and met the enrollment criteria, the only enrollment data available is for 2004 and 2005. In 2004, 34 families enrolled and in 2005 an additional 27 families enrolled in the Families First program in the NOR-MAN region.

**Wait Times**

Wait times are one of the ways we measure the quality of our health care system. Reducing wait times is a key part of both the NRHA’s and Manitoba government’s overall plan to continue to improve the health care system and help get more Manitobans living healthy lives.

In fact, Manitoba has been taking action on wait times since the late 1990s when they became concerned about excessive wait times for cancer treatments and cardiac surgery. Today, Manitobans enjoy a health care system that both patients and experts rank among the highest in Canada in delivering quality.

The NRHA reports yearly on our wait time by program areas as shown in Table 7.12 for the period ending August 2009. For the NRHA, wait time areas of concern relate to our recruitment challenges of qualified allied health care professionals. Wait time areas of concern noted in our Scorecard were:

- Physiotherapy
- Audiology
- Speech Language
- Mental Health (children)
- Rosaire House
- Long Term Care (Flin Flon)

<table>
<thead>
<tr>
<th>Program Area</th>
<th>Wait Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy Priority (The Pas)</td>
<td>24 days, 44 days</td>
</tr>
<tr>
<td>Physiotherapy Priority (Flin Flon)</td>
<td>14 days, 25 days</td>
</tr>
<tr>
<td>Audiology</td>
<td>71 people</td>
</tr>
<tr>
<td>Speech Language Pathology</td>
<td>2 to 4 months</td>
</tr>
<tr>
<td>DER The Pas</td>
<td>2 week or less, 1 week</td>
</tr>
<tr>
<td>DER Flin Flon</td>
<td>2 weeks or less, 6 weeks or less, 6 - 8 weeks or less</td>
</tr>
<tr>
<td>DER Snow Lake</td>
<td>2 week or less, 6 weeks or less</td>
</tr>
<tr>
<td>DER Outlying Communities</td>
<td>6 weeks or less</td>
</tr>
<tr>
<td>Mental Health Youth</td>
<td>3 to 4 weeks, 1 week</td>
</tr>
<tr>
<td>Mental Health Adult</td>
<td>3 to 4 weeks, 1 week</td>
</tr>
<tr>
<td>Rosaire House</td>
<td>91 on wait list (annual average), 8 week wait time</td>
</tr>
<tr>
<td>Home Care HCA/HSW Nursing Services</td>
<td>4 people, 5 people</td>
</tr>
<tr>
<td>CT Scan – The Pas</td>
<td>2 weeks, (MB = 6 weeks)</td>
</tr>
<tr>
<td>Ultrasound – The Pas</td>
<td>6 weeks, (MB = 7 weeks)</td>
</tr>
<tr>
<td>Ultrasound – Flin Flon</td>
<td>2 weeks</td>
</tr>
<tr>
<td>X-Ray – The Pas</td>
<td>Same Day</td>
</tr>
<tr>
<td>X-Ray – Flin Flon</td>
<td>Same Day</td>
</tr>
<tr>
<td>Long Term Care (July 2009)</td>
<td>17 people - Flin Flon, 3 people - The Pas</td>
</tr>
</tbody>
</table>

Table 7.12: NRHA Wait Times
Source: NOR-MAN Regional Health Authority, Responsiveness Scorecard, October 2009
Telehealth

Use of the Telehealth technology within the NOR-MAN region continues to show great promise. Not only does using the Telehealth equipment help us to save on our travel costs, it also makes it easier for NOR-MAN residents to access services closer to home. Currently, the NOR-MAN region has Telehealth equipment in Flin Flon General Hospital (two units), St. Anthony’s General Hospital (two units), Snow Lake Health Centre, and in the communities of Pukatawagan, Grand Rapids and Easterville.

As is shown in Figure 7.43, the main use of the Telehealth equipment during 2007/07 was for clinical purposes at 41%.

When reviewing the time trend data from 2002/03 to 2007/08, the NOR-MAN region has seen an increase in both clinical and education use, and a decrease in the administration use. Overall, the number of telehealth events occurring in the NOR-MAN region has increased from a low of 137 events in 2002/03 to a current high of 1,431 events in 2007/08.

Our unique Dermatology clinic continues to grow in popularity and accounts for a large portion of our total clinical usage.

New Telehealth services in 2008/09 includes:
- Speech therapy services
- Pediatric TB follow-up clinic
- Orthopedic consultations
- Pediatric bleeding disorders

Figure 7.43: MBTelehealth Overall Network Utilization Summary - NOR-MAN
Source: Manitoba Telehealth, NRHA Report, 2009
Northern Patient Transportation Program (NPTP)

The Northern Patient Transportation Program costs continue to increase every year as do the number of travel warrants being issued. Figure 7.44 shows a twelve (12) year history of the Northern Patient Transportation Program in the NOR-MAN region.

Of note, is the fact that our warrants continue to increase and this is an expense that we have little control over. Physicians have the final say over the mode of transportation required by their patient.

Of note, is the fact that 7% of the total warrants were for air ambulance travel yet it accounts for 52% of the total NPTP budget in 2008/09.

Table 7.13 shows the reasons for NPTP travel for The Pas by physician specialty and Table 7.14 shows the Flin Flon physician specialty.
When reviewing the NPTP travel data for the 2008/09 fiscal year by the top three diagnostic category, the top reason for travel varies between The Pas and Flin Flon:

- **The Pas** = Mammogram at 16%, Ultrasound at 9% and MRI at 61%
- **Flin Flon** = CT: The Pas at 25%, Mammogram at 10% and MRI at 10%

### Emergency Medical Services (EMS)

NOR-MAN Emergency Medical Services are provided in the following NOR-MAN communities: Flin Flon, The Pas, Snow Lake,
Cranberry Portage, and Grand Rapids. Of note, we assumed responsibility for the management of the Snow Lake EMS service effective April 1, 2010.

During the period of January 1 to December 31, 2008, The Pas EMS responded to 1,827 calls of which 1,155 (63%) were primary calls and 672 were transfers. In Flin Flon, EMS responded to 1,203 calls of which 533 (44%) were primary calls and 670 were transfers. In Grand Rapids, there were 297 calls of which 110 (37%) were primary calls and 187 were transfers. In Cranberry Portage, there were 122 calls of which 121 (99%) were primary calls and 1 transfer.

The number of EMS calls increased in The Pas from 1,767 in 2007 to 1,827 calls in 2008 and for Flin Flon, there was a slight increase in calls from 1,198 in 2007 to 1,203 in 2008.

When reviewing the top three reasons for the EMS callouts by community, we note both similarities and differences:

- **Cranberry Portage** - medical reasons at 58 (main reasons are other, respiratory distress and potential cardiac); falls at 10 and violence with 9 calls

- **Flin Flon** - medical reasons at 2,788 (main reasons are other, respiratory distress, general illness and potential cardiac); falls at 53 and other with 20 calls

- **Grand Rapids** - medical reasons at 57 (main reasons are other, general illness and OB/Gyn); MVA Traffic at 6, and falls with 4 calls

- **The Pas** - medical reasons at 707 (main reasons are other, respiratory distress and GI distress); violence at 81; and falls with 77 calls

The goal in Manitoba for “Dispatch to Arrival Time, in Town limits” is arriving in **8 minutes**, 90% of the time. The Pas has exceeded the provincial target and Flin Flon was slightly higher than the province target.
Summary

This chapter explored two questions:

1. Where do NOR-MAN residents for Health Services?
2. Are residents receiving quality services?

These questions were examined by looking at the following health system performance indicators: Accessibility, Continuity of Services, Effectiveness and Service Utilization.

The following provides a summary of the key findings in this chapter:

- NOR-MAN residents place greater importance on family physicians due to the extremely low levels of access to specialists within the NRHA.

- NOR-MAN residents are seeing physicians approximately five times per year with 80.9% of physician visits taking place in our region.

- The top cause of physician visits are for respiratory at 12.4% and injury & poisonings at 9.0%.

- Our ambulatory consultation rates are statistically different (lower) than provincial rate.

- Our ambulatory visits to specialists are statistically different (lower) than provincial rate - and our change over time was statistically significant increase.

- When NOR-MAN residents do visit specialists, the majority (83.4%) occur in Winnipeg. Of note, specialist visits within the region have greatly increased over the past few years, which will hopefully help to improve access issues. With Telehealth, the opportunity to
access specialist closer to home will only be improved

- **NOR-MAN** females visit physicians more often for mental illness issues than do males

- Our continuity of care rates have **decreased** slightly from **70.4%** to **67.3%** - we are now similar to Manitoba

- We have a statistically (**higher**) rate of residents being admitted to hospital at **10.4%** in comparison to **7.0%**

- The majority of NOR-MAN patients are being hospitalized in NOR-MAN at **68.0%**

- Both NOR-MAN and Manitoba experienced a **decline** in our hospital short stays—but we are still statistically (**higher**) 

- Our long stay hospital days were statistically different (**higher**) than Manitoba in 2000/01 due to long term care beds on the 4th floor - in 2005/06, we observed a statistically **significant decrease** over time due to the PCH clients being moved to the Northern Lights Manor in February 2001

- The top reasons for being hospitalized in NOR-MAN are for childbirth and pregnancy at **22.7%** followed by injuries and poisonings at **13.5%**, diseases of the respiratory system at **10.0%**.

- The percentage of Non-Manitobans using our hospital facilities is **22%**

- Our Hospitalizations for Ambulatory Care Sensitive Conditions are statistically **higher** than the provincial rate—however, we did experience a **decrease**
• NOR-MAN residents with mental illness disorders continue to be admitted to hospital more often

• NOR-MAN residents are receiving less knee replacement surgery than Manitobans as a whole - our rate is increasing

• NOR-MAN residents are receiving less hip replacement surgery than Manitobans as a whole - our rate is increasing

• NOR-MAN residents have lower levels of PCI than Manitobans as a whole - we experienced a statistically significant change over time - increase

• NOR-MAN residents experienced higher rates of CABG - our rate increased

• NOR-MAN residents experienced similar rates of Cardiac Catheterization to provincial rate - our rate has increased

• NOR-MAN residents are having less cataract surgeries than Manitoba as a whole

• Our rates of antidepressant use are statistically different (lower) than the Manitoba rates - the change over time was a statistically significant increase for both NOR-MAN and Manitoba as a whole

• Our rates of antidepressant prescription follow-up rates are lower than the provincial rate

• More NOR-MAN diabetic residents are receiving eyes exams - in both time periods our rates are statistically different (higher) than the provincial rates.

• NOR-MAN males are reporting an all cancer survival rate of 52% compared to a provincial rate of 58% and NOR-MAN females are
reporting an all cancer survival rate of 57% compared to a provincial rate of 59%.

- The good news is that NOR-MAN males have a higher 5 year cancer survival rate for both colorectal and lung cancer. Prostate cancer survival rates are of concern.

- The good news is that NOR-MAN females have a higher 5 year cancer survival rate for colorectal cancer. Lung cancer survival rates are a concern.

- Of note, District III has the lowest rates of C-sections in the NOR-MAN region and their rate decreased in the second time period and is now lower than the provincial rate.

- NOR-MAN vaginal births rates after a C-section, is statistically different (lower) at 26.8% than the province rate 34.9% - the good news is we have had statistically significant increase over time.

- Our tonsillectomy / adenoidectomy rates have experienced a statistically significant change over time - lower.

- NOR-MAN new home cares case have decreased from 3.6% to 3.4%.

- Our home care closing rates has remained constant at a rate of 1.3%.

- Our average length of stay for home care has decreased slightly from 234.7 days to 222.0 days.

- Our admission rates to PCH for residents age 75 and older was at 3%.

- The good news for our region is that 75% of admissions fall within the level three and four categories. This is significantly higher than the
Manitoba percentage of **56.4%** for the same levels of care

- During the 2004/05 -2005/06 time period, our median wait time for PCH admission was **2.9 weeks**, which is statistically different (lower) than the provincial wait time of **6.9 weeks**

- When reviewing the risk factors for the Families First Program, the NOR-MAN region’s rate for all seven risk factors are higher than the provincial rates

- Wait time areas of concern include: Physiotherapy, Audiology, Speech Language, Mental Health (children), Rosaire House and Long Term Care (Flin Flon)

- Telehealth use continue to increases, our main use was for clinical services at **41%**

- Our NPTP costs continue to increase every year as do the number of warrants. Of note, **7%** of the total warrants were for air ambulance yet it accounted for the largest percentage at **52%** of the NPTP budget

- When looking at why people are using NPTP travel for diagnostic purposes, Mammogram is top reason for The Pas and CT travel to The Pas for Flin Flon

- When looking at why people are using NPTP travel by physician specialty, Orthopedics was the top reason in The Pas and Internal Medicine in Flin Flon

- During the period of January 1 to December 31, 2008, EMS responded to **1,827** calls in The Pas, **1,203** calls in Flin Flon, **297** calls in Grand Rapids and **122** calls in Cranberry Portage
Chapter 8

How well does the NOR-MAN Regional Health Authority serve our residents?

The NOR-MAN Regional Health Authority is committed to providing quality programs and services throughout the NOR-MAN region. This chapter will explore the question, How well does the NOR-MAN Regional Health Authority serve our residents?

It will focus on four key areas of our organizational infrastructure:

1. Human Resources
2. Fiscal Resources
3. Complaint Management
4. Quality Improvement
   - Quality Management Structure
   - Quality Scorecards
   - Accreditation
   - Patient Safety
   - Risk Management

This chapter will end with a review of the health system performance results from our community consultation activities and client satisfaction surveys including:

1. Issues/Concerns expressed by our Residents
2. Health System Performance Survey Results
3. Client Satisfaction Survey Results
Human Resources

Health care is a labour-intensive industry and the health workforce is the foundation of the health care system.

For the NRHA, our human resources include our paid staff as well as the many volunteers that are part of our service delivery.

It is important to have a clear picture of the composition of our staff. As of March 31, 2009, the NRHA employed 989 individuals. Key staff facts for the time period of 2008/09 are:

- Our staff is comprised of 89.0% females and 11.0% males
- Full-Time employee count is 446 or 46%
- Part-Time employee count is 254 or 26%
- Casual employee count is 275 or 28%
- Average age of our staff is 45.4 years
- Our staff is comprised of 91.4% unionized members
- Our average employee vacation leave is 4.9 weeks
- Our self-declared aboriginal workforce rate is 17.7%
- Our staff turnover rate was 8.9% which included eight (8) retirements

Figure 8.1 shows the NRHA regional staffing profile by union association. The majority of our staff work in the area of facility support at 41%, followed by Nursing at 27%. The smallest component of our workforce is Senior Management at 1%, followed by out of scope at 8%.
Work Life Staff Satisfaction

As part of our May 2008 Accreditation Survey, we participated in the Accreditation Canada’s Work Life Pulse in October 2007. We achieved a 61% response rate. The following are some of the results from the survey:

- 57% responded that overall, they were satisfied with the organization
- 92% said they are satisfied with their job
- 66% were satisfied with their supervisor
- 57% felt the organization supports their learning and development
- 48% indicated that they were satisfied with their involvement in decision making
- 46% felt that they can trust the organization
- 38% were satisfied with communications within the organization and 51% satisfied with the communications in their work area
- 93% said their health was acceptable, very good or excellent

The Human Resource CQI Team reviewed the results from the survey and identified three (3) theme areas that required further exploration with staff. Staff focus groups were held throughout the region based on these major themes:

1. Communications
2. Leadership
3. Healthy Workplace

A number of recommendations were identified by the staff. The Human Resources Team is currently working on addressing the recommendations as part of our Human Resources plan.
Physician Profile

As of April 1, 2010, our physician profile is comprised of the following:

- General Practice at 17
- General Practice/Surgeon at 1
- General Practice/OBS at 2
- General Practice/Anesthesia at 2
- Internal Medicine at 1
- Psychiatry at 1
- Medical Office of Health at 1

According to the Canadian Institute for Health Information, there is growing evidence that the practice patterns of physicians are changing. The vast majority of rural physicians are General Practice/Family Practice. In the past, they provided a broad array of medical services, because accessing specialist care in a rural area is often difficult and impractical. But, a growing number of GP/FPs are narrowing the range of medical services they provide. The end result being, that when a GP/FP in a rural area reduces their scope of practice, there is a potential loss of some locally available services.

Fiscal Resources

The NRHA continues to incur a deficit annually, the majority of this deficit is directly related to the Northern Patient Transportation Program and our human capital issues. Specific sectoral expenses will be reviewed as a percentage of our total operating costs as followed:

- Acute Care costs
- Community costs
- Personal Care Home costs
- Information Technology costs

Acute Care Costs

The proportion of our total expenses going to Acute Care has remained fairly stable with only a
small yearly percentage increase as shown in Table 8.1.

<table>
<thead>
<tr>
<th>Acute Care Costs by RHA</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba</td>
<td>60%</td>
<td>60%</td>
<td>59%</td>
<td>53%</td>
<td>52%</td>
</tr>
<tr>
<td>Burntwood</td>
<td>54%</td>
<td>55%</td>
<td>55%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>NOR-MAN</td>
<td>51%</td>
<td>54%</td>
<td>54%</td>
<td>55%</td>
<td>56%</td>
</tr>
<tr>
<td>Churchill</td>
<td>80%</td>
<td>83%</td>
<td>80%</td>
<td>81%</td>
<td>78%</td>
</tr>
<tr>
<td>Parkland</td>
<td>43%</td>
<td>44%</td>
<td>43%</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>N. Eastman</td>
<td>32%</td>
<td>34%</td>
<td>33%</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>Interlake</td>
<td>39%</td>
<td>40%</td>
<td>41%</td>
<td>38%</td>
<td>40%</td>
</tr>
<tr>
<td>Winnipeg</td>
<td>69%</td>
<td>68%</td>
<td>67%</td>
<td>57%</td>
<td>55%</td>
</tr>
<tr>
<td>Brandon</td>
<td>60%</td>
<td>60%</td>
<td>63%</td>
<td>62%</td>
<td>62%</td>
</tr>
<tr>
<td>Assiniboine</td>
<td>38%</td>
<td>37%</td>
<td>36%</td>
<td>37%</td>
<td>37%</td>
</tr>
<tr>
<td>Central</td>
<td>44%</td>
<td>42%</td>
<td>43%</td>
<td>42%</td>
<td>41%</td>
</tr>
<tr>
<td>S. Eastman</td>
<td>41%</td>
<td>40%</td>
<td>36%</td>
<td>36%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Table 8.1: Acute Care Costs by RHA
Source: Manitoba Health, NRHA Profile Document, 2008/09

The NRHA, in the 2006/07 time period, reported the third highest percentage of costs attributed to Acute Care at 56%, behind both Churchill at 78% and Brandon at 62%. Manitoba’s rate was slightly lower at 52%.

Community Costs

The proportion of our total expenses going to Community Care costs has remained fairly stable, except for a small yearly decrease which occurred in 2005/06 as shown in Table 8.2.

The NRHA, in the 2006/07 time period, reported the sixth highest percentage of costs attributed to Community at 17%,

<table>
<thead>
<tr>
<th>Community Costs by RHA</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manitoba</td>
<td>15%</td>
<td>16%</td>
<td>16%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Burntwood</td>
<td>29%</td>
<td>30%</td>
<td>32%</td>
<td>33%</td>
<td>32%</td>
</tr>
<tr>
<td>NOR-MAN</td>
<td>19%</td>
<td>18%</td>
<td>18%</td>
<td>17%</td>
<td>17%</td>
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<tr>
<td>Churchill</td>
<td>8%</td>
<td>6%</td>
<td>8%</td>
<td>8%</td>
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<tr>
<td>Parkland</td>
<td>20%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>N. Eastman</td>
<td>22%</td>
<td>23%</td>
<td>25%</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td>Interlake</td>
<td>25%</td>
<td>24%</td>
<td>25%</td>
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<td>25%</td>
</tr>
<tr>
<td>Winnipeg</td>
<td>14%</td>
<td>14%</td>
<td>15%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Brandon</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Assiniboine</td>
<td>14%</td>
<td>14%</td>
<td>15%</td>
<td>14%</td>
<td>14%</td>
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<tr>
<td>Central</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>S. Eastman</td>
<td>23%</td>
<td>24%</td>
<td>22%</td>
<td>23%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Table 8.2: Community Costs by RHA
Source: Manitoba Health, NRHA Profile Document, 2008/09
behind Burntwood at 32%, South Eastman at 27%, Interlake at 25%, North Eastman at 24% and Parkland at 19%.

**Personal Care Home Costs**

Manitoba’s rate was slightly lower at 15%.

The proportion of our total expenses going to our Personal Care Homes (PCH) has remained fairly stable with a small decrease in the last two years as shown in Table 8.3.

The NRHA, in the 2006/07 time period, reported the second lowest percentage of costs attributed to PCH costs at 13%, behind Winnipeg at 10%. Both Burntwood and Churchill RHAs’ did not operate PCH’s in 2006/07. Manitoba’s rate was 14%.

### Administrative Costs

Administrative costs are described as general administration, finance, human resource, communication costs. When reviewing our administration costs as a percentage of our total operating costs, our rate has remained stable at 5% for the last five (5) years. Currently, our rate is the same as the provincial rate at 5%.

### Information System Costs

For the NRHA, our Information System costs as a percentage of our total operating costs, are the lowest in the province.
In 2007/08, our rate was 0.5% which is significantly lower than the rural average of 1.3% and the Manitoba average is 1.6%.

Due to our ongoing deficit, we have been unable to invest more into information technology to keep up with the national and provincial benchmarks.

**Complaint Management**

We have an external Complaint Management process which is coordinated through our Executive Director of Communications. We take all complaints seriously and ensure that there is a timely investigation and response back to the complainant. In addition to our complaint form, we also have a General Information and Complaint Line to allow residents throughout the region to call toll free.

In 2008/09, we received 85 complaints, which was higher than the previous year of 70, as well as seven (7) compliments. The majority of complaints related to staff/physician behaviour and physician resources.

A summary of complaints/compliments is provided yearly to the Board, Senior Management and staff of the NRHA and the public in the Client Community Focus Scorecard.

**Quality Improvement**

**NOR-MAN Quality Management Structure**

Improving the quality of our services is a continuous process that must involve participation from all levels in the organization. As such, we have a Quality Management Structure in place in the region which is based on four (4) guiding principles:
1. Establishing a culture that demonstrates a commitment to quality care and services

2. Providing leadership and support to facilitate and involve staff in quality improvement through team work

3. Managing and improving processes so results are achieved

4. Meeting and exceeding the needs of our clients.

We have a Regional Manager of Quality and Risk Management in place who oversees our integrated Quality, Risk and Patient Safety Strategy for our region.

We have a number of Continuous Quality Improvement Teams (CQI) teams reporting to a Quality Council. Common issues are brought forward and addressed at this table. In September 2007, we reconfigured all our CQI Teams based on the new Accreditation process.

This section will review the following component of our Quality, Risk and Patient Safety program including:

- Quality Scorecards
- Accreditation
- Patient Safety
- Risk Management
- Occurrence Reporting and Management

**Quality Scorecards**

We publish four (4) Quality Scorecards annually focusing on how our health system is performing based on the following areas:

1. Work Life
2. Responsiveness
3. System Competency
4. Client/Community Focus.

(Scorecards – refer to Appendix F)
Accreditation

Accreditation Canada is a not-for-profit, independent organization that provides health organizations with an external peer review to assess the quality of their services based on standards of excellence. Complying with Accreditation Canada standards and Required Organizational Practices (ROP’s) reduces the potential for adverse events occurring within health care and service organizations.

Accreditation Canada introduced a new accreditation program called Qmentum in 2008 based on the latest research and evidence and extensive feedback from clients, surveyors, board members and staff. Qmentum emphasizes health system performance, risk prevention planning, client safety, performance measurement, and governance. Accreditation works on a three-year cycle which includes the following components:

**Standards** - Qmentum standards are national standards of excellence for health service organizations to strive towards as part of their quality improvement journey. Accreditation standards assess governance, risk management, leadership, infection prevention and control, and medication management, as well as services in over 30 health care sectors.

**Required Organizational Practises (ROP’S)** - ROP’s are embedded into each standard set. They are essential practices that organizations must have in place to enhance patient/client safety and minimize risk in six (6) patient safety areas: Safety Culture; Communication; Medication Use; Worklife/Workforce; Infection Control; and Risk Assessment. When we were surveyed in May 2008, there were 26 ROP’s. By 2011, our next survey date, there will be 40 ROP’s.

(Required Organizational Practices – refer to Appendix G)
**Performance Measures** - Qmentum uses a variety of methods to collect data and measure organizational performance. There are required indicators that must be submitted to Accreditation Canada annually in the area of Patient Safety. In addition, there are three Qmentum instruments that must be completed once in the three year cycle. These are:

- Governance Functioning Tool - completed by board members
- Patient Safety Culture Tool - completed by staff members
- Worklife Pulse Tool - completed by staff members

**Self-Assessment** - The self assessment is a structured process that helps organizations assess their current performance against the standards, determine which areas required more detailed review and follow-up, set priorities, and develop action plans to address areas needing improvement.

**Quality Performance Roadmap** - The roadmap is a comprehensive record of each client’s accreditation activities and result. The Quality Performance Roadmap helps organizations manage their accreditation journey.

**Customized Survey Plan** - The customized survey plan is developed for each organization by Accreditation Canada to guide the on-site survey activities.

**On-site Survey** - The onsite survey is an opportunity for surveyors to discuss the organization’s progress in addressing self-identified areas for improvement, and to share their expertise with organization staff. Depending on the size and complexity of the organization, the on-site survey may last between three and five days.
**Priority processes** - Priority processes are systems or processes that Accreditation Canada has identified as having a significant impact on patient/client safety and quality of care or service. Surveyors assess priority processes using tracers during the survey visit.

**Tracers** - Tracers are an interactive activity used during the survey visit to assess a priority process. Surveyors, accompanied by a staff person, “trace” the path of a client or an administrative process to gather evidence about an organization’s quality and safety of care services.

**Accreditation Reports** - Three accreditation reports (on-site, forecast and final reports) are submitted to the organization at various times during the accreditation process. This helps maintain an ongoing link between the organization and Accreditation Canada and shows the progress achieved throughout the process.

NRHA was one of the first regions in Canada to participated in the new Qmentum program. We successfully participated in our Accreditation Canada survey visit from May 4 - 9, 2008 receiving “Accreditation with Conditions.” Our conditions included three (3) reports to Accreditation Canada (February 2009, November 2009, and May 2010) outlining our progress on three outstanding (3) Required Organizational Practices and twenty-six (26) High Risk Criterion.

Based on compliance with national standards, we exceeded the national compliance rate in six (6) of the eight (8) quality dimensions and met or exceeded the national compliance rate in twelve (12) of fourteen (14) standard sections.
Standards

Qmentum standards provide a mechanism for health service organizations to embed accreditation and quality improvement activities into their daily operations. During our May 2008 survey visit, we were evaluated on 14 different standard sets. **We met or exceeded the national compliance rate in twelve (12) of fourteen (14) standard sections.** The following provides a summary of each standard and how we compared to the national rates:

- **Sustainable Governance** standards are built on five key functions of governance: developing the mission, vision and values; collecting and using knowledge and information; developing the organization; building relationships with stakeholders; and demonstrating accountability. **Our rate was 100% compared to 88%.**

- **Effective Organization** standards are based on the organization, rather than individual or position-specific competencies. They clarify the requirements for effective operational and performance management supports, decision-making structures, and the infrastructure needed to drive excellence and quality improvement in health service delivery. **Our rate was 100% compared to 86%.**

- **Infection Prevention and Control (IPAC)** standards include structure, process, and outcome performance measures to promote assessment of organizational compliance against standards of excellence, Required Organizational Practices (ROPs), and indicators. **Our rate was 91% compared to 91%.**

- **Managing Medications** standards address the safe use and effective management of
medication, and are to be used by organizations with or without an on-site pharmacy. Our rate was 96% compared to 91%.

- **Populations with Chronic Conditions** standards address the importance of primary care, the need to align acute and tertiary care to support the services provided by primary care providers, and the importance of integrating services across the continuum of care. Our rate was 75% compared to 78%.

- **Child and Youth Populations** Standards are for organizations with regional programs that organize and coordinate services to meet the needs of children, youth, and their families. Children and youth are defined as those people from 28 days to 17 years of age. Our rate was 100% compared to 83%.

- **Maternal Child populations** standards focus on healthy living; health promotion and disease prevention; identification of at-risk client groups and early interventions; and integration and coordination of services across the system to meet the needs of the maternal/child populations they serve. Our rate was 100% compared to 75%.

- **Emergency Department Services** standards are sector and service-based standards based upon five key elements of service excellence: clinical leadership, people, process, information, and performance. Our rate was 72% compared to 77%.

- **Home Care Services** standards are sector and service-based standards based upon five key elements of service excellence: clinical leadership, people, process, information, and performance. Our rate was 92% compared to 75%.
• **Long Term Care** standards are sector and service-based standards based upon five key elements of service excellence: clinical leadership, people, process, information, and performance. Our rate was **92%** compared to **79%**.

• **Medicine Service** standards are sector and service-based standards based upon five key elements of service excellence: clinical leadership, people, process, information, and performance. Our rate was **84%** compared to **72%**.

• **Mental Health** (acute) **Services** are sector and service-based standards based upon five key elements of service excellence: clinical leadership, people, process, information, and performance. Our rate was **92%** compared to **72%**.

• **Obstetrics Service** standards are sector and service-based standards based upon the five key elements of service excellence: clinical leadership, people, process, information, and performance. Our rate was **84%** compared to **80%**.

• **Operating rooms** standards complement the surgical care standards, which address aspects of service in the pre-operative and post-operative environment. Our rate was **95%** compared to **91%**.

**Quality Dimensions**

Accreditation Canada defines quality through eight (8) dimensions which are based on literature. We exceeded the national compliance rate in six (6) of eight (8) Quality Dimensions. Our compliance rates for each Quality Dimension compared to the national rates were:
• **Population Focus** - means we are working with communities to anticipate and meet needs. *Our rate was 91% compared to 90%*

• **Accessibility** - means we are providing timely and equitable service. *Our rate was 97% compared to 93%*

• **Safety** - means we are keeping people safe. *Our rate was 89% compared to 85%*

• **Worklife** - means we are supporting wellness in the work environment. *Our rate was 96% compared to 91%*

• **Client-centered Services** - means we are putting clients and families first. *Our rate was 96% compared to 91%*

• **Effectiveness** - means we are doing the right things to achieve the best possible results. *Our rate was 89% compared to 91%*

• **Continuity of Services** - means our clients are experiencing coordinated and seamless services. *Our rate was 88% compared to 91%*

• **Efficiency** - means we are making the best use of our resources. *Our rate was 95% compared to 91%*

**Patient Safety**

Through directed funding from Manitoba Health, a new Patient Safety Coordinator was hired and began work in May 2009. This position is responsible for investigating all Critical Incidents and coordinating a Patient Safety strategy for the region.

Accreditation Canada is committed to playing a major role in improving patient safety through Accreditation. The Accreditation process is a way of identifying conditions of unsafe practice and supporting health care organizations to promote
safe care. In particular, it is a means of reducing risk and fostering attention to continuous quality improvement.

Accreditation Canada’s accreditation program has made patient safety an essential element. By complying with Accreditation Canada standards, the potential for adverse events occurring within health care and service organizations is reduced.

As part of the Accreditation Canada survey process, NOR-MAN Regional Health Authority participated in an on-line Patient Safety Culture Survey in October 2009. Our response rate of 34% was higher than the requirement as specified by Accreditation Canada.

Some of the highlights from the survey results were:

- As an organization, 93.2% of respondents rated our overall patient safety score as “Acceptable, Very Good or Excellent” compared to the national average of 94%.

- 94.7% NRHA of respondent ranked their individual unit as “Acceptable, Very Good or Excellent” compared to the national average of 96%.

The majority of staff agreed that patient safety decisions are made at the appropriate level (73.5%); there is good communication around these issues (63.3%); and there is an environment where patient safety is valued (68.5%).

**Areas of improvement that were identified** as a result of the survey results included:

- Patient safety needs to be considered when making program changes including balancing patient safety vs. the need for productivity.

- Staff needs to be recognized for actions taken
and a job well done to preserve patient safety.

- Majority of staff recognize that health care errors constitute a real threat to our patients but many go unreported. It is important to ensure staff understand the occurrence reporting process and when and what to report.

- That there is consistent disclosure to the family involved in an event and the need to involve family in the entire process of understanding the event and possible solutions for resolution.

- Providing consistent feedback to staff regarding changes put into place based on occurrence reports.

**Risk Management**

Risks in health care are inherent at all levels of the organization and apply across the health care continuum. Our Risk Management program manages risks in three high level areas of risk:

- **Business Risk** – “Risks that may relate to the delivery of health care that include internal and external; factors impacting on the operations of the department.”

- **Resource Risk** - “Risks that relate to the resources used by the organization to accomplish its objectives.”

- **Compliance Risk** – “Risks that originate from the requirement to comply with a regulatory framework, policies, directives or legal agreements.”

Risk is managed through a number of mechanisms in our organization including:

- Occurrence Reporting and Management
- Complaint Management
- Workplace, Safety and Health
- Accreditation
- HIROC Risk Assessment
Occurrence Reporting and Management

Occurrence reporting and management is an important component of our Risk Management Program. Our occurrence reporting process is a web-based Access application housed with the Brandon RHA. Our Occurrence Reporting System is maintained by our Regional Manager of Quality and Risk.

All NRHA Occurrence Reporting policies and procedures have been revised to reflect Manitoba Health policies for reporting, managing and disclosure of Critical Occurrences (CO) and Critical Incidents (CI).

Figure 8.2 shows our occurrence rates for the past three years. During the period of 2006/07 to 2008/09, we have experienced an increase in the number of occurrences being reported from 1,346 in 2006/07 to 1,806 in 2008/09.

<table>
<thead>
<tr>
<th>Occurrence Reporting by Type</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occurrence</td>
<td>1346</td>
<td>1532</td>
<td>1806</td>
</tr>
<tr>
<td>Critical Occurrence</td>
<td>4</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Critical Incident</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Figure 8.2: Occurrence Reporting by Type
Source: NRHA System Competency Scorecard, December 2009

- Quality Audits
- Satisfaction Surveys
- Failure Mode Effects & Analysis
- Root Cause Analysis.

Occurrence

Is an event or circumstance that resulted in or could have resulted in an unintended, undesired outcome (does not involve substantial risk or harm) involves anyone or anything including damage/loss to property or equipment

Critical Occurrence (CO)

Involves substantial risk or harm to staff, visitors, others associated, property or equipment (does not involve patient, resident or client)

Critical Incident (CI)

Results in disability, death, admission to hospital or prolonged hospital stay, which was not the result of the client’s health status

Near Miss

Could have resulted in an unintended, undesired client outcome including disability, death, admission to hospital or prolonged hospital stay, and was not a result of the client’s health status

(Accreditation Canada)
Of the occurrences reported in 2008/09, 634 (34%) were falls, 460 (24%) were reported in the miscellaneous category, 405 (22%) were aggressive/abusive, 256 (14%) were medication variances and 115 (6%) were workplace injury.

Although at first glance, the increase in occurrence may be considered to be a negative for the organization, we believe that this is a positive indication that more staff are reporting occurrences. We will continue to encourage the reporting of occurrences by staff, as it is a vehicle for addressing patient safety concerns and identifying opportunities for improvement.

**Issues/Concerns expressed by our Residents**

Our 2009/10 Community Health Assessment would not be complete without the engagement of our residents in a number of different consultation activities. This section will look at what issues and concerns were expressed by our residents.

The following themes were consistently expressed in all our consultations activities. They include:

- Economic stress
- Access to services
- Travel issues
- Communications
- Mental Health and wellness
- Chronic Disease Prevention and Management

**Economic Stress**

As a northern region, we are reliant on resource based industries like mining, forestry, farming and fishing. With our current economic climate, issues related to employment were voiced in all communities. Issues expressed during our...
various consultation activities included the need for employment opportunities especially for youth in their home community, loss of high paying resource jobs due to either the temporary or permanent closure of major industry sectors and the need for economic development to be ongoing at the community level.

Lack of an adequate income, significantly impacts our ability to obtain /provide nutritious food and acceptable housing, among other things. As well, our education levels impacts the type of employment we qualify for, our ability to understand and comply with healthy living activities.

Access to Services

The largest issue that was voiced is related to the need to increase NRHA staff throughout the region, especially physicians. Most NOR-MAN residents appear to believe that their first point of contact with the health care system needs to be with a physician.

The issue of “lack of physicians” was identified during our Forces of Change Assessment, by our Key Knowledge and Key Informant Interviews and by all three sectors of the Health System Performance Survey. The only difference between the results from the various tools was the importance placed on the issue (physicians ranked this issue the lowest).

Of concern to the NRHA is comments like “We have no physicians so people don’t try to see a doctor.” Encouragement comes from comments such as “It is time to think outside of the box and create new and innovative approaches because there has been many years of lack of services.”

During discussions in a couple of communities, the idea of the opening of a walk-in clinic in Flin
Flon was seen as a positive option by residents. They believe that this type of service would reduce use of the ER department and allow patients more timely access to physician services.

Although our wait times for diagnostic services are shorter than the Manitoba average, some residents still identified long wait times for appointments as a concern.

**Travel Issues**

The issue of travel, was discussed on a couple of different levels throughout our consultation activities. Concerns were expressed about the distances some residents have to travel to access service in the NOR-MAN region. When living in a community other than Flin Flon, The Pas and Snow Lake, the communities where the physicians who work for the NRHA are located, you now require transportation to access services. Some of the communities identified issues around the availability of taxi service to the major centre for access to a health care services such as physician appointment.

The other major travel issue identified and discussed was the Northern Patient Transportation Program. Residents are still not fully understanding the program, especially around how the decisions are made with respect to how a patient travels and the amount of funding the patients receives if required to overnight in the city.

The potential for the development of a mobile health clinic was identified and seen to be an option for some of our smaller communities.

**Communications**

The issue of communication was again expressed as a concern, similar to the last CHA consultation process. Residents still do not feel that the NRHA
is providing the public with enough information about the programs and services being provided, nor the operations of the organization.

A number of suggestions were provided by our consultation participants, as ways for us to improve our communications with the general public including the following suggestions: “We are aware of some of the services. There is a great need for some type of booklet outlining all the services, the contact numbers or people and the community the service is provided in.”

“I am not sure but it would be great for the community to know what current health needs are and to be informed on how these needs will be met in the future.”

Mental Health and Wellness

According to the Canadian Institute for Health Information, mental health is increasingly moving to the forefront of discussions on overall health and well-being. This discussion is often focused on care for mental illness, such as depression, alcohol dependency and social anxiety disorders. A recent report by the Public Health Agency of Canada, however notes that mental health is “the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges that we face.” Whereas mental illness is “a biological condition of the brain . . . Associated with significant distress and impaired functioning”.

Issues related to both mental illness and mental health were expressed in all our consultation activities, and by all sectors. For our physicians, it was ranked fifth (5th); for our partners, it was ranked fourth (4th); and for our staff they ranked it third (3rd).

One of the main issues was the lack of access to mental health clinicians on a regular basis in the
person’s home community. As an organization, we are working on implementing a new mental health delivery strategy that once all mental health vacancies have been filled, will be initiated.

Mental health promotion and education activities were also identified as a need, especially for the youth our region. Residents were concerned about the use of alcohol and drugs, suicides and attempts and lack of knowledge on how to address these and similar issues. Suggestions were expressed relating to developing a closer connection with the education system and the need for ongoing community education and awareness programming.

**Chronic Disease Prevention and Management**

When reviewing our consultation data the **issue of chronic disease was expressed by all consultation participants.** The top disease of concern identified by our staff, physicians, and our community partners was diabetes. Other issues that were also identified included obesity, heart health, and cancer all of which have the same risk factors as diabetes.

The major issues here is that most of these diseases are related to personal health choices of our residents. The NRHA needs to continue to educate our residents on the need to make healthy lifestyle choices - to make the easy choice the right choice.

**A number of positive suggestions were provided and participants wanted to ensure that we continue to work towards reducing these types of health issues.** “**A good job is done already. I really think getting the community involved in the promotion would go a long way - coming from people rather than the “health authority.”**” “**The Chief could announce national diabetes, the mayor submit a notice to the newspaper when it is HIV/Hep C month.**”
Most consultation participants were grateful for the work that has been done by the NRHA in the last number of years to provide both the evidence and the tools to make healthy lifestyle changes. “Keep pushing education, somehow reach people in need and get them to identify their needs.”

Our ongoing challenge will be in introducing new and exciting programs and services in partnership with other organizations and agencies to ensure exposure to all NOR-MAN residents.

The last questions, we asked our consultation participants was either to “identify the things that the NRHA is doing right?” or “overall, in your opinion what are the strengths of the NRHA?”

All groups identified the caring committed staff of the NRHA as being the number one (1) response. They feel that our current staff is knowledgeable and experienced.

Our Primary Health Care Centers are seen as being a positive move by participants for bringing community services together. “With the new RHA building there is a lot more open communication.”

Also a number of participants identified that they were pleased with our current health promotion and prevention education programs, specific programs such as our teen clinic, our tobacco tackle program, our various nutrition related programs being provide were identified.

For those individuals who took part in our consultation activities, there was agreement that based on our current fiscal realities we are providing an adequate number of programs and services to our residents.
Health System Performance

As part of our consultation activities we conducted three Health System Performance surveys with the following sectors:

- Staff
- Physician
- Partners

Each survey asked each sector to rate a series of questions on responsiveness, satisfaction and importance. The results from each question follows:

- **Question 1 - I believe the NRHA is responsive to residents health care needs?**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree/ Mostly Disagree</th>
<th>Agree/Mostly Agree/ Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>15.4%</td>
<td>84.7%</td>
</tr>
<tr>
<td>Physicians</td>
<td>3.8%</td>
<td>96.2%</td>
</tr>
<tr>
<td>Partners</td>
<td>15.9%</td>
<td>84.1%</td>
</tr>
</tbody>
</table>

Table 8.4: Question 1
Source: NRHA Health System Performance Survey 2009/10

- **Question 2 - I believe that when residents need a healthcare services they know where to go?**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree/ Mostly Disagree</th>
<th>Agree/Mostly Agree/ Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>28.6%</td>
<td>71.4%</td>
</tr>
<tr>
<td>Physicians</td>
<td>20.9%</td>
<td>79.1%</td>
</tr>
<tr>
<td>Partners</td>
<td>22.7%</td>
<td>77.2%</td>
</tr>
</tbody>
</table>

Table 8.5: Question 2
Source: NRHA Health System Performance Survey 2009/10

- **Question 3 - How satisfied do you feel residents are with the accessibility of NRHA services and programs?**

<table>
<thead>
<tr>
<th></th>
<th>Dissatisfied/Very Dissatisfied</th>
<th>Neutral</th>
<th>Satisfied/Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>30.5%</td>
<td>36.0%</td>
<td>33.6%</td>
</tr>
<tr>
<td>Physicians</td>
<td>11.5%</td>
<td>46.2%</td>
<td>42.3%</td>
</tr>
<tr>
<td>Partners</td>
<td>34.1%</td>
<td>38.6%</td>
<td>27.3%</td>
</tr>
</tbody>
</table>

Table 8.6: Question 3
Source: NRHA Health System Performance Survey 2009/10
**Question 4** - How satisfied do you feel residents are with the friendliness of NRHA staff?

<table>
<thead>
<tr>
<th></th>
<th>Dissatisfied/Very Dissatisfied</th>
<th>Neutral</th>
<th>Satisfied/Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>12.5%</td>
<td>29.1%</td>
<td>58.2%</td>
</tr>
<tr>
<td>Physicians</td>
<td>7.6%</td>
<td>42.3%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Partners</td>
<td>16.6%</td>
<td>23.8%</td>
<td>59.5%</td>
</tr>
</tbody>
</table>

*Table 8.7: Question 4*  
*Source: NRHA Health System Performance Survey 2009/10*

**Question 5** - How satisfied do you feel residents are with the quality of NRHA services and programs?

<table>
<thead>
<tr>
<th></th>
<th>Dissatisfied/Very Dissatisfied</th>
<th>Neutral</th>
<th>Satisfied/Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>15.1%</td>
<td>41.0%</td>
<td>43.9%</td>
</tr>
<tr>
<td>Physicians</td>
<td>7.6%</td>
<td>26.9%</td>
<td>65.4%</td>
</tr>
<tr>
<td>Partners</td>
<td>31.8%</td>
<td>29.5%</td>
<td>38.6%</td>
</tr>
</tbody>
</table>

*Table 8.8: Question 5*  
*Source: NRHA Health System Performance Survey 2009/10*

**Question 6** - How satisfied do you feel residents are with the delivery methods of NRHA services and programs?

<table>
<thead>
<tr>
<th></th>
<th>Dissatisfied/Very Dissatisfied</th>
<th>Neutral</th>
<th>Satisfied/Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>19.6%</td>
<td>39.3%</td>
<td>41.1%</td>
</tr>
<tr>
<td>Physicians</td>
<td>7.6%</td>
<td>53.8%</td>
<td>38.4%</td>
</tr>
<tr>
<td>Partners</td>
<td>29.5%</td>
<td>34.1%</td>
<td>36.4%</td>
</tr>
</tbody>
</table>

*Table 8.9: Question 6*  
*Source: NRHA Health System Performance Survey 2009/10*

**Question 7** - How satisfied do you feel residents are with the timeliness of NRHA services and programs?

<table>
<thead>
<tr>
<th></th>
<th>Dissatisfied/Very Dissatisfied</th>
<th>Neutral</th>
<th>Satisfied/Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>31.3%</td>
<td>36.2%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Physicians</td>
<td>15.3%</td>
<td>38.5%</td>
<td>46.2%</td>
</tr>
<tr>
<td>Partners</td>
<td>37.2%</td>
<td>44.2%</td>
<td>18.6%</td>
</tr>
</tbody>
</table>

*Table 8.10: Question 7*  
*Source: NRHA Health System Performance Survey 2009/10*

**Question 8** - Overall, how satisfied do you feel residents are with the NRHA?

<table>
<thead>
<tr>
<th></th>
<th>Dissatisfied/Very Dissatisfied</th>
<th>Neutral</th>
<th>Satisfied/Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>17.2%</td>
<td>42.9%</td>
<td>39.9%</td>
</tr>
<tr>
<td>Physicians</td>
<td>4.0%</td>
<td>40.0%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Partners</td>
<td>32.6%</td>
<td>34.9%</td>
<td>32.5%</td>
</tr>
</tbody>
</table>

*Table 8.11: Question 8*  
*Source: NRHA Health System Performance Survey 2009/10*
• Question 9 - How important do you believe accessibility of NRHA services and programs is to residents?

<table>
<thead>
<tr>
<th></th>
<th>Unimportant/Very Unimportant</th>
<th>Neutral</th>
<th>Important/Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>4.7%</td>
<td>7.6%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Physicians</td>
<td>0.0%</td>
<td>12.0%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Partners</td>
<td>0.0%</td>
<td>2.3%</td>
<td>97.7%</td>
</tr>
</tbody>
</table>

Table 8.12: Question 9
Source: NRHA Health System Performance Survey 2009/10

• Question 10 - How important do you believe friendliness of NRHA staff is to residents?

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<thead>
<tr>
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<th>Unimportant/Very Unimportant</th>
<th>Neutral</th>
<th>Important/Very Important</th>
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<tbody>
<tr>
<td>NRHA Staff</td>
<td>0.6%</td>
<td>5.9%</td>
<td>93.5%</td>
</tr>
<tr>
<td>Physicians</td>
<td>0.0%</td>
<td>11.5%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Partners</td>
<td>0.0%</td>
<td>4.5%</td>
<td>95.4%</td>
</tr>
</tbody>
</table>

Table 8.13: Question 10
Source: NRHA Health System Performance Survey 2009/10

• Question 11 - How important do you believe the quality of NRHA services and programs is to residents?

<table>
<thead>
<tr>
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<th>Unimportant/Very Unimportant</th>
<th>Neutral</th>
<th>Important/Very Important</th>
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<tr>
<td>NRHA Staff</td>
<td>1.2%</td>
<td>3.7%</td>
<td>95.1%</td>
</tr>
<tr>
<td>Physicians</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Partners</td>
<td>0.0%</td>
<td>2.3%</td>
<td>97.7%</td>
</tr>
</tbody>
</table>

Table 8.14: Question 11
Source: NRHA Health System Performance Survey 2009/10

• Question 12 - How important do you believe the delivery method of NRHA services and programs is to residents?

<table>
<thead>
<tr>
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<th>Neutral</th>
<th>Important/Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>1.2%</td>
<td>10.1%</td>
<td>88.6%</td>
</tr>
<tr>
<td>Physicians</td>
<td>0.0%</td>
<td>11.5%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Partners</td>
<td>2.3%</td>
<td>4.5%</td>
<td>93.2%</td>
</tr>
</tbody>
</table>

Table 8.15: Question 12
Source: NRHA Health System Performance Survey 2009/10

• Question 13 - How important do you believe timeliness of NRHA services and programs is to residents?

<table>
<thead>
<tr>
<th></th>
<th>Unimportant/Very Unimportant</th>
<th>Neutral</th>
<th>Important/Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRHA Staff</td>
<td>0.9%</td>
<td>4.6%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Physicians</td>
<td>0.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Partners</td>
<td>2.3%</td>
<td>6.8%</td>
<td>90.9%</td>
</tr>
</tbody>
</table>

Table 8.16: Question 13
Source: NRHA Health System Performance Survey 2009/10
Overall, the Health System Performance survey results show that a large majority of survey respondents agreed that we are responsive to the health care needs of our residents.

In terms of satisfaction levels, survey respondents felt residents were most satisfied with the friendliness of staff and least satisfied with the timeliness of services.

When reviewing the importance of services, survey respondents felt residents rated the quality of service as most important, followed by timeliness of services. Delivery methods of NRHA services and programs was rated the lowest in importance.

Client Satisfaction

Currently within the NRHA, the following departments are conducting ongoing client satisfaction surveying:

- **Long Term Care Resident Satisfaction Experience** - survey is administered every two years
- **Acute Care Client Satisfaction Experience** - survey process and tool currently under redevelopment and scheduled for a fall/winter 2010 implementation
- **Rosaire House Client Satisfaction Experience** - survey is administered at the time of client discharge
- **Home Care Client Satisfaction Experience** - in-person interviews July 2007 to September 2008
- **Hospice and Palliative Care Family Satisfaction Survey** - administered every two years
• **Support Services Client Satisfaction Experience - Acute Care** - survey is administered to all clients during hospital stay

• **Support Services Client Satisfaction Experience - Long Term Care** - survey is administered annually

• **Primary Health Care Client Satisfaction Experience** - pilot survey was administered October to November 2008 and currently the pilot survey process including the tool, distribution method, delivery schedule and analysis criteria are being evaluated - redeveloped survey will be implemented in the fall of 2010

• **Community Mental Health Consumer Satisfaction Experience** - provincial survey tool is administered every two years

Current highlights from each from of these surveys are:

**Long Term Care Resident Satisfaction Experience** - results from the last survey administered in August 2009 are:

- 38% responded that their needs are being met all of the time
- 20% responded that their needs are being met most of the time
- **21% responded that the meals were not tasty or visually appealing**
- 18% responded that there was not enough variety, choice or selection in the menu
- 9% responded that they feel staff does not keep them informed of changes in their condition/treatment
- 6% responded that they feel staff does not respond to their concerns in a timely manner
Rosaire House Client Satisfaction Experience - results from the last survey administered April 1, 2008 to March 31, 2009 are:

- Overall satisfaction was **91%**
- **99%** responded that they learned about their addiction
- **100%** felt better about self
- **72%** responded that they were satisfied with meals

Home Care Client Satisfaction Experience - results from the last survey administered between July 2007 and September 2008 are:

- **98.0%** responded that household maintenance services received was positive
- **97.4%** responded positively about the nursing services that they receive
- **96%** responded positively about both promptness and reliability of home care staff
- **95.7%** responded that the length of time to receive services was positive
- **70.3%** responded negatively about awareness of the NRHA complaint/Compliment form
- **40.7%** responded negatively about their contact time with the Resource Coordinator

Hospice and Palliative Care Family Satisfaction Survey - results from the last survey administered between April to September 2009 are suppressed due to the small number of participants

Support Services Client Satisfaction Experience - Acute Care - results from the last survey administered between April 2008 to March 2009 are:

- Overall food service satisfaction for St. Anthony’s Hospital was **88%** - this rate is **above** the Aarmark standard

65% of clients are from the NOR-MAN region

Overall satisfaction average for St. Anthony’s Hospital was **87.5%**
• Overall housekeeping satisfaction for St. Anthony’s Hospital was 93.5% - this rate is above the Aarmark standard

• Overall food service satisfaction for Flin Flon General Hospital was 96.6% - this rate is above the Aarmark standard

• Overall housekeeping satisfaction for Flin Flon General Hospital was 93.5% - this rate is above the Aarmark standard

Support Services Client Satisfaction Experience
- Long Term Care - results from the last survey administered between April 2008 to March 2009 are:

• Overall food service satisfaction for St. Paul’s was 79% - this rate is below the Aarmark standard

• Overall housekeeping satisfaction for St. Anthony’s Hospital was 94.0% - this rate is above the Aarmark standard

• Overall food service satisfaction for Flin Flon PCH was 96.9% - this rate is above the Aarmark standard

• Overall housekeeping satisfaction for Flin Flon PCH was 98.5% - this rate is above the Aarmark standard

• Overall food service satisfaction for NLM was 100% - this rate is above the Aarmark standard

• Overall housekeeping satisfaction for NLM was 100% - this rate is above the Aarmark standard

Primary Health Care Client Satisfaction Experience - results from the last survey administered between October 2008 to November 2009 are:

• 92% responded that the overall quality of care
and service received at Primary Health Care Centres was excellent/very good

- 89% responded positively that their privacy was respected
- 84% responded positively about the amount of time spent with the Health Care Provider

Community Mental Health Consumer Satisfaction Experience - results from the last survey administered in December 2009 are:

- 100% of respondents that staff encouraged me to take responsibility for how I live my life
- 100% responded that I like the services I received here
- 97.4% responded that staff were willing to see me as often as I felt it was necessary
- 97.4% of staff here believe that I can grow, change and recover
- 93.3% responded that staff asked about both my mental health and drug, alcohol or gambling concerns
- 46.2% responded that they are seeing an addictions worker and got some help with their mental health concerns in addition to their addiction concerns
- 50% responded that they got some help for their drug, alcohol or gambling concerns in addition to their mental health concerns
- 56.5% responded that their housing situation has improved

Summary

This chapter explored the question, how well does the NOR-MAN Regional Health Authority serve our residents. It focused on four (4) key areas of our organizational infrastructure: (1) Human Resources; (2) Fiscal Resources; (3) Complaint Management; and (4) Quality Improvement.
It also provided a review of the health system performance results from our community consultation activities and client satisfaction surveys including:

- Issues/Expressed by our Residents;
- Health System Performance Survey results
- Client Satisfaction Survey results.

Summary of the key findings include:

- As of March 31, 2009 the NRHA employed 989 individuals
- Our staff is comprised of 91.4% unionized members
- Our self-declared aboriginal workforce rate is 17.7%
- The majority of our staff work in the area of facility support at 41%, followed by nursing at 27%
- The smallest component of our workforce is Senior Management at 1%, followed by out of scope at 8%
- As part of our May 2008 Accreditation Survey, we participated in the Accreditation Canada’s Work Life Pulse in October 2007
  - 57% of our staff responded that overall, they were satisfied with the organization
  - 92% said they are satisfied with their job
- Our Human Resource CQI Team reviewed the results from the survey and identified three (3) theme areas that required further exploration with staff including: Communications, Leadership and Healthy Workplace
- Our physician profile is comprised of the following:
  - General Practice at 17
  - General Practice/Surgeon at 1

Communication Focus Groups:
- Regular All Staff Meetings
- Email Notice of New Hires
- Access to Email Off-Site
- Groupwise Directory Update
- NRHA IntraNet.

Recommendations from Leadership Focus Groups:
- New Manager Orientation
- Regular Staff Meetings
- Review Employee Suggestion Program
- Job Description Project
- Leadership Development Program

Recommendations from Healthy Workplace Focus Groups:
- Smoking cessation
- Health clinic
- Ability Management
- Healthy Eating choices
- Social events
- Staff Wellness
During the Fin Flon “Forces of Changes Assessment” the main item of discussion was the issue of physicians and the problems associated with accessing services and the inability to obtain a Family Physician.

- General Practice/OBS at 2
- General Practice/Anesthesia at 2
- Internal Medicine at 1
- Psychiatry at 1
- Medical Office of Health at 1

- We continue to incur a deficit annually, the majority of this deficit is directly related to the Northern Patient Transportation Program and our human capital issues

- The proportion of our total expenses going to Acute Care has remained fairly stable at 56%

- The proportion of our total expenses going to Community Care has remained fairly stable at 17%

- The proportion of our total expenses going to our Personal Care Homes (PCH) has remained fairly stable at 13%

- Our administration costs as a percentage of our total operating costs, remain stable at 5% which is on par with the provincial rate

- Our Information System costs as a percentage of our total operating costs are 0.5% which is lowest in the province

- We have an external Complaint Management process which is coordinated through our Executive Director of Communications

- In addition to our complaint form, we also have a General Information and Complaint Line to allow residents throughout the region to call toll free

- In 2008/09, we received 85 complaints - the majority of our complaints are related to staff/physician behaviour and physician resources
• Improving the quality of our services is a continuous process that must involve participation from all levels in the organization.

• We have a Regional Manager of Quality and Risk in place who oversees our integrated Quality, Risk and Patient Safety Strategy for our region.

• We publish four (4) Quality Scorecards annually focusing on how our health system is performing based on the following areas:
  1. Work Life
  2. Responsiveness
  3. System Competency
  4. Client/Community Focus

• NRHA was one of the first regions in Canada to participated in the new Qmentum program. We successfully participated in our Accreditation Canada survey visit in May 2008 receiving “Accreditation with Conditions.”

• Based on compliance with national standards, we exceeded the national compliance rate in six (6) of the eight (8) quality dimensions and met or exceeded the national compliance rate in twelve (12) of fourteen (14) standard sections.

• Through directed funding from Manitoba Health, a new Patient Safety Coordinator was hired and began work in May 2009. This position is responsible for investigating all Critical Incidents and coordinating a Patient Safety strategy for the region.

• As part of the Accreditation Canada survey process, NOR-MAN Regional Health Authority participated in an on-line Patient Safety Culture Survey in October 2009. As an organization, 93.2% of respondents rated our overall patient safety score as “Acceptable,

Accreditation Canada has recognized our Quality Scorecard as a Best Practice and is using our model in their national education sessions.

All outstanding 26 Recommendations and 3 ROP’s were successfully met with the submission of required reports in February and November 2009.

Sustainable Governance, Effective Organization, Child and Youth Populations, and Maternal Child Population standards section received 100% compliance rate.
Very Good or Excellent compared to the national average of 94%.

- Risk is managed through a number of mechanisms in our organization including:
  - Occurrence Reporting and Management
  - Complaint Management
  - Workplace
  - Safety and Health
  - Accreditation
  - HIROC Risk Assessment
  - Quality Audits
  - Satisfaction surveys
  - Failure Mode Effects & Analysis
  - Root Cause Analysis.

- Occurrence reporting and management is an important component of our Risk Management Program - During the period of 2006/07 to 2008/09, we experienced an increase in the number of occurrences being reported from 1,346 in 2006/07 to 1,806 in 2008/09.

- Of the occurrences reported 34% were falls, 22% were aggressive/abusive, 14% were medication variances and 6% were workplace injury.

- The following themes were consistently expressed as concerns in all our consultations activities. They include:
  - Economic stress
  - Access to services
  - Travel issues
  - Communications
  - Mental Health and wellness
  - Chronic Disease Prevention and Management

- Areas expressed as strengths during our consultation included:
  - Caring, committed and knowledgeable staff
  - Primary Health Care facilities
• Adequate number of programs and services available

• Overall, the Health System Performance survey results show that a large majority of survey respondents agreed that we are responsive to the health care needs of our residents

• In terms of satisfaction levels, survey respondents felt residents were most satisfied with the friendliness of staff and least satisfied with the timeliness of services

• When reviewing the importance of services, survey respondents felt residents rated the quality of service as most important, followed by timeliness of services - delivery methods of NRHA services and programs was rated the lowest in importance

• Currently a number of departments are conducting ongoing client satisfaction surveying - the results of these surveys was highlighted
Chapter 9

What has happened since our last Community Health Assessment?

A 1986 Health Canada Report, titled Achieving Health for All: A Health Promotion Framework, reported that the health of Canadians had improved over the past few decades. But, there remained three major challenges. They were:

1. Disadvantaged groups had significantly lower life expectancy, poorer health and higher prevalence of disability.

2. Various forms of preventable diseases and injuries continued to impact the health and quality of life of Canadians.

3. Many suffered from chronic disease, disability or emotional stress and did not have the community support to help them cope and live a meaningful life.

Twenty four (24) years later and these challenges still exist in Canada. What about NOR-MAN? Have we made progress on improving the health status and conditions that are affecting our residents? What have we accomplished? What challenges still exist?

This chapter will explore these questions in the following three sections:

1. NRHA’s 2011-16 Strategic Planning process including the key elements that were considered in its development

2. Major accomplishments we have achieved since our last Community Health Assessment in 2004.

3. Current challenges we are facing as an organization.
Background

The NOR-MAN Regional Health Authority (NRHA) published its first Community Health Assessment in 1997/98 and its second Comprehensive Community Health Assessment (CHA) in 2003/04.

These reports and the work leading up to their publication, reflected our attempt to gain a greater understanding of the health issues and concerns in our region. The results from the 2003/04 Community Health Assessment formed the basis for the 2006-11 Strategic Plan.

NOR-MAN 2006-11 Strategic Plan

The 2006-11 Strategic Plan for the NOR-MAN Regional Health Authority (NRHA) is a progressive document that was built on the work and planning that has been underway in the region since the Authority’s inception in April 1997.

As part of the strategic planning process, the NRHA Board revisited and refined its previous Board Ends and Strategic Priorities to better reflect our current reality. To achieve our mission, the Board set out four (4) Board Ends and twenty-eight (28) Strategic Priorities to guide the NRHA through the next five years (see chapter 2). These included:

1. Healthy Communities
2. Healthy People
3. Optimal Access to Services
4. Excellence in Patient Safety and Quality of Care

In order for the Board to arrive at their new Board Ends and Strategic Priorities, the following
elements, in addition to the results of the Community Health Assessment, were also considered in their deliberations:

- Establishing criteria for priority setting
- Undertaking a Situational Assessment
- Understanding the progress achieved since our first Community Health Assessment
- Understanding present challenges that we were facing
- Determining opportunities and common themes

This section of the report will provide a brief description of what was considered in each of these areas:

**Priority Setting Criteria**

It was recognized that with finite resources and a multitude of health challenges, that we needed to establish criteria on which to base priorities. This task was completed as part of the Community Health Assessment Release of Findings Retreat that was held in November 2004 with the Board, Senior Management, the Community Health Assessment Advisory and Research Teams and the District Health Councils.

These criteria were collectively decided by the participants and were then used by the Board and Senior Management in determining the Board Ends and Strategic Priorities for 2006-11. The criterion were as follows:

- Efficient use of resources / human and financial
- Impact on a large number of people / positive or negative
• Something can be done / support for change on the issue

• Growing/ increasing problem

• Long-term consequences / positive or negative

• Can be monitored

**Situational Assessment**

As part of the strategic planning process, a situational assessment of the region was conducted using a SWOT (Strength, Weaknesses, Opportunities and Threats) Analysis. The SWOT analysis took into consideration both internal (strengths and weaknesses) and external (opportunities and threats) considerations facing the region.

**Progress since the first Community Health Assessment**

As part of our review, we also wanted to examine the progress we had made since our first Community Health Assessment. Results from our 2003/04 Community Health Assessment reported that although we continue to be one of the more unhealthy regions in the province, our efforts were paying off. Some significant improvements in health status in our region since the 1997/98 Community Health Assessment were reported including:

• Our health was improving with statistically significant decreases in premature mortality rates and increases in life expectancy rates

• We had a higher rate of former smokers

• We had seen a significant improvement in preventative screening rates including cervical and mammography screening rates

• Childhood, influenza and pneumococcal
immunization rates were steadily improving

- Infant mortality rates were lower than the Manitoba average

- According to the Canadian Community Health Survey, NOR-MAN residents reported that they were more active than average Manitobans

- The majority who responded to the telephone survey said that they were happy with the services that they were provided and rated the quality of services good to excellent

As a northern region, we recognized that we also continued to face a number of serious health concerns including:

- Although our health status was seeing statistically significant improvements, unfortunately, our rates were still poorer than the Manitoba average for premature mortality rates and life expectancy

- We continued to have higher rates of chronic diseases relating to unhealthy lifestyle choices including the fact that more females smoked, we were more likely to be exposed to second hand smoke, to drink heavily, and be overweight

- Diabetes was our number one health issue with the concern that rates were reaching epidemic proportions in our region, particularly amongst the Aboriginal population

- Injuries were a concern and we were more likely to get injured and be hospitalized for an injury

- Teenage pregnancy rates were two times higher than the Manitoba average
• Stress, mental health and addictions were identified as concerns
• Higher birth weights, in particular their correlation to Diabetes, was identified
• The poorer health status of Aboriginal people was also noted
• STI rates were one of the highest in Manitoba
• Late stage diagnosis of illnesses and conditions was identified

Challenges

As part of the review process, a number of challenges were identified as impacting the work of the NOR-MAN Regional Health Authority. These included:

Service Provision

The majority of health care resources were spent on illness care, yet health care services explained only about one-quarter of a person’s health status. The other three-quarters of what makes a person healthy is influenced by such factors as income, social support, education, physical environment, personal health practices and genetics.

Although physician-centered, hospital-based care will always be a core component of the health care delivered in NOR-MAN, the challenge was on how resources would be shifted to prevention and promotion of health while maintaining existing services.

Jurisdictional Issues

The NOR-MAN Regional Health Authority is not mandated to provide all health services in all NOR-MAN communities. A number of other agencies provide health services to

Traditionally in health care, we have focused on:
• Illness rather than health
• Curing versus preventing illness
• Hospitals and physicians as the first access point into the system.

In addition to the NRHA, health services are also provided by:
• Manitoba Health
• Swampy Cree Tribal Health Centre
• First Nation Regional Health Authorities
• Northern Medical Unit
residents in the region. The provincial and federal governments provide a limited range of services in smaller Aboriginal communities. If services are not coordinated between the various jurisdictions, it results in gaps in service, lack of continuity of services and limited access to services in some of our outlying areas.

Capital Issues

It was noted that we have the oldest acute care facilities in the province. Space constraints, operational inefficiencies and safety and security concerns were all identified as issues. Major capital development was identified for both St. Anthony’s and Flin Flon General Hospitals. We were informed by Manitoba Health that approval for funding for new facilities was not feasible given the current fiscal reality. As a result, capital upgrades would have to be a priority for the region.

Human Resources

Recruitment and retention of qualified staff and physicians continued to be the number one challenge for the NRHA. In particular, physician shortages in the region was impacting residents’ ability to gain access to physician services. The need to continue investing in developing northern human resources and recruiting and retaining qualified staff was identified as a priority.

Residents knowledge of health services and involvement in improving health

Many reported in the previous community health assessment that they did not know where to go to address a concern. A need to increase resident knowledge of available health care services as well as how to access

![St. Anthony’s Hospital was built in 1928 and Flin Flon General Hospital in 1932.](image)

![We have 989 employees:](image)

- 46% work full time
- 26% work part time
- 89% are female
- 91% unionized
- 17.7% self declared as Aboriginal
- Average age is 45.4 years
services was identified. As many of our health issues related to lifestyle, residents’ ability to take responsibility for their own health and for making good healthy living choices was considered critical.

**Opportunities/ Common Themes**

As a result of the above review, a number of common themes/ opportunities were identified as areas that we would need to continue to strive towards in order to reach our Mission. It was reinforced in the Strategic Planning process, that these were areas that have been our focus since our first Strategic Plan in 1997 and included:

- Improve access to services
- Enhance awareness of NRHA services
- Improve service integration and better coordinate services in the community
- Strengthen primary prevention activities
- Build individual and community capacity for improving health
- Work in partnership
- Communicate and consult with our communities
- Ensure health care delivery model is culturally sensitive
- Be innovative in how we deliver services
- Use innovative cost-effective approaches in an evidence-based environment
- Develop northern Human Resources and continue to work at attracting and retaining an adequate and skilled workforce
Accomplishments since our Last Community Health Assessment

Since our last Community Health Assessment, we have made great strides towards the advancement of our Board Ends and Strategic Priorities. The following provides a summary of some of the highlights by Board End:

Healthy Communities

Communications

- Executive Director of Communications coordinates communications, public relations and complaints for the Region.
- Our Website was redeveloped in 2004 and is updated regularly. All public documents are posted on our website.
- NRHA Corporate Office now has a General Information and Complaint Line to allow residents throughout the region to call toll free.
- NRHA Services Overview document was developed and is updated annually and circulated to partnering agencies and posted on our website.

Environment

- We continue to work closely with major industries, Manitoba Health, MB Conservation & communities regarding environmental concerns.
- We formed a Green Team which is focusing on nine (9) key “green” strategies.
- In 2006, we implemented an Energy Project which involved a number of upgrades and renovations which has resulted in 15.4% energy cost savings and a reduction of 670
We save $20,000 in our utility bills, 380,000 Kwh, 1.3 million litres of water and 300 tonnes of greenhouse gas emissions annually as a result of our power smart design for our EMS facilities. This is equivalent to taking 100 cars off the road.

- All capital projects now incorporate "green" building design elements with our goal to be "close to" LEED certification where possible.

- The Pas (2006) and Grand Rapids EMS facility (2008) were awarded a Manitoba Hydro Power Smart designation as a result of achieving more than 25% energy efficiency through its green building design.

- Due to elevated concentrations of some heavy metals in soil in Flin Flon area reported by MB Conservation in 2007, a comprehensive Human Health Risk Assessment is underway, with a final report expected in June 2010. Our Medical Officer of Health and staff have been actively involved with this study.

**Partnerships**

- We currently have eight (8) active District Health Councils (DHC) who continue to be an important community link to the NRHA Board and staff.

- Since our last Strategic Plan, over eight million dollars ($8,287,201) in external grants have been obtained for priority initiatives.

- Senior Management and staff of the NRHA participate on a number of intersectoral committees throughout the region. Some partnerships of note include The Pas Wellness Centre Committee, North Forks Economic Development Authority, Flin Flon Soil Study Community Advisory Committee, Snow Lake Sustainable In 2005-06, The Pas Homeless Project secured funding to build a Homeless Shelter in The Pas. The Pas Homeless Shelter opened in The Pas in Feb/08.
Community Plan Advisory Committee, The Pas Homeless Shelter, Parent Child Coalition, Chronic Disease Prevention Initiative (CDPI), Play it Safer, Children’s Therapy Initiative (CTI) and the Baby Friendly Initiative.

- We are an active partner with the Swampy Cree Tribal Council (SCTC) Round Table, Manitoba Keewatinook Ininew Okimowin (MKO) and Manitoba Métis Federation (MMF) Aboriginal Health Transition Fund (AHTF) projects. The goal of these projects is to generate recommendations for developing policy on Aboriginal health.

**Healthy People**

**Chronic Disease Prevention**

- In January 2007, the very successful Manitoba Retinal Screening Vision Program (MRSVP), a wait time initiative, was undertaken. To date, we have done screenings in all communities in our region.

- We have participated in the Chronic Disease Prevention Initiative (CDPI) for the past 5 years. We have two (2) active District Steering Committees, encompassing all three (3) districts, which continue to implement and coordinate innovative initiatives relating to smoking, physical activity, mental wellness and healthy eating.

- Primary Health Care staff continue to offer a number of programs related to chronic disease prevention including Heart to Heart, Get Better Together, weekly blood pressure clinics, Ticker Challenge, and “Catch Health.”

In 2008, a total of 453 clients were screened with 10% referred to Retinal Specialists, 2% to Glaucoma Specialists, 8% to General Ophthalmologists, 6% to Optometrists, and 4% to Family Physicians.

We received $23,600 in funding for the Healthy Northern Foods Initiative, CDPI Partnership for school nutrition and community gardening projects.
• We have been actively involved in the development of the new Wellness Centre in The Pas.

Mental Health and Addictions

• Mental Health and Addictions staff have been working diligently on the Co-Occurring Disorder Initiative (CODI). The goal of CODI is to improve access to services and treatment for NRHA residents with co-occurring mental health and substance use disorders.

Suicide Prevention

• We have two (2) active interagency Suicide Prevention Committees in The Pas and Flin Flon, which are focusing their work on the provincial Youth Suicide Prevention Strategy.

Child Health

• In 2006-07, through the Children’s Therapy Initiative (CTI), an Occupational Therapist (OT) was hired full-time for the region which allowed a shifting of resources so that children previously not eligible could receive OT services.

• In 2006-07, we received provincial funding for the Healthy Smiles, Happy Child Project. The long term goal of the project is to decrease the number of young children requiring oral surgery. This project has since ended as funding has lapsed.

• Teen Pregnancy Reduction Committees continue to be active in Flin Flon, The Pas and surrounding areas.

• In 2006, we received funding from Healthy Child Manitoba for the development of
Youth Health Clinics in The Pas, Flin Flon and Cranberry Portage. Our clinics have been very successful and we have extended services now to clients who are not yet in their teen years as well as post-high school youth.

- Risk Factor Surveillance surveying (Youth Health Survey) for grades 6-12 has occurred in all schools in the region in 2009. Next steps are to review the results with the local schools and school boards with the intent of partnering in projects to meet identified issues/concerns.

- The Families First program continues to offer an excellent service to families in the region and the demand for the service has continued to grow.

- Nurses Who Immunize Committee is active in the region and includes representatives from NRHA, MB Health Nursing Stations and FNIH communities.

- Stop FAS Program is in its seventh (7th) year in The Pas and we were selected in 2009 by Healthy Child Manitoba to host a new Stop FASD program in Flin Flon.

- Breastfeeding committees in the region are presently working on the accreditation process for the Baby Friendly Initiative in order to meet the standards to be recognized for their work in promoting and supporting breastfeeding and baby friendly hospitals.

Injury Prevention

- The Injury Prevention Committee is working on an Injury Prevention Strategy focusing on four regional priorities: Falls

Tobacco Tackle Teams have continued in schools in Flin Flon, Cranberry Portage, Cormorant and The Pas – projects were completed in all school with the assistance of CDPI funding

The administration of the school leaving booster in grade 8 instead of grade 9 was initiated in 2008/09

This process was deemed beneficial as the number of students receiving the immunization has improved
Prevention, Road Safety, Suicide and Personal/Home Safety.

- Prevent Alcohol and Risk Related Trauma in Youth (P.A.R.T.Y), a hard hitting hospital based program, has been successfully offered at the Flin Flon General Hospital. The program targets grade nine (9) and ten (10) students to take responsibility for high-risk behaviours such as drinking and driving, drugs and driving, and not wearing a seatbelt or a helmet.

Women’s Health

- The Manitoba Mobile Breast Screening Program (MBSP) has had a significant impact on breast screening rates. Since the program began, our breast screening rates have been above the provincial rate in all reporting periods.

- Over the past several years, there has been an increase in promotion of the importance of cervical screening. A number of initiatives have been undertaken including the introduction of the Well Women’s and Youth Health Clinics at the Primary Health Care Centres in The Pas, Flin Flon and Cranberry Portage.

Men’s Health

- The Primary Health Care Men’s Health Team offers support, resource and counselling to men on a variety of topics including stress, mental health, chronic disease prevention, heart health, Hepatitis C counselling and travel health, etc.

Senior’s Health

- A Falls Management Program is in place in all Long Term Care, Acute Care and
Community programs.

- A Well Senior’s initiative is in place to promote quality of life, aging in place and seniors’ wellness. Some of the programs implemented throughout the region including Movement that Matters, Congregate Meal Programs and In Motion group activities.

- Recreational programming is available in all of the NRHA Personal Care Homes. These activities are provided by certified Recreation Facilitators and volunteers, in combination with the Adult Day programs in Flin Flon and The Pas.

Aboriginal Health

- We developed an Aboriginal Health Strategy that focuses on four key areas: (1) Partnerships and Linkages; (2) Culturally Sensitive Environment; (3) Recruitment and Retention of Aboriginal People; and (4) Improvement of Aboriginal Health.

- We are an active partner with the SCTC, MKO and MMF Aboriginal Health Transition Fund (AHTF) projects.

- Aboriginal Liaisons continue to be in place at The Pas Health Complex and Flin Flon General Hospital. They provide support to all Aboriginal people who access acute care and long term care services including in-patient and out-patient treatments as requested.

Staff Health

- A Respectful Workplace Strategy has been implemented within the region which includes a multi-faceted program consisting of the following strategies:
(1) Respectful Workplace Sessions; (2) Ethics; (3) Virtues Program; (4) Conflict Resolution; (5) Customer Service; (6) Non-violent Crisis Intervention; and (7) Stress Management.

- A Comprehensive Wellness Program is in place including Employee Assistance; Attendance Management; Respiratory Protection; Ability Management; CPR/ First Aid; Smoking Cessation, Safety Prevention and Hearing Conservation; and Employee Wellness Initiatives.

Optimal Access to Services

Primary Health Care

- Our Primary Health Care model is fully functioning in the region with four (4) multidisciplinary teams: Infant/ Child, Youth/Women’s, Men’s and Senior’s Team.

Specialty Services

- We continue to offer a number of itinerant specialty clinics in the region. In 2008-09, this accounted for 155 physician days and 70 allied health professional days. The availability of these services not only saves NPTP dollars, but also provides the opportunity for residents to access services locally.

- The first CT in the region was installed in The Pas in October 2003. We have averaged approximately 2800 scans per year and have reduced the number of referrals out of the region to less than 5%.
Dialysis

- Since our last CHA, new expanded Dialysis departments have been built in Flin Flon and The Pas. Flin Flon expanded from two to four stations in February 2006. The Pas increased from four to ten stations in April 2008.

Cancer Services

- We continue to provide CancerCare Outreach Centres in Flin Flon and The Pas. In 2007/08, 66% of NRHA residents were able to receive Chemotherapy treatments within the region.

Telehealth

- The MB Telehealth Network has continued to grow, reaching a total of 67 sites in Manitoba at the end of 2008/09. The Telehealth sites in Flin Flon and The Pas continue to be among the busiest in the province.

Capital Improvements

- With funding from Manitoba Health between 1999 to 2008, we have invested over $22 million in capital, safety and security projects in the region.

Excellence in Patient Safety and Quality of Care

Quality, Risk Management and Patient Safety

- Since our last CHA, we have participated in two Accreditation Canada survey visits. Our last survey visit was in May 2008. We exceeded the national compliance rate in 7 of the 8 quality dimensions and met or

Accreditation Canada Compliance Rates

<table>
<thead>
<tr>
<th>Category</th>
<th>NRHA (National average)</th>
<th>Population Focus 91% (90%)</th>
<th>Accessibility 97% (93%)</th>
<th>Safety 89% (85%)</th>
<th>Work Life 96% (91%)</th>
<th>Client-centred 96% (91%)</th>
<th>Effectiveness 89% (91%)</th>
<th>Continuity 88% (91%)</th>
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<td>Flin Flon: $10,818,318</td>
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The Pas Telehealth site experienced an increase in utilization of 30% in 2008/09. Clinical utilizations was 48.6% in The Pas, 43.5% in Flin Flon and 33% in Snow Lake.
We successfully completed the 5 year HIROC Risk Assessment process in 2010.

Our Regional Incident Management System ensures an organizational and planning system is in place that defines the roles, responsibilities and the operating procedures to be used in the event of emergency incidents. Admin on-call rotation is in place to ensure senior leaders available 24/7.

In 2009, two half-time Spiritual Care Coordinators for the Pas and Flin Flon were hired through directed funding from Manitoba Health.

exceeded the national compliance rate in 10 of 12 standards sections.

- We have maintained an integrated Quality Management structure with all CQI teams reporting to Quality Council. In September 2007, we reconfigured all our CQI Teams based on the new Accreditation process.

- Through directed funding from Manitoba Health, a new Patient Safety Coordinator was hired and began work in May 2009. This position is responsible for investigating all Critical Incidents and coordinating a Patient Safety strategy for the region.

Workplace Safety and Health

- Regional and site specific Workplace, Safety and Health committees continue to review injuries and make recommendations on areas for further training and/or policy development. In 2008-09, we hired two (0.6 FTE) Training Assistants to assist with mandatory training needs of the organization with a special emphasis being placed on lifts and transfers; and Non-Violent Crisis Intervention training.

Disaster Management

- Our Regional Alert and Response Team continues to be active in the development and maintenance of the Regional Emergency Response Plan, the Regional Incident Management System (IMS) and the Regional Pandemic Response Plan.

Patient Care Model

- We continue to implement our regional Patient Care Model which encompasses the
following components: (1) Nursing Leadership Framework; (2) Patient Care Documentation System; (3) Nurse Managed Care Strategy; (4) Regional Clinical Policy and Procedure development; (5) Regional Ethics Framework; (6) Nurse Practitioner Proposal; (7) Workplace Integration of New Nurses; and (8) Spiritual Care

Recruitment and Retention

- We continue to seek out creative ways to deal with staff and physician shortages including continuing with student sponsorships and return of services agreements; High School Bursary Program; and incentives to students completing senior practicum experience with RHA, to name a few.

- We continue to ensure the ongoing development of recruitment and retention strategies with an emphasis to enhance northern Human Resources in order to deal with staff and physician shortages.

Recognized Best Practices

- In April 2007, the Province undertook an External Review of all RHA’s. As part of the review, we were noted for six (6) best practices:

  1. Quality Scorecard
  2. Community Health Assessment process
  3. Primary Health Care approach
  4. Ethical Framework
  5. Patient Documentation project
  6. Work Integration of New Nurses Program

- Accreditation Canada has also recognized our Quality Scorecard as a Best Practice
and is using our model in their national education sessions.

Current Challenges

The challenges that we identified in our last Strategic Plan are ongoing and will continue to be areas that we will need to work on. These include:

- Shifting resources to prevention and promotion while maintaining existing services.
- As we are not mandated to provide all health services in all NOR-MAN communities, ongoing partnerships with Aboriginal agencies will continue to be a priority for the RHA.
- Ongoing improvements and maintenance to our facilities is required as a result of our old infrastructure.
- The need to continue investing in developing Northern Human Resources and recruiting and retaining qualified staff.
- The need to increase resident knowledge of available health care services as well as how to access services as residents still report that they are unsure of how to access services.
- The need to continue to strive for a health care delivery model that is culturally sensitive continues to be a priority for us. We have struggled in the past few years to find a suitable model for delivering cultural sensitivity training for our staff. This will be a priority in the coming years.
- Telehealth has expanded in our region in the past several years to include The Pas, Flin Flon, Snow Lake, Pukatawagan, Grand Rapids and Easterville. The need to extend Telehealth Services to our Primary Health Care Centres,
Moose Lake, Cormorant, Cranberry Portage and Sherridon will be targeted over the next few years.

**Funding/ Infrastructure Issues**

Funding and infrastructure issues are a challenge that was identified to Manitoba Health due to our ongoing funding levels and deficit situation in the past several years. The majority of our deficit is directly related to the Northern Patient Transportation (NPTP) Program and human capital, which leaves little room for reallocation. Some of our funding and infrastructure pressures include:

- **Operating Expenses**  
  Our operating expenses continue to increase each year at a rate that is higher than our allocated funding level from Manitoba Health. The largest majority of the increase is related to negotiated wage increases, cost of living increases, utility increases, and transportation costs increases.

- **Physician Remuneration**  
  Physician remuneration costs increased by 9% in the 2009-10 fiscal year. Increases were largely related to negotiated payment increases to physicians as well physician shortages and the need to depend on locum services (in particular for Anesthesia and Obstetric Services in The Pas and Obstetrical and Surgical Services in Flin Flon).

- **Northern Patient Transportation Program**  
  We continue to see a deficit in the Northern Patient Transportation Program (NPTP) program. This is a provincial program, which is grossly under funded, and one which we have little to no ability to control costs. In 2000-01, when NPTP became the responsibility of NRHA to fund, the funding level was at $2.26 million (with a
In 2008-09, the year end audited expenses for NPTP was $6,982,568 (with a deficit of $1.5 million). This constitutes a 68% increase in NPTP costs since the program went in globe in 2000-01.

Since 2000-01, NRHA has had to reallocate anywhere from $1.5 to $2.6 million per year from other program areas in order to deliver this provincially mandated service that is required for our northern residents. NPTP deficit figures are consistent with our overall deficit we have experienced in past years. We are anticipating a budgetary increase from Manitoba Health in 2010-11 to address this problem.

• Aging Equipment
  Our basic and specialized equipment is aging with many critical pieces of equipment being at their end of their useful lifespan. The basic equipment allocation is insufficient to be able to strategically plan for replacement or allow for the ever greening of equipment.

  Our specialized equipment requests submitted in our Health Plan each year continues to grow and we are often faced with submitting an emergent request to Manitoba Health for replacement when a piece of equipment fails.

• Information Technology
  Our investment in Information Technology has been at just over half of a percentage (0.5%) of our total budget for the past several years. The national benchmark is four percent (4%). In addition, we have the second lowest budget allocation dedicated to IT in comparison to the rest of the Regional Health Authorities in Manitoba. Due to our ongoing deficit, we have been unable to invest more into information technology to keep up with the national or provincial benchmark.
Summary

The 2006-11 Strategic Plan for the NOR-MAN Regional Health Authority (NRHA) is a progressive document that was built on the work and planning that was underway in the region since the Authority’s inception in April 1997.

To achieve our Mission, the Board set out four (4) Board Ends and twenty-eight (28) Strategic Priorities to guide the NRHA for the next five years. The four Board Ends were:

1. Healthy Communities
2. Healthy People
3. Optimal Access to Services
4. Excellence in Patient Safety and Quality of Care

In order for the Board to arrive at these new Board Ends and Strategic Priorities, there were five (5) key elements considered in their deliberations, in addition to the results of the first Community Health Assessment:

- Establishing criteria for priority setting
- Undertaking a Situational Assessment
- Understanding the progress achieved since our first Community Health Assessment
- Understanding present challenges that we were facing
- Determining opportunities and common themes

This chapter has confirmed that since our last Community Health Assessment, we have made great strides towards the advancement of our Board Ends and Strategic Priorities.

A series of accomplishments were highlighted for each of the four Board Ends.

- Under the Board End “Healthy Communities,” accomplishments were highlighted in the
following areas:
- Communications—internal and external
- Environmental citizenship
- Partnerships

• Under the Board End “Healthy People,” accomplishments were highlighted in the following areas:
  - Chronic Disease Prevention
  - Mental Health and Addictions
  - Suicide Prevention
  - Child Health
  - Injury Prevention
  - Women’s Health
  - Men’s Health
  - Senior’s Health
  - Aboriginal Health
  - Staff Health

• Under the Board End “Optimal Access to Services,” accomplishments were highlighted in the following areas:
  - Primary Health Care
  - Specialty Services
  - Dialysis
  - Cancer Services
  - Telehealth
  - Capital Improvements

• Under the Board End “Excellence in Patient Safety and Quality of Care,” accomplishments were highlighted in the following areas:
  - Quality and Risk Management
  - Patient Safety
  - Workplace Safety and Health
  - Disaster Management
  - Patient Care Model
  - Recruitment and Retention
  - Recognized Best Practices

Finally, we ended the chapter with a review of current challenges facing the organization. It was noted that the challenges that were identified in
our last Strategic Plan continue to be areas that we will need to work on. These included:

- Shifting resources to prevention and promotion while maintaining existing services

- As we are not mandated to provide all health services in all NOR-MAN communities, the need for ongoing partnerships with Aboriginal agencies is required

- The need for ongoing improvements and maintenance to our facilities as a result of our old infrastructure

- The need to continue investing in developing Northern Human Resources and recruiting and retaining a qualified workforce

- The need to increase resident knowledge of available health care services and how to access services

- The need to continue to strive for a health care delivery model that is culturally sensitive

- The need to extend Telehealth Services to our Primary Health Care Centres, Moose Lake, Cormorant, Cranberry Portage and Sherridon.

In addition, funding and infrastructure issues were identified as a significant challenge due to our ongoing funding levels and deficit situation in the past several years. The following areas were identified as pressures:

- Our operating expenses continue to increase each year at a rate that is higher than our allocated funding level from Manitoba Health.

- Physician remuneration costs continue to increase and is largely related to negotiated payment increases, physician shortages and the need to depend on locum services.
• We continue to see a deficit in the Northern Patient Transportation Program (NPTP) program. This is a provincial program, which is grossly under funded.

• Our basic and specialized equipment is aging with many critical pieces of equipment being at their end of their useful lifespan. The basic equipment allocation is insufficient to be able to strategically plan for replacement or allow for the ever greening of equipment.

• Due to our ongoing deficit, we have been unable to invest more into information technology to keep up with the national or provincial benchmark.
Chapter 10

What Are Our Next Steps?

The 2008/09 NOR-MAN Regional Health Authority Community Health Assessment report is built upon the previous work done during our first two Community Health Assessment Reports. This document is the stepping stone for the development of our 2011 – 2016 Strategic Plan.

Whether at an individual, family, community or RHA level, we all have a role to play in improving our health status. We are recommending the following actions be taken to answer the question - “What are our next steps?”

As Individuals, we can:

- Be smoke free
- Be active
- Eat healthy - follow the Canada’s Food Guide
- Use alcohol wisely - drink in moderation
- Take a break - enjoy the beauty around you
- Become active in your community – volunteer
- Be a friend
- Be an educated voter
- Be a life long learner
- Become more aware of the health services available and how to access them

As Families, we can:

- Start right – breastfeed, read and play with your children starting at birth
• Spend time together
• Work out together – take the dog or better yet the kids for a nightly stroll
• Eat together - make mealtime, family time
• Lend a hand - help your neighbors and friends
• Think green

As a Community, we all can:
• Adopt the philosophy that it takes an entire village to raise a child. Is your community child friendly?
• Think green
• Ensure that social supports are available
• Get involved - working together to improve the health of your community
• Advocate for the health of the people in your community
• Be active in community events
• Work in partnership with other groups
• Partner on community health development projects
• Get involved in your District Health Council

As the NOR-MAN Regional Health Authority, we are committed to:

• Using the data and information collected during the community health assessment, to ensure that we do evidence-based planning
• Continue to focus on prevention and health promotion - this is key to helping people become and stay healthy

• Continue to provide quality services for assisting people to regain their health when they are sick or injured.

• Continue to advocate for the health of the people in our region – whether this means promoting tobacco cessation, increasing opportunities for physical activity or better day care, transportation and affordable housing.

• Provide leadership and continue to work in partnerships - this is necessary to develop initiatives that will improve the health of our communities.

• Demonstrate what can be done when we put our creative minds to it – like our commitment to Primary Health Care, the appropriate service, by the appropriate provider, at the appropriate location and time

• Continue to enhance efficiency and build a health care system that does a quality job – now and in the future.

• Continue to ensure proper accountability and prudent expenditures of public funds

• Continue to be open to innovative, cost-effective approaches in an evidence-based environment

• Continue to enhance the awareness of regional and community NRHA services and programs - many residents do not know how or where to obtain services and related health care information
• Continually work at improving access to physician services - thereby shortening the waiting time for an appointment (Advanced Access)

• Continually work at improving access to health care services - increase use of Telehealth service

• Continue to address the issue of transportation costs - related to accessing health care services in and out of the region

• Continually work at attracting and retaining high quality staff

• Continually work at improving our communication skills - both to our staff (internal) and to our NOR-MAN residents as a whole (external)

• Continue to work at providing an environment that is culturally sensitive

• Continue to be responsive to the unique needs of our residents - individuals and communities

• Continue to work at providing a supportive work environment

• Continually work at supporting our staff in making “healthy lifestyle choices”

If each of us were to take an active role in improving our own health, we as a region would be moving towards achieving our Mission of:

Healthy People in Healthy Communities
“Working Together to Improve Our Health”
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## CHA Report Indicator Index

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<th>Category</th>
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<td>5-39</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Core</td>
<td>Proportion of Adolescents / Teenagers on SSRIs &amp; Stimulants</td>
<td>5-39</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-Core</td>
<td>Cultural Indicators</td>
<td>F-2</td>
</tr>
<tr>
<td>D. Mortality</td>
<td></td>
<td>Non-Core</td>
<td>Total Mortality Rate</td>
<td>5-2</td>
</tr>
</tbody>
</table>

2009/2010 NRHA Community Health Assessment
Index
Page Index - 1
## CHA Report Indicator Index

<table>
<thead>
<tr>
<th>Category</th>
<th>Ref. No.</th>
<th>Core vs Non-Core vs Other</th>
<th>Indicator Name</th>
<th>Page #’s Where Indicator Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. Mortality (continued)</td>
<td>D-2</td>
<td>Core</td>
<td>Infant Mortality</td>
<td>5-6</td>
</tr>
<tr>
<td></td>
<td>D-4</td>
<td>Non-Core</td>
<td>Top 5 Cancer Mortalities</td>
<td>5-10</td>
</tr>
<tr>
<td></td>
<td>D-5</td>
<td>Non-Core</td>
<td>Injury Morality Rates</td>
<td>5-12</td>
</tr>
<tr>
<td></td>
<td>D-8</td>
<td>Core</td>
<td>Unintentional Injury Deaths</td>
<td>5-12</td>
</tr>
<tr>
<td></td>
<td>D-9</td>
<td>Core</td>
<td>Suicide Rates</td>
<td>5-7</td>
</tr>
<tr>
<td></td>
<td>D-11</td>
<td>Core</td>
<td>Life Expectancy</td>
<td>5-4</td>
</tr>
<tr>
<td></td>
<td>D-12</td>
<td>Core</td>
<td>Top 5 Causes of Mortality</td>
<td>5-9</td>
</tr>
<tr>
<td></td>
<td>D-14</td>
<td>Core</td>
<td>Premature Mortality Rates</td>
<td>5-3</td>
</tr>
<tr>
<td></td>
<td>D-19</td>
<td>Non-Core</td>
<td>Potential Years of Life Lost (PYLL) due to all deaths</td>
<td>5-5</td>
</tr>
</tbody>
</table>

### Dimension: Determinants of Health & Social Well Being

<table>
<thead>
<tr>
<th>E. Health Behaviours</th>
<th>E-1</th>
<th>Core</th>
<th>Body Mass Index (International Standard)</th>
<th>6-39</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E-2</td>
<td>Core</td>
<td>Nutrition: Fruit and Vegetable Consumption</td>
<td>6-38</td>
</tr>
<tr>
<td></td>
<td>E-3</td>
<td>Non-Core</td>
<td>Frequency of Heavy Drinking</td>
<td>6-36</td>
</tr>
<tr>
<td></td>
<td>E-4</td>
<td>Core</td>
<td>Smoking</td>
<td>6-33</td>
</tr>
<tr>
<td></td>
<td>E-5</td>
<td>Core</td>
<td>Leisure-time Physical Activity</td>
<td>6-41</td>
</tr>
<tr>
<td></td>
<td>E-7</td>
<td>Non-Core</td>
<td>Breastfeeding Practices (Initiation)</td>
<td>6-30</td>
</tr>
</tbody>
</table>
| | E-8 | Core | Childhood Immunization Rates:  
• 1 year olds  
• 2 year olds  
• 7 year olds | 6-25  
6-27  
6-28 |
| | E-9 | Core | Adult Influenza Immunization Rates | 6-46 |
| | E-10 | Core | Adult Pneumococcal Immunization | 6-47 |
| | E-13 | Core | Sexually Transmitted Infections: Chlamydia | 6-52 |
| | E-14 | Core | Sexually Transmitted Infections: Gonorrhea | 6-51 |
| | E-15 | Core | Sexually Transmitted Infections: HIV | 6-53 |
| | E-16 | Core | Breast Cancer Screening (Mammography) | 6-45 |
| | E-17 | Core | Cervical Cancer Screening (PAP Smears) | 6-43 |

<table>
<thead>
<tr>
<th>F. Socio-Economic Conditions</th>
<th>F-2</th>
<th>Core</th>
<th>Income Inequality: Income Status (LICO)</th>
<th>6-3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F-3</td>
<td>Core</td>
<td>Income Inequality: Median Income of Individuals and Households</td>
<td>6-4</td>
</tr>
<tr>
<td></td>
<td>F-4</td>
<td>Non-Core</td>
<td>Income - Average Household Income</td>
<td>6-5</td>
</tr>
<tr>
<td></td>
<td>F-6</td>
<td>Non-Core</td>
<td>Labor Force Participation Rate</td>
<td>6-9</td>
</tr>
</tbody>
</table>
# CHA Report Indicator Index

<table>
<thead>
<tr>
<th>Category</th>
<th>Ref. No.</th>
<th>Core vs Non-Core vs Other</th>
<th>Indicator Name</th>
<th>Page #’s Where Indicator Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>F. Socio Economic Conditions (continued)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F-7 Non-Core Occupation</td>
<td></td>
<td>Non-Core</td>
<td>Occupation</td>
<td>6-9</td>
</tr>
<tr>
<td>F-9 Core Unemployment Rate</td>
<td></td>
<td>Core</td>
<td>Unemployment Rate</td>
<td>4-27 6-11</td>
</tr>
<tr>
<td>F-10 Non-Core Youth Unemployment</td>
<td></td>
<td>Non-Core</td>
<td>Youth Unemployment</td>
<td>6-12</td>
</tr>
<tr>
<td>F-11 Non-Core High School Completion</td>
<td></td>
<td>Non-Core</td>
<td>High School Completion</td>
<td>4-17</td>
</tr>
<tr>
<td>F-12 Core Education Level</td>
<td></td>
<td>Core</td>
<td>Education Level</td>
<td>4-21</td>
</tr>
<tr>
<td>F-13 Core Housing - Housing Affordability</td>
<td></td>
<td>Core</td>
<td>Housing - Housing Affordability</td>
<td>6-16</td>
</tr>
<tr>
<td>F-18 Core Teen Birth Rates</td>
<td></td>
<td>Core</td>
<td>Teen Birth Rates</td>
<td>6-21</td>
</tr>
<tr>
<td>G. Environmental Factors</td>
<td>G-1</td>
<td>Core</td>
<td>Second-hand Smoke Exposure</td>
<td>6-54</td>
</tr>
<tr>
<td>G-3 Non-Core Any other Environmental Factors of Significance</td>
<td>G-3</td>
<td>Non-Core</td>
<td>Any other Environmental Factors of Significance</td>
<td>6-55</td>
</tr>
<tr>
<td>H. Personal Resources</td>
<td>H-1</td>
<td>Non-Core</td>
<td>Life Stress</td>
<td>6-53</td>
</tr>
<tr>
<td>H-4 Non-Core Social Support: Marital Status</td>
<td></td>
<td>Non-Core</td>
<td>Social Support: Marital Status</td>
<td>4-13 6-15</td>
</tr>
<tr>
<td>H-6 Core “Readiness for School” Indicators form “EDI”</td>
<td>H-6</td>
<td>Core</td>
<td>“Readiness for School” Indicators form “EDI”</td>
<td>6-31</td>
</tr>
<tr>
<td>H-9 Core School Changes</td>
<td></td>
<td>Core</td>
<td>School Changes</td>
<td>6-14</td>
</tr>
</tbody>
</table>

## Dimension: Governance (RHA Governance for CHA)

| J. Leadership                                | J-1      | Non-Core                  | New Programs/Services or program/service revision as a result of findings of 2004 CHA | 9-9                              |

## Dimension: Health System Performance

| N. Accessibility                             | N-1      | Core                      | Operational Hospital Beds per 1000 Residents            | 7-14                              |
| N-2 Non-Core Acute Care Occupancy           |          |                           | Acute Care Occupancy                                    | 7-15                              |
| N-5 Core In & Out Flow of RHA Inpatients     |          | Core                      | In & Out Flow of RHA Inpatients                         | 7-17                              |
| N-6 Core Use of Physicians                   |          | Core                      | Use of Physicians                                        | 7-3                               |
| N-7 Core Ambulatory Visit Rate               |          | Core                      | Ambulatory Visit Rate                                    | 7-4                               |
| N-8 Core Ambulatory Consultation Rates       |          | Core                      | Ambulatory Consultation Rates                            | 7-9                               |
| N-9 Non-Core Ambulatory Visit Rate to Specialists | N-9 | Non-Core                  | Ambulatory Visit Rate to Specialists                      | 7-10                              |
| N-10 Core Where RHA Residents went for visits to GP/FPs | N-10 | Core                      | Where RHA Residents went for visits to GP/FPs           | 7-6                               |
| N-11 Core Where RHA Residents went for visits to Specialists | N-11 | Core                      | Where RHA Residents went for visits to Specialists       | 7-11                              |
## CHA Report Indicator Index

<table>
<thead>
<tr>
<th>Category</th>
<th>Ref. No.</th>
<th>Core vs Non-Core vs Other</th>
<th>Indicator Name</th>
<th>Page #’s Where Indicator Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>N. Accessibility</td>
<td>N-13</td>
<td>Core</td>
<td>Families First Program Risk Factors, i.e. the % of families with newborns:</td>
<td>7-51, 7-48, 7-48, 7-49</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• with 3 or more risk factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• alcohol use by mothers during pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• maternal depression and anxiety disorders combined</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• income support or financial difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• mother with less than grade 12 education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N-14</td>
<td>Core</td>
<td>Screening For and Use of Families First Program</td>
<td>7-51</td>
</tr>
<tr>
<td></td>
<td>N-15</td>
<td>Core</td>
<td>Supply of PCH Beds</td>
<td>7-44</td>
</tr>
<tr>
<td></td>
<td>N-20</td>
<td>Non-Core</td>
<td>EMS Response Time</td>
<td>7-56</td>
</tr>
<tr>
<td></td>
<td>N-22</td>
<td>Non-Core</td>
<td>Wait time for Diagnostic Procedures:</td>
<td>7-52</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ultrasound</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• MRI</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• CT Scans</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Angiograms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N-23</td>
<td>Core</td>
<td>Wait time for Community Programs / Rehab Services</td>
<td>7-52</td>
</tr>
<tr>
<td></td>
<td>N-24</td>
<td>Non-Core</td>
<td>Primary Health Care Initiative Programs</td>
<td>E-9</td>
</tr>
<tr>
<td>O. Safety</td>
<td>O-1</td>
<td>Non-Core</td>
<td>Staff Flu Immunization</td>
<td>F-8</td>
</tr>
<tr>
<td></td>
<td>O-3</td>
<td>Non-Core</td>
<td>Themes of Critical Care Occurrences (CCO’s)</td>
<td>F-6</td>
</tr>
<tr>
<td>P. Work Life</td>
<td>P-1</td>
<td>Non-Core</td>
<td>Organizational Chart</td>
<td>D-1</td>
</tr>
<tr>
<td></td>
<td>P-4</td>
<td>Non-Core</td>
<td>Performance Management Process</td>
<td>F-8</td>
</tr>
<tr>
<td></td>
<td>P-11</td>
<td>Non-Core</td>
<td>Staff Education Budget</td>
<td>F-6</td>
</tr>
<tr>
<td></td>
<td>P-12</td>
<td>Non-Core</td>
<td>Staff Education Activities</td>
<td>F-6</td>
</tr>
<tr>
<td></td>
<td>P-16</td>
<td>Non-Core</td>
<td>Workplace Wellness Initiatives</td>
<td>F-8</td>
</tr>
<tr>
<td></td>
<td>P-17</td>
<td>Non-Core</td>
<td>Number of WCB Claims</td>
<td>F-8</td>
</tr>
<tr>
<td></td>
<td>P-18</td>
<td>Non-Core</td>
<td>Staff Satisfaction Survey</td>
<td>8-3, F-8</td>
</tr>
<tr>
<td></td>
<td>P-19</td>
<td>Non-Core</td>
<td>Staff Turnover Rate</td>
<td>F-8</td>
</tr>
<tr>
<td>Q. Client-Centered Services</td>
<td>Q-1</td>
<td>Non-Core</td>
<td>Annual General Meeting</td>
<td>F-2</td>
</tr>
<tr>
<td></td>
<td>Q-2</td>
<td>Non-Core</td>
<td>Easily Accessible Information on Services</td>
<td>F-2</td>
</tr>
<tr>
<td></td>
<td>Q-9</td>
<td>Non-Core</td>
<td>Results of RHA Initiated Client Satisfaction Survey</td>
<td>8-29</td>
</tr>
<tr>
<td></td>
<td>Q-10</td>
<td>Non-Core</td>
<td>Complaint Management Process</td>
<td>8-7</td>
</tr>
</tbody>
</table>

2009/2010 NRHA Community Health Assessment

Index

Page Index - 4
<table>
<thead>
<tr>
<th>Category</th>
<th>Ref. No.</th>
<th>Core vs Non-Core vs Other</th>
<th>Indicator Name</th>
<th>Page #'s Where Indicator Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>R. Continuity of Services</td>
<td></td>
<td>Core</td>
<td>Continuity of Care</td>
<td>7-13</td>
</tr>
<tr>
<td></td>
<td>R-2</td>
<td>Core</td>
<td>Antidepressant Prescription Follow-up</td>
<td>7-31</td>
</tr>
<tr>
<td>T. Effectiveness</td>
<td>T-1</td>
<td>Core</td>
<td>Ambulatory Care Sensitive Conditions</td>
<td>7-22</td>
</tr>
<tr>
<td></td>
<td>T-6</td>
<td>Core</td>
<td>5 Year Cancer Survival Rates for:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• All Cancers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Melanoma</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Colorectal</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Breast</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Cervical</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Prostate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Lung</td>
<td>7-34</td>
</tr>
<tr>
<td></td>
<td>T-7</td>
<td>Core</td>
<td>Re-admission Rate for Acute Myocardial Infarction</td>
<td>7-31</td>
</tr>
<tr>
<td></td>
<td>T-8</td>
<td>Core</td>
<td>Caesarian Section</td>
<td>7-35</td>
</tr>
<tr>
<td></td>
<td>T-9</td>
<td>Core</td>
<td>Vaginal Birth After Caesarian Section</td>
<td>7-36</td>
</tr>
<tr>
<td></td>
<td>T-11</td>
<td>Core</td>
<td>Hysterectomy</td>
<td>7-37</td>
</tr>
<tr>
<td></td>
<td>T-12</td>
<td>Core</td>
<td>Tonsillectomy / Adenoidectomy</td>
<td>7-38</td>
</tr>
<tr>
<td>U. Demographics</td>
<td>U-1</td>
<td>Core</td>
<td>Population Attributes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Population Numbers</td>
<td>4-2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Population Pyramids</td>
<td>4-10</td>
</tr>
<tr>
<td></td>
<td>U-2</td>
<td>Core</td>
<td>Population Projections</td>
<td>4-12</td>
</tr>
<tr>
<td></td>
<td>U-3</td>
<td>Core</td>
<td>Population Attributes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Dependency Ratio</td>
<td>4-36</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Aboriginal Population by Region</td>
<td>4-3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Lone Parent Families</td>
<td>4-36, 6-16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Language Spoken in the Home</td>
<td>4-37</td>
</tr>
<tr>
<td></td>
<td>U-4</td>
<td>Core</td>
<td>Internal / External Migration</td>
<td>4-16</td>
</tr>
<tr>
<td></td>
<td>U-5</td>
<td>Core</td>
<td>Geographic Attributes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Internal Migrant Mobility</td>
<td>4-16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Urban Population</td>
<td>4-9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Population Density</td>
<td>4-8</td>
</tr>
<tr>
<td>V. Utilization</td>
<td>V-1</td>
<td>Core</td>
<td>Physician Visit Rates by Top 10 Causes</td>
<td>7-8</td>
</tr>
<tr>
<td></td>
<td>V-2</td>
<td>Core</td>
<td>Physician Visits ‘for’ Mental Illness</td>
<td>7-12</td>
</tr>
<tr>
<td></td>
<td>V-3</td>
<td>Core</td>
<td>Total Hospital Separation Rates</td>
<td>7-17</td>
</tr>
<tr>
<td>Category</td>
<td>Ref. No.</td>
<td>Core vs Non-Core vs Other</td>
<td>Indicator Name</td>
<td>Page #’s Where Indicator Reported</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------</td>
<td>---------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>V. Utilization (continued)</td>
<td>V-4</td>
<td>Core</td>
<td>Separations ‘for’ Mental Illness Disorders:</td>
<td>7-23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• From Acute Care Hospitals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• From Mental Health Centres</td>
<td></td>
</tr>
<tr>
<td></td>
<td>V-5</td>
<td>Non-Core</td>
<td>Separations by Cause</td>
<td>7-21</td>
</tr>
<tr>
<td></td>
<td>V-7</td>
<td>Core</td>
<td>Hospital Days Used:</td>
<td>7-18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• For Short Stays</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• For Long Stays</td>
<td>7-19</td>
</tr>
<tr>
<td></td>
<td>V-10</td>
<td>Core</td>
<td>Cataract Surgery (Age 50+)</td>
<td>7-29</td>
</tr>
<tr>
<td></td>
<td>V-11</td>
<td>Core</td>
<td>Hip Replacement Surgery</td>
<td>7-25</td>
</tr>
<tr>
<td></td>
<td>V-12</td>
<td>Core</td>
<td>Knee Replacement Surgery</td>
<td>7-24</td>
</tr>
<tr>
<td></td>
<td>V-13</td>
<td>Core</td>
<td>Cardiac Catheterization Rates</td>
<td>7-28</td>
</tr>
<tr>
<td></td>
<td>V-14</td>
<td>Core</td>
<td>Percutaneous Coronary Intervention Rates</td>
<td>7-26</td>
</tr>
<tr>
<td></td>
<td>V-15</td>
<td>Core</td>
<td>Coronary Artery Bypass Graft (CABG) Surgery</td>
<td>7-27</td>
</tr>
<tr>
<td>W. Human Resources</td>
<td>W-6</td>
<td>Non-Core</td>
<td>Program Inventory**</td>
<td>Appendix E</td>
</tr>
<tr>
<td>X. System Capacity</td>
<td>X-4</td>
<td>Non-Core</td>
<td>Staff / Management Ratio</td>
<td>8-2</td>
</tr>
<tr>
<td>Y. Fiscal</td>
<td>Y-1</td>
<td>Core</td>
<td>% Operating Budget Spent on Acute / PCH / Community Costs</td>
<td>8-4</td>
</tr>
<tr>
<td></td>
<td>Y-2</td>
<td>Non-Core</td>
<td>% Operating Budget Spent on Administration</td>
<td>8-6</td>
</tr>
<tr>
<td></td>
<td>Y-3</td>
<td>Non-Core</td>
<td>Information System Costs as a % of Total Operating Costs by RHA</td>
<td>8-6</td>
</tr>
<tr>
<td></td>
<td>Y-6</td>
<td>Non-Core</td>
<td>Total Food Services Costs per Meal Day by RHA</td>
<td>F-6</td>
</tr>
<tr>
<td></td>
<td>Y-11</td>
<td>Non-Core</td>
<td>% Spent on Programs Per Program Area</td>
<td>F-6</td>
</tr>
<tr>
<td>BB. Other</td>
<td>BB-1</td>
<td>Core</td>
<td>Home Care Utilization:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• New Home Care Cases (Incidence)</td>
<td>7-40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Open Home Care Cases (Prevalence)</td>
<td>7-41</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Case Closing Rates</td>
<td>7-42</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Average Length of Home Care Cases</td>
<td>7-43</td>
</tr>
<tr>
<td></td>
<td>BB-2</td>
<td>Core</td>
<td>PCH Utilization:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• By Level of Care on Admission</td>
<td>7-45</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Median Length of Stay, by Level of Care</td>
<td>7-46</td>
</tr>
</tbody>
</table>

2009/2010 NRHA Community Health Assessment
Index
Page Index - 6
The Community Health Assessment is a dynamic ongoing process undertaken to identify the strengths and needs of the NOR-MAN region, enable region-wide establishment of health priorities and facilitate collaborative action planning directed at improving health status and quality of life for all NOR-MAN residents.

The NOR-MAN Regional Health Authority (NRHA) believes that a Community Health Assessment should not be done in isolation and to be effective, needs to be done with the community rather than to the community. The NRHA Community Health Assessment process has been designed to ensure the systematic gathering of statistical data, solicitation of perspectives from community members and ongoing collection of information about service providers and other community resources.

The following important factors need to be considered as the 2008/09 Community Health Assessment plans are undertaken. Firstly, that the NOR-MAN Regional Health Authority is not mandated to provide all health services in all communities in the NOR-MAN region. Because of the diversity of the NOR-MAN region, there are a number of agencies/organizations that provide health care services in the region. And secondly, that Saskatchewan residents from the Mamawetan Churchill River Health Authority and Peter Ballantyne Cree Nation use acute, ambulatory, diagnostic, emergency care and physician services provided by the NOR-MAN Regional Health Authority.

The 2008/09 Community Health Assessment (CHA) will build on the work that has been undertaken in the region since the completion of the 2003/04 assessment. The various NRHA Community Health Assessment Teams will examine the way health services are used, what health services are needed, and the ability of the region to respond to those needs to ensure that decisions about programs, services and resource allocations are based on both qualitative and quantitative evidence.

**Mission Statement:** Healthy People in Healthy Communities – Working Together to Improve Our Health

**Mandate:** To complete a comprehensive Community Health Assessment of the NOR-MAN region that will provide the data necessary to link health needs with the resources available to achieve positive health outcomes.

**Goal:** To provide a solid base of facts and data to guide decision making within the NOR-MAN Regional Health Authority
Objectives: The following objectives will be addressed by the NOR-MAN RHA Community Health Assessment Team:

1. To provide a third baseline of information from which the NRHA can compare and contrast health status changes over time.

2. To present initial findings to community residents and other stakeholders in order to better understand reasons for health status changes and potential new emerging health care issues.

3. To involve community residents and groups in the planning process as a vehicle for community development and action.

4. To use the information collected to help set priorities for future planning based on sound evidence and consultation with key stakeholders (NRHA 5 Year Strategic Plan).

5. To use the information collected to guide policy and program development within the NOR-MAN Regional Health Authority (NRHA Annual Health Plan).

6. To provide information on which to base funding allocations.

7. To widely disseminate the report so that other community agencies can have information for planning.

8. To ensure structured and ongoing processes for Community Health Assessment.

Research Principles: The NOR-MAN RHA Community Health Assessment planning model is based on the following research principles:

1. In order to understand all of the factors that contribute to individual and community well-being, a broad definition of health will be adopted.

2. A multi-method research approach will be used to allow the CHA Research Team and the Expert Working Groups Teams to assess needs from different perspectives.

3. The Community Health Assessment will incorporate a community development approach in its research design. The District Health Councils (DHC) may be the research team’s link to communities and they will be involved in the planning process at the community level.
4. There will be wide community consultation throughout all phases of the project.

5. The report will not sit on the shelf. It will be widely disseminated and will form the basis for strategic planning.

Committee Structure: The NOR-MAN RHA Community Health Assessment Team will consist of the following four components:

1. NHRA CHA Advisory Team
2. NRHA CHA Research Team
3. NRHA CHA Community Committees
4. NRHA Regional Manager Decision Support

NRHA Community Health Assessment Advisory Team

The NRHA CHA Advisory Team will consist of interested individuals from the Board of Directors, Senior Management, Regional Managers, the Medical Officer of Health and various community partners.

The primary function of the NRHA CHA Advisory Team is to provide input and direction into the development of the goals and objectives for the 2008/09 NRHA Community Health Assessment process and to bring forward information on current and future health needs from the various sources.

Potential membership could consist of the following individuals:
- Drew Lockhart, CEO
- Sue Lockhart, Executive Director of Planning, Research & Development
- Corliss Patterson, Executive Director of Communication/PR
- Lil Rourke, Executive Director Finance & Support Services (CFO)
- Pat Bilquist, Executive Director of Community & Long Term Care
- Tanis Campbell, Regional Care Advocate Primary Health Care
- Dr. Lawrence Elliott, Medical Officer of Health
- NRHA Board of Directors Representative (s)
  - Doug Lauvstad
  - Doris Habermann
  - Joan Niquanicappo
- Community Partner Representatives
  - First Nation Representative (s)
    - Swampy Cree Tribal Council
NRHA Community Health Assessment Research Team

The NRHA CHA Research Team will consist of the individuals who are currently working as Regional/Community Health developers within the NRHA.

The primary function of the NRHA CHA Research Team is to assist in the development of the 2008/09 CHA action plan / timelines, and to actively participate in the planned consultation activities at both the regional and community levels.

Membership consists of the following individuals:

- Don Gamache, Regional/Community Health Developer
- Christa McIntyre, Regional/Community Health Developer
- Lesa Nordick, Regional/Community Health Developer
- Fran Labarre, Regional/Community Health Developer
- Deanna Johnson, Regional/Community Health Developer
- Tanis Campbell, Regional Care Advocate
- Jamie Simard, CHA Administrative Data Entry/Programmer
- Catherine Hynes, NRHA Regional Manager Decision Support

- Internal & External Resource Personnel as required

NRHA Community Health Assessment Community Committees

Each NRHA community will have a functioning NRHA CHA Community Committee representing their community. These community committees will be the current District Health Council (DHC):

The primary function of the NRHA Community Committee is to be the link to their community to ensure community participation in all NRHA CHA consultation activities.

The following NOR-MAN communities will be asked to be involved:

- Manitoba Keewatinowi Okimakanak (MKO)
- Manitoba Metis Federation Representative(s)
- MMF The Pas Region
- Mamatewan Churchill River Regional Health Authority Representative
- UCN Dean of Health
- Catherine Hynes, NRHA Regional Manager Decision Support
- Flin Flon - District Health Council
- The Pas / OCN - District Health Council
- Snow Lake - District Health Council
- Cranberry Portage - District Health Council
- Sherridon / Cold Lake - new committee
- Cormorant - District Health Council
- Grand Rapids / Misipawistik Cree Nation - District Health Council
- Easterville / Chemawawin Cree Nation - District Health Council

**NRHA Community Health Assessment Coordinator**

The NRHA Regional Manager Decision Support coordinates the Community Health Assessment process and is responsible for keeping the process moving with appropriate support staff.

- Catherine Hynes, NRHA Regional Manager Decision Support

**Meetings:**

Regular meeting will be held at the call of the Chair:

- **NRHA CHA Advisory Team**
  - Meetings will be held quarterly prior to the NRHA Board of Directors monthly meeting
  - Meetings will be chaired by Sue Lockhart, Executive Director of Planning, Research & Development
  - Meeting agendas and minutes will be circulated by Catherine Hynes, NRHA Regional Manager Decision Support
  - Meeting recorder will be Catherine Hynes, NRHA Regional Manager Decision Support

- **NRHA CHA Research Team**
  - Meetings will be held monthly or as required by the call of the Chairperson
  - Meetings will be chaired by Catherine Hynes, NRHA Regional Manager decision Support
  - Meeting agendas and minutes will be circulated by the Catherine Hynes, NRHA CHA Coordinator
  - Meeting recorder will be Jamie Simard, CHA Administrative Data Entry/Programmer

- **NRHA CHA Community Committees**
Meetings will be co-chaired by a community member and the appointed Research Team member (current DHC Liaison) for that community.

- Meeting agendas and minutes will be circulated by the appointed Research Team member.
- Meeting recorder will be rotated among team member for that community.
- CHA will be a standing DHC agenda item.

For all NRHA Community Health Assessment Team meetings, items not placed on the pre-circulated agenda will be discussed under new business.

**Decision Making:**
All NRHA Community Health Assessment Teams will make decisions using a consensus approach. If and when necessary, they may decide to use other approaches (i.e. majority vote).

**Accountability:**
All NRHA Community Health Assessment Teams will be accountable to the NRHA CHA Advisory Team who is accountable to the NOR-MAN Regional Health Authority Board of Directors.

**Glossary of Terms:**
Is currently being developed for use by the NRHA Community Health Assessment Teams.
NRHA 2009/2010 Community Health Assessment
Community Consultation Questions

As part of the NRHA’s 2009/2010 Community Health Assessment a comprehensive community consultation format was developed.

A series of public community consultation activities were held in each community in the NOR-MAN Regional Health Authority region. All of the various community consultation activities that were used during our Community Health Assessment were participatory, and involved local community members.

A number of different consultation activities were offered to both NOR-MAN and northeastern Saskatchewan residents. The individuals, groups and organizations contacted to participate in the consultation activities represented a wide variety of community interests including older adults, youth, young parents, service organizations, business owners, health care providers, local government, environment, justice and education.

The 2009/10 NRHA Community consultation activities and the related questions asked are:

- **Board/District Health Council Retreat** - the following questions were asked:
  1. What is occurring or might occur in your community that affects the health of NOR-MAN residents?
  2. What specific threats are generated by these occurrences?
  3. What specific opportunities are generated by these occurrences?

- **Forces of Change Assessment** - the following questions were asked:
  1. What is occurring or might occur in your community that affects the health of your community?
  2. What specific threats are generated by these occurrences?
  3. What specific opportunities are generated by these occurrences?
  4. How has the health of your community changed over the last 3 years?
  5. What has influenced that change? (both positive and negative)
6. What do you think are the most important health issues in your community today?
7. Which of the health issues just identified (question #6) could be realistically addressed? (with current NRHA funding allocations and staffing levels)
8. Which of the issues identified in question #7 do you feel should be prioritized for action in the next 5 years?
9. What recommendations do you have for addressing this list of issues?

- **Key Knowledge Interviews** - the following questions were asked:
  1. What is the purpose/mandate of your agency/organization?
  2. Who is the contact person(s)?
  3. What services/programs does your agency/organization provide?
  4. Who is the population your agency/organization serves?
  5. What are your agency/organizations hours of operation?
  6. In your opinion, what are the strengths of your agency/organization?
  7. In your opinion, what challenges does your agency/organization face?
  8. Is your agency/organization aware of the programs/services provided by the NRHA to NOR-MAN residents? If yes, which services/programs are you aware of?
  9. How can we better promote NRHA programs/services?
  10. Has your agency/organization partnered with the NRHA in the past? If yes, provide details.
  11. What, if any, are the potential partnership opportunities available between your agency/organization and the NOR-MAN Regional Health Authority?
  12. Has the 2004 NRHA Comprehensive Community Health Assessment Report been used by your agency/organization? If yes, how was it used? How did it change or benefit your agency/organization? If no, why not?
  13. How has the health of your community changed in the past 3 years?
  14. In your opinion what are the most important health issues in your community today?
  15. In your opinion what are some of the health issues of community residents that are not being addressed?
16. Which of these health issues identified in question 15 do you feel should be prioritized for action in the next 5 years?
17. What are the chronic diseases that your agency/organization deals with most often?
18. Many of our current chronic diseases relate to lifestyle choices. From your agency/organization’s perspective what is preventing residents from your community from making healthy lifestyle choices?
19. In your opinion what is the best way to support people in making better lifestyle choices? (modifiable risk factors)
20. In your opinion, what are the most important health services for community residents? Specifically, for those living with chronic conditions.
21. How do we better reach community residents with health promotion/illness prevention messaging and programming?
22. Overall in your agency/organization’s opinion, what are the strengths of the NOR-MAN Regional Health Authority?
23. Overall in your agency/organization’s opinion, what are the challenges being faced by the NOR-MAN Regional Health Authority?
24. Do you have any additional comments?

- **Key Informant Interview** - the following questions were asked:

  1. What do you like most about living in (name community)?
  2. What concerns you most about living here?
  3. How has the health of your community changed in the past 3 years?
  4. What are the most important health issues in your community today?
  5. What are some of the health needs of community residents that are not being addressed?
  6. Which of these health issues identified in question 5 do you feel should be prioritized for action in the next 5 years?
  7. Which chronic diseases are most common in your community today?
8. Many of our current chronic diseases relate to lifestyle choices. What is preventing residents from your community from making healthy lifestyle choices?

9. What is the best way to support people in making better lifestyle choices? (modifiable risk factors)

10. What are the most important health services for community residents? Specifically, for those living with chronic conditions.

11. How do we better reach community residents with health promotion/illness prevention messaging and programming?

12. Has the NOR-MAN Regional Health Authority partnered with any community based agencies/organizations in the past 3 years? If yes, name the agencies & organizations.

13. What are the potential partnership opportunities in your community? (list of ideas) Who would you suggest that the NRHA contact to discuss potential partnership opportunities?

14. Overall, in your opinion what are the strengths of the NOR-MAN Regional Health Authority?

15. Overall, in your opinion what are the challenges being faced by the NOR-MAN Regional Health Authority?

16. Do you have any additional comments?

- **Health System Performance Staff Survey** - the focus of the survey was on both satisfaction and importance. Also included were questions on service delivery and health concerns. A copy of the survey is found on the following pages.

- **Health System Performance Physician Survey** - the focus of the survey was on both satisfaction and importance. Also included were questions on service delivery and health concerns. A copy of the survey is found on the following pages.

- **Health System Performance Partner Survey** - the focus of the survey was on both satisfaction and importance. Also included were questions on service delivery and health concerns. A copy of the survey is found on the following pages.
Please take a few minutes to complete the following staff survey. Your answers will assist the NOR-MAN Regional Health Authority in enhancing the Community Health Assessment Community Consultation Process. Your answers will be confidential and anonymous. **Deadline to respond is Friday February 26, 2010.**

**Key Instructions:**
- For questions involving scales, please circle only one answer from the scale for each statement. Please pay close attention to the scale types. **Agreement, satisfaction and importance scales have been used.**
- We are asking for **your opinion** on health system performance by the NOR-MAN Regional Health Authority.
- Throughout the survey the term “resident” is used to refer to those we provide services to.

<table>
<thead>
<tr>
<th>I believe that the NRHA is responsive to residents health care needs.</th>
<th>Strongly Agree</th>
<th>Mostly Agree</th>
<th>Agree</th>
<th>Mostly Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

| I believe that when residents need a health care service they know where to go. |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How satisfied do you feel residents are with the accessibility of NRHA services and programs? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How satisfied do you feel residents are with the friendliness of NRHA staff? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How satisfied do you feel residents are with the quality of NRHA services and programs? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How satisfied do you feel residents are with the delivery methods of NRHA services and programs? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How satisfied do you feel residents are with the timeliness of NRHA services and programs? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| Overall, how satisfied do you feel residents are with the NRHA? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How important do you believe accessibility of NRHA services and programs is to residents? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How important do you believe friendliness of NRHA staff is to residents? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How important do you believe quality of NRHA services and programs is to residents? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How important do you believe delivery methods of NRHA services and programs is to residents? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |

| How important do you believe timeliness of NRHA services and programs is to residents? |
|---|---|---|---|---|---|
| | 5 | 4 | 3 | 2 | 1 |
In your opinion, what are the strengths of the NOR-MAN Regional Health Authority? Why?

__________________________________________________________________________________

In your opinion, what are the weaknesses of the NOR-MAN Regional Health Authority?

__________________________________________________________________________________

From your perspective, what ideas / suggestions do you have to improve health service delivery?

__________________________________________________________________________________

From your perspective, what do you believe to be the top three (3) health issues in the NOR-MAN region?

__________________________________________________________________________________

From your perspective, what is preventing NOR-MAN residents from making healthy lifestyle choices?

__________________________________________________________________________________

In your opinion, what health issues need to be prioritized for action in the next five (5) years?

__________________________________________________________________________________

We would like to ask a few questions about you. We require this information to ensure that the survey results represent a broad cross-section of the NRHA staff.

Please check one response per question

<table>
<thead>
<tr>
<th>Number of years of service?</th>
<th>Less than 1 year</th>
<th>11-20 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-3 years</td>
<td>21-25 years</td>
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<tr>
<td></td>
<td>4-10 years</td>
<td>26+ years</td>
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</table>

<table>
<thead>
<tr>
<th>What is your employment status?</th>
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</thead>
<tbody>
<tr>
<td>Full-time</td>
</tr>
<tr>
<td>Casual</td>
</tr>
<tr>
<td>Part-time</td>
</tr>
<tr>
<td>Contract</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Which department/area do you currently work in?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
</tr>
<tr>
<td>Administration</td>
</tr>
<tr>
<td>Community</td>
</tr>
<tr>
<td>Support Services</td>
</tr>
<tr>
<td>Other</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Which community are you based in?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon</td>
</tr>
<tr>
<td>Snow Lake</td>
</tr>
<tr>
<td>The Pas</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which age category are you in?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 24 years</td>
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<tr>
<td>25-34 years</td>
</tr>
<tr>
<td>35-44 years</td>
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<tr>
<td>45-54 years</td>
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<tr>
<td>55-64 years</td>
</tr>
<tr>
<td>65+ years</td>
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<thead>
<tr>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
</tbody>
</table>

Thank you for completing this staff survey.

Please return completed survey by Friday February 26, 2010.
Completed surveys are to be sent through interoffice mail Attention: Catherine Hynes, RHA Corporate Office - 84 Church Street
If you have any questions, please do not hesitate to contact Catherine Hynes, Regional Manager Decision Support at 687-1338
Please take a few minutes to complete the following staff survey. Your answers will assist the NOR-MAN Regional Health Authority in enhancing the Community Health Assessment Community Consultation Process. Your answers will be confidential and anonymous. **Deadline to respond is Monday February 15, 2010.**

**Key Instructions:**
- For questions involving scales, please circle only one answer from the scale for each statement. Please pay close attention to the scale types. **Agreement, satisfaction and importance scales have been used.**
- We are asking for your **opinion** on health system performance by the NOR-MAN Regional Health Authority.
- Throughout the survey the term “resident” is used to refer to those we provide services to.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Mostly Agree</th>
<th>Agree</th>
<th>Mostly Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe that the NRHA is responsive to residents' health care needs.</td>
<td>5</td>
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<td>4</td>
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<td>2</td>
<td>1</td>
</tr>
<tr>
<td>How satisfied do you feel residents are with the accessibility of NRHA services and programs?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>How satisfied do you feel residents are with the friendliness of NRHA staff?</td>
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<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>How satisfied do you feel residents are with the quality of NRHA services and programs?</td>
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<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>How satisfied do you feel residents are with the delivery methods of NRHA services and programs?</td>
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<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>How satisfied do you feel residents are with the timeliness of NRHA services and programs?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Overall, how satisfied do you feel residents are with the NRHA?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<table>
<thead>
<tr>
<th>Question</th>
<th>Very Important</th>
<th>Important</th>
<th>Neutral</th>
<th>Unimportant</th>
<th>Very Unimportant</th>
</tr>
</thead>
<tbody>
<tr>
<td>How important do you believe accessibility of NRHA services and programs is to residents?</td>
<td>5</td>
<td>4</td>
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<tr>
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<td>1</td>
</tr>
</tbody>
</table>
In your opinion, what are the strengths of the NOR-MAN Regional Health Authority?
__________________________________________________________________________________

In your opinion, what are the weaknesses of the NOR-MAN Regional Health Authority?
__________________________________________________________________________________

From your physician perspective, what ideas / suggestions do you have to improve health service delivery in the NOR-MAN Regional Health Authority?
__________________________________________________________________________________

From your perspective, what do you believe are the top three (3) health issues in the NOR-MAN region?
__________________________________________________________________________________

From your perspective, what is preventing NOR-MAN residents from making healthy lifestyle choices?
__________________________________________________________________________________

In your opinion, what health issues need to be prioritized for action in the next five (5) years?
__________________________________________________________________________________

We would like to ask a few questions about you. We require this information to ensure that the survey results represent a broad cross-section of the NRHA Physicians.

Please check one response per question

Number of years of service in the NOR-MAN region?

Less than 1 year  □  1–10 years □  11–20 years □  21–25 years □  26+ years □

Physician type?

Contract □  Itinerant □  Fee-for-Service □  Other □

Physician Specialty? (please check all that apply)

Anesthesiology □  Internal Medicine □  Emergency Room □  Long Term Care □
Family Medicine □  Support Services □  General Surgery □  Psychiatry □
General Surgery □  Radiology □  Gynecology □

Home community?

Flin Flon □  The Pas □  Snow Lake □  Other □

Which age category are you in?

Under 24 years □  25–34 years □  35–44 years □  45–54 years □
45–64 years □

Gender

Male □  Female □
Please take a few minutes to complete the following staff survey. Your answers will assist the NOR-MAN Regional Health Authority in enhancing the Community Health Assessment Community Consultation Process. Your answers will be confidential and anonymous. **Deadline to respond is Friday February 26, 2010.**

**Key Instructions:**
- For questions involving scales, please circle only one answer from the scale for each statement. Please pay close attention to the scale types. **Agreement, satisfaction and importance scales have been used.**
- We are asking for **your opinion** on health system performance by the NOR-MAN Regional Health Authority.
- Throughout the survey the term “resident” is used to refer to those we provide services to.

<table>
<thead>
<tr>
<th>I believe that the NRHA is responsive to residents' health care needs.</th>
<th><strong>Strongly Agree</strong></th>
<th><strong>Modestly Agree</strong></th>
<th><strong>Agree</strong></th>
<th><strong>Mostly Disagree</strong></th>
<th><strong>Strongly Disagree</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I believe that when residents need health care services they know where to go.</th>
<th><strong>Very Satisfied</strong></th>
<th><strong>Satisfied</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Dissatisfied</strong></th>
<th><strong>Very Dissatisfied</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How satisfied do you feel residents are with the accessibility of NRHA services and programs?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How satisfied do you feel residents are with the friendliness of NRHA staff?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
</tr>
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<tbody>
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<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How satisfied do you feel residents are with the quality of NRHA services and programs?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
</tr>
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<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How satisfied do you feel residents are with the delivery methods of NRHA services and programs?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How satisfied do you feel residents are with the timeliness of NRHA services and programs?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall, how satisfied do you feel residents are with the NRHA?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How important do you believe accessibility of NRHA services and programs is to residents?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
</tr>
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<tbody>
<tr>
<td></td>
<td>5</td>
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<td>3</td>
<td>2</td>
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</tbody>
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<tr>
<th>How important do you believe friendliness of NRHA staff is to residents?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
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<td>2</td>
<td>1</td>
</tr>
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<th>How important do you believe the quality of NRHA services and programs is to residents?</th>
<th><strong>Very Important</strong></th>
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<th><strong>Unimportant</strong></th>
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<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

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<thead>
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<th>How important do you believe the delivery method of NRHA services and programs is to residents?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
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<td></td>
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<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How important do you believe the timeliness of NRHA services and programs is to residents?</th>
<th><strong>Very Important</strong></th>
<th><strong>Important</strong></th>
<th><strong>Neutral</strong></th>
<th><strong>Unimportant</strong></th>
<th><strong>Very Unimportant</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
In your opinion, what are the strengths of the NOR-MAN Regional Health Authority?
__________________________________________________________________________________

In your opinion, what are the weaknesses of the NOR-MAN Regional Health Authority?
__________________________________________________________________________________

From your perspective, what ideas / suggestions do you have to improve health service delivery?
__________________________________________________________________________________

From your perspective, what do you believe to be the top three (3) health issues in the NOR-MAN region?
__________________________________________________________________________________

From your perspective, what is preventing NOR-MAN residents from making healthy lifestyle choices?
__________________________________________________________________________________

In your opinion, what health issues need to be prioritized for action in the next five (5) years?
__________________________________________________________________________________

We would like to ask a few questions about you. We require this information to ensure that the survey results represent a broad cross-section of the NRHA partners.

**Please check one response per question**

<table>
<thead>
<tr>
<th>Which sector best describes your organization?</th>
<th>Health / Wellness</th>
<th>Service / No profits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justice / Protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ministerial / Church Groups</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many people are employed by the organization?</th>
<th>None</th>
<th>26 - 50 people</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less than 5 people</td>
<td>51 - 100 people</td>
</tr>
<tr>
<td></td>
<td>6 - 10 people</td>
<td>101 or more people</td>
</tr>
<tr>
<td></td>
<td>11 - 25 people</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which is your home community?</th>
<th>Cormorant</th>
<th>Cranberry Portage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easterville</td>
<td></td>
<td>Chemawawin CN</td>
</tr>
<tr>
<td>Grand Rapids</td>
<td></td>
<td>Misipawistik CN</td>
</tr>
<tr>
<td>Flin Flon</td>
<td></td>
<td>Snow Lake</td>
</tr>
<tr>
<td>Moose Lake</td>
<td></td>
<td>Mosakahiken CN</td>
</tr>
<tr>
<td>Pukatawagan</td>
<td></td>
<td>Mathias Colomb CN</td>
</tr>
<tr>
<td>Sherridon</td>
<td></td>
<td>R.M. of Kelsey</td>
</tr>
<tr>
<td>The Pas</td>
<td></td>
<td>Opaskwayak CN</td>
</tr>
<tr>
<td>Wanless</td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Creighton</td>
<td></td>
<td>Denare Beach</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which best describes your role in the organization?</th>
<th>Administration</th>
<th>Direct Service Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Management</td>
<td>Volunteer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What are your years of service in the organization?</th>
<th>Less than 1 year</th>
<th>11 - 20 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - 3 years</td>
<td>21- 25 years</td>
</tr>
<tr>
<td></td>
<td>4 - 10 years</td>
<td>26 or more years</td>
</tr>
</tbody>
</table>

Thank you for completing this staff survey.
NOR-MAN Regional Health Authority
Organizational Overview
2009 - 2010

Board of Directors
Marc Jackson, Chair Snow Lake
Vivian McKenzie, Vice Chair Cranberry Portage
John Marnock, Treasurer The Pas
Dan Davie, Director Wanless
Doris Habermann, Director Flin Flon
Ernie Hunt, Director Pukatawagan
Marie Jebb, Director Opaskwayak Cree Nation
Doug Lauvstad, Director The Pas
Stella Neff, Director Grand Rapids
Joan Niquanicappo, Director Opaskwayak Cree Nation
Gretta Redahl, Director Flin Flon
Allan Rivard, Director La Ronge, Saskatchewan
Doris Young, Director Opaskwayak Cree Nation

Senior Management
Drew Lockhart Chief Executive Officer
Dr. Lawrence Elliott Medical Officer of Health
Pat Bilquist, Executive Director Community & Long Term Care
Susan Lockhart, Executive Director Planning, Research & Development
Lois Moberly, Executive Director Clinical Services - Flin Flon General Hospital
Candice Rookes, Executive Director Clinical Services - St. Anthony’s
Corliss Patterson, Executive Director Communications / Public Relations
Wanda Reader, Executive Director Human Resources
Lil Rourke, Executive Director Finance & Support Services (CFO)
The NOR-MAN Regional Health Authority (NRHA) delivers a range of services through the following facilities: Flin Flon General Hospital, St. Anthony’s Hospital, Snow Lake Health Centre, St. Paul’s Residence, Northern Lights Manor, Flin Flon Personal Care Home, Rosaire House, Primary Health Care – The Pas, Primary Health Care – Flin Flon (two sites), Cranberry Portage Wellness Centre, Cormorant Health Care Centre, and Sherridon Health Care Centre.

NRHA services are delivered based on the following ten provincial core services:

- **Health Promotion / Education Services**
  - To support individuals and communities to improve their health

- **Health Protection Services**
  - To protect residents from exposure to preventable disease and to reduce the spread of communicable diseases

- **Prevention & Community Health Services**
  - To deliver effective community based interventions that can prevent health problems from arising and/or reduce their impacts on individuals, families and communities

- **Treatment, Emergency & Diagnostic Services**
  - To offer high quality, cost effective treatment, emergency and diagnostic services

- **Developmental and Rehabilitation Support Services**
  - To develop services that help people to live productive lives in their communities

- **Home-based Care Services**
  - To promote the independence of individuals who require in-home health services or supports and prevent institutionalization
● **Long Term Care Services**
  • To provide personal and extended care services and to ensure that residents of long term care facilities maintain and improve their quality of life

● **Mental Health Services**
  • Access to the full range of mental health services at a regional level, including wellness and prevention programs, community-based assessment and treatment, and in-patient treatment centre

● **Substance Abuse/Addictions Services**
  • To address the health related needs of young victims of FASD and prevent their occurrence and to intervene directly in the addictive process, access to a residential addiction centre

● **Palliative Care Services**
  • To provide care to people whose disease does not respond to curative approaches and to provide support to these individuals and their families during the end stages of illness

The NRHA has chosen to add Physician Services to our core service mandate:

● **Physician Services**
  • To recruit, hire and retain the number and type of physicians that are required to improve the health status of NOR-MAN residents

The NOR-MAN Regional Health Authority strives to deliver high quality programs and services throughout the region to ensure there will be "**Healthy People in Healthy Communities - Working Together to Improve Our Health**".

**NOR-MAN Regional Health Authority 2010 Bed Map by facility:**

**Flin Flon General Hospital**

- 42 Bed facility
  - 6 Obstetrical beds
  - 18 Adult Medical beds
  - 7 Pediatric beds
  - 8 Surgical beds
  - 2 Special Care Unit beds
  - 1 Palliative Care beds
St. Anthony’s General Hospital

- 40 Bed facility
  - 8 Psychiatric beds
  - 8 Obstetrical beds
  - 12 Adult Medical beds
  - 2 Pediatric beds
  - 5 Surgery beds
  - 3 Special Care Unit beds (1 unit currently closed)
  - 2 Palliative Care beds

Snow Lake Health Centre

- 6 Bed facility
  - 2 Acute Care beds
  - 4 Long Term Care beds

Flin Flon Personal Care Home

- 30 Bed Facility
  - Level III & IV

Flin Flon Northern Lights Manor

- 36 Bed Facility
  - Level III & IV
  - 1 Respite Care bed (included in total number of beds)

St. Paul’s Residence

- 60 Bed Facility
  - Level III & IV
  - 1 Respite Care bed (included in total number of beds)

Rosaire House

- 20 bed residential addiction centre
NRHA Acute Care Service:

<table>
<thead>
<tr>
<th>Service</th>
<th>Flin Flon General Hospital</th>
<th>St. Anthony’s General Hospital</th>
<th>Snow Lake Health Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Liaison/Interpretative Services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Diagnostic Imaging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Radiology</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Fluoroscopic Services</td>
<td></td>
<td>Itinerant</td>
<td></td>
</tr>
<tr>
<td>- Ultrasound</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- CT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>4 stations</td>
<td>8 of 10 stations (operational)</td>
<td></td>
</tr>
<tr>
<td>Emergency Services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Infection Control</td>
<td>✓</td>
<td>✓</td>
<td>Itinerant</td>
</tr>
<tr>
<td>Dietitian Services</td>
<td>✓</td>
<td>✓</td>
<td>Itinerant</td>
</tr>
<tr>
<td>Palliative Care Services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medicine</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Laboratory Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Transfusion Medicine</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Hematology including Coagulation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>- Chemistry including Urinalysis</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Microbiology</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- ECG</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Stress and Event recording</td>
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</tr>
<tr>
<td>- Holter Monitoring</td>
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<td></td>
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</tr>
<tr>
<td>Operating Room/Surgery</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- emergent surgery</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- elective surgery</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- day surgery</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>✓</td>
<td>✓</td>
<td>Itinerant</td>
</tr>
<tr>
<td>Psychiatric Unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Care Unit</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>✓</td>
<td>Vacant</td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Acupuncture – Pain Modality</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Respiratory Care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Social Work</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

2009/2010 NRHA Community Health Assessment
Appendix E - NRHA Service Overview
Page E - 4
## Patient Safety
- Patient Safety Education and Awareness Programs
- CI / CO Investigations
- Occurrence Reporting
- Med Reconciliation

## Spiritual Care

## MBTelehealth Services:
- Clinical Consultation
  - Surgery – pre-op
  - Surgery Follow-up
  - Dermatology
  - Oncology
  - Psychiatry/Mental Health
  - Wound Care
  - Pediatric Diabetes
  - FASD Assessments
  - Nutrition Assessments
  - Professional Education
  - Administration
  - Support for Patients, Families and Communities

## Northern Patient Transportation Program (NPTP) Office

## Medivac Services

### NRHA Emergency Medical Services

<table>
<thead>
<tr>
<th>NRHA Owned Ambulance Service</th>
<th>First Nation Owned Ambulance Service</th>
<th>Community Owned Ambulance Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flin Flon Station</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creighton</td>
<td>Serviced by Flin Flon</td>
<td></td>
</tr>
<tr>
<td>Denare Beach</td>
<td>Serviced by Flin Flon</td>
<td></td>
</tr>
<tr>
<td>Snow Lake</td>
<td>Station</td>
<td></td>
</tr>
<tr>
<td>Cranberry Portage</td>
<td>Station</td>
<td></td>
</tr>
<tr>
<td>Sherridon</td>
<td>Serviced by Cranberry Portage</td>
<td></td>
</tr>
<tr>
<td>The Pas</td>
<td>Station</td>
<td></td>
</tr>
</tbody>
</table>
NRHA Owned Ambulance Service | First Nation Owned Ambulance Service | Community Owned Ambulance Service
---|---|---
OCN | Serviced by The Pas |  |  
Cormorant | Serviced by The Pas |  |  
Grand Rapids | Station |  |  
Easterville | Station |  |  
Moose Lake | Serviced by The Pas |  |  
Pukatawagan | Air Ambulance only |  |  

NRHA Volunteer Services:

The following volunteer groups provide services in all NRHA Hospital facilities:

- Community Clergy - Pastoral Care Services
- Flin Flon Health Auxiliary - operates a Book lending program, and members volunteer as Telehealth Greeters
- The Pas Health Complex Health Auxiliary - operates a Gift Shop
- Snow Lake Health Auxiliary - operates a Second Hand Store

Types of Physician Services provided in the NOR-MAN Region:

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**NRHA Physicians**

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**Public Health Inspector:**

The following NOR-MAN communities receive Public Health Inspector Services through Manitoba Health & Healthy Living:

- The Pas
- Snow Lake
- Sherridon / Cold Lake
- Moose Lake
- Grand Rapids
- R.M. of Kelsey
- Flin Flon
- Cranberry Portage
- Cormorant
- Easterville
- Wanless
- Unorganized Territory

**NRHA District Health Councils (DHC) are active in the following communities:**

The NOR-MAN Regional Health Authority has seven active District Health Councils (DHCs) in the region. DHCs are an important link between the communities they...
represent and the NRHA Board of Directors and staff. The purpose of each District Health Council is:

✓ to advise and assist the NRHA Board on community health issues and concerns;
✓ to actively participate in local health initiatives;
✓ to be a liaison between their community and the NRHA.

Each of the following NOR-MAN communities has an active District Health Council.

| ✓ Flin Flon               | ✓ The Pas / OCN               | ✓ Snow Lake               |
| ✓ Snow Lake              | ✓ Easterville                |
| ✓ Cranberry Portage / Sherridon | ✓ Cormorant / Moose Lake     |

NRHA Primary Health Care Services:

The NOR-MAN Regional Health Authority delivers a wide range of community based programs and services referred to as “Primary Health Care”. Primary Health Care is the most appropriate health care by the most appropriate provider in the most appropriate setting. Primary Health Care provides an alternative to accessing health care services through the hospital or physicians’ office. The move to a primary health care model of service delivery will improve an individual’s access to services and programs to ensure they receive the very best quality of care, giving them more involvement in their own care and offer an alternate location for seeking the care they need. NRHA Primary Health Care programs and services are designed using a community development / harm reduction approach with a primary focus in health promotion and prevention.

The NRHA has four (4) multi-disciplinary client-centre teams:

- Infant/Child
- Men’s
- Youth/Women’s
- Seniors
NRHA Primary Health Care Services include but are not limited to the following programs and services:

(Chart Key: ✓ Primary Health Care staff provided service / ♦ physician provided service)

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NRHA Long Term Care Services

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<td>- Patient Safety Education and</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Awareness Programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- CI / CO Investigations</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Occurrence Reporting</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Med Reconciliation</td>
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</tbody>
</table>

**NRHA Quality Scorecard**

The NOR-MAN Regional Health Authority produces four Quality Scorecards yearly - Client/Community Focus, Responsiveness, System Competency and Worklife. These four components are the NRHA corporate “report card.” The NRHA Quality Scorecard reports on how our health system is doing (health system performance) and provides a vehicle for the board, management and staff to monitor health system performance based on priorities set by our Strategic Plan.

**NRHA Quality Scorecards (current and past) are available on our website at** [www.norman-rha.mb.ca](http://www.norman-rha.mb.ca). If you have any questions related to our NRHA Quality Scorecard data please do not hesitate to contact us:
NRHA Contacts

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NOR-MAN Regional Health Authority
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Telephone: 204-687-1338
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Website: [www.norman-rha.mb.ca](http://www.norman-rha.mb.ca)
QUALITY SCORECARD
VITAL STATISTICS - CLIENT/COMMUNITY FOCUS
March 2009

2009/2010 NRHA Community Health Assessment
Appendix F - NRHA Quality Scorecards - Client / Community Focus
Page F - 1
Quality Scorecard: Client / Community Focus
March 2009

Client / Community Focus

Communicatio
- Communication CQI Initiatives
- Annual General Meetings Held
- Info to access NRHA services
- Listing of NRHA documents
- Complaint Mgmt Process

Confidentialitat
- Management of Confidentiality
- Security of Info & Data

Participation and
- District Health Councils
- NRHA Partnerships
- Grants obtained in Partnerships
- Informed Consent

Respect & Caring
- Respect for Cultural Beliefs
- Respect for Spiritual Needs
- Client Input Page 17
- Needs of Dying Clients Met

Involvement in Community
- Improving Health of Environment Page 21
- Plan for Managing Health Hazards

NOR-MAN Regional Health Authority Quality Scorecard: Client / Community Focus

Colour Codes: ☐ Optimal; ☐ Good/ Ongoing CQI; ☐ Warning/Room for Improvement; ☐ Trouble/ Extensive Work Req’d; ☐ In Development

2009/2010 NRHA Community Health Assessment
Appendix F - NRHA Quality Scorecards - Client / Community Focus
Page F - 2
QUALITY SCORECARD

VITAL STATISTICS ON RESPONSIVENESS

October 2009

What EMS responded to in 2008?
% EMS Calls by Injury/Illness

<table>
<thead>
<tr>
<th></th>
<th>Medical</th>
<th>Falls</th>
<th>Violence</th>
<th>Motor Vehicle</th>
<th>Other</th>
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<tbody>
<tr>
<td>Grand Rapids</td>
<td>71%</td>
<td>5%</td>
<td>3%</td>
<td>14%</td>
<td>7%</td>
</tr>
<tr>
<td>Cranberry</td>
<td>65%</td>
<td>11%</td>
<td>6%</td>
<td>6%</td>
<td>8%</td>
</tr>
<tr>
<td>Portage</td>
<td>69%</td>
<td>14%</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>The Pas</td>
<td>70%</td>
<td>8%</td>
<td>8%</td>
<td>6%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Saskatchewan Residents

ER Visits - 2008/09

Discharges - 2008/09

Newborns - 2008/09

Where NOR-MAN Residents Access Hospital Services?

Inpatient Cases - 2007/08

Inpatient Days - 2007/08

Hospital Discharges

Newborn Bed Occupancy Rates

Hospital Bed Occupancy Rates

2009/2010 NRHA Community Health Assessment
Appendix F - NRHA Quality Scorecards - Responsiveness
Page F - 3
Quality Scorecard: Responsiveness
October 2009

Responsiveness

Client Satisfaction
- PCH Satisfaction
- Mental Health Satisfaction
- Acute Care Satisfaction
- Rosaire House Satisfaction
- Home Care Satisfaction
- Palliative Care Satisfaction
- Support Services Care Satisfaction
- Primary Health Care Satisfaction

Availability
- % Inpatient services provided in the region
- NPTP Travel by Physician Specialty
- NPTP Travel by Diagnostic Category
- Telehealth Unavailability
- % scheduled DER Client Days Cancelled
- % Attendance DER appointment/session
- Primary Health Care Utilization

Accessibility
- % residents receiving Chemo in region
- % Home Care Requests
- CT Utilization
- Retinal Screening Referrals
- Average Length of Stay

Timeliness
- Access to Dialysis in region
- Itinerant Clinic Days
- Retinal Screening Referrals
- EMS Response Averages
- Average Length of Stay

Continuity
- Average Wait Times
- Rosaire House Utilization
- Home Care On Call
- Senior Management On Call
- % Clients Breastfeeding at 4 months

Colour Codes: □ Optimal; □ Good/ Ongoing CQI; □ Warning/Room for Improvement; □ Trouble/ Extensive Work Req’d; □ In Development

2009/2010 NRHA Community Health Assessment
Appendix F - NRHA Quality Scorecards - Responsiveness
Page F - 4
**QUALITY SCORECARD**

**Vital Statistics on System Competency**

**December 2009**

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**NOR-MAN RHA Board of Directors**

Marc Jackson, Chair (Snow Lake)

Vivian McKenzie, Vice Chair (Cranberry Portage)

John Marnock, Treasurer (The Pas)

Daniel Davie (Wanless)

Doris Habermann (Flin Flon)

Ernie Hunt (Pukatawagan)

Marie Jebb (OCN)

Doug Lauvstad, (The Pas)

Stella Neff (Grand Rapids)

Joan NiquiNappo, (OCN)

Gretta Redahl (Flin Flon)

Allan Rivard (La Ronge)

Doris Young (The Pas)

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nrha@normanrha.mb.ca

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**NOR-MAN RHA MISSION**

**Healthy People in Healthy Communities**

**“Working Together to Improve Our Health”**

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**VALUES**

- Dynamic, innovative, realistic, inclusive and stable leadership.
- Honesty, respect, truthfulness and effective, open communication with those we work with and serve.
- Informed choices for people and personal responsibility for health, wellness & safety.
- Being responsive to the unique needs of individuals & communities;
- A fundamental quest for excellence in all facets of the organization;
- The person’s right to informed, participatory decision making;
- The person’s right and need for confidentiality of information;
- Innovative, cost-effective approaches in an evidence-based environment;
- Proper accountability and prudent expenditure of public funds; and
- Personal and professional growth and development for Board and staff to meet emerging challenges.

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**Board Ends & Strategic Priorities**

The NRHA Board of Directors has set out 4 Board Ends and related Strategic Priorities for the NRHA:

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**HEALTHY COMMUNITIES**

- Increased public awareness of health care services.
- Increased resident involvement in activities that promote healthy lifestyles & personal well-being.
- Increased awareness of illness caused by physical environmental factors.
- Increased culture of trust, cooperation and strong partnerships with Aboriginal groups, community agencies & other jurisdictions responsible for health.
- Increased understanding of regional health needs.

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**OPTIMAL ACCESS TO SERVICES**

- Increased on-site resources in our outlying communities.
- Improved access to services through Primary Health Care.
- Increased knowledge of Primary Health Care.
- Increased specialty services and programs based on demonstrated need & cost effectiveness.
- Maintenance & improvement to our infrastructure.
- Increased use of technology.
- Increased awareness of NPTP.
- Reduced jurisdictional barriers to improve access to services

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**HEALTHY PEOPLE**

- Decreased incidence & prevalence of chronic illnesses (including but not limited to Diabetes, tobacco-related illness, Cancer, Cardiovascular, Renal).
- Increased awareness of Mental Health and Co-occurring Disorders Initiative (CODI) and expansion of services accordingly.
- Reduced incidence of suicides.
- Decreased incidence & prevalence of addictive practices and behaviors.
- Improved infant/child/ youth health & promotion of healthy lifestyles.
- Reduced incidence of injuries & poisonings.
- Improved women’s health & promotion of healthy lifestyles.
- Improved men’s health & promotion of healthy lifestyles.
- Improved senior’s health & promotion of healthy lifestyles.
- Improved Aboriginal health & promotion of healthy lifestyles.
- Improved staff health & promotion of healthy lifestyles.

---

**EXCELLENCE IN PATIENT SAFETY & QUALITY OF CARE**

- Ensure safety and quality of care by:
  - Creating a culture of patient safety;
  - Coordinating services across the continuum; and
  - Creating a work life and physical environment that supports the safe delivery of care.
- Ensure accountability within the health system.
- Ensure evidence-based decision-making is used throughout the organization.
- Ensure sustainability within the health system by:
  - Optimizing the efficiency and effectiveness in the use of resources;
  - Ensuring an adequate and skilled workforce; and
  - Developing northern Human Resources.

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2009/2010 NRHA Community Health Assessment

Appendix F - NRHA Quality Scorecards - System Competency

Page F - 5
Quality Scorecard: System Competency
December 2009

System Competency

Appropriateness
- C-Section Rates

Effectiveness
- Immunization Rates
- Cervical Screening Rates
- Staff Training Indicator
- Occurrence by Type of Event

Competence
- Mobile Breast Screening Rates
- Occurrence by Category
- Miscellaneouss Occurrences
- Culture of Patient Safety Survey Results

Safety
- Readmission Rates
- Healthcare Associated Infection Rates
- Fall Occurrence by Sector
- FIPPA Requests

Legitimacy
- Telehealth Utilization Rates
- Occurrence by Facility

Efficiency
- Mammography Screening Rates
- Total Direct Costs
- ER Operating Costs

System Alignment
- Mobile Breast Screening Rates
- Dialysis Total Direct Costs
- ER Operating Costs
- FIPPA Requests

Colour Codes:
- Optimal
- Good/ Ongoing CQI
- Warning/ Room for Improvement
- Data Limitations
- Trouble/ Extensive Work Req’d
- In Development

NOR-MAN Regional Health Authority Quality Scorecard: System Competency

2009/2010 NRHA Community Health Assessment
Appendix F - NRHA Quality Scorecards - System Competency
Page F - 6
QUALITY SCORECARD
WORKING LIFE: VITAL STATISTICS
(April 1, 2008 to March 31, 2009)
FEBRUARY 2010

% UNIONIZED STAFF

Regional Staffing Profile

% WORKFORCE SELF-DECLARED ABORIGINAL

PHYSICIAN PROFILE
(As of January 2010)

Physician Type | The Pas | Flin Flon | Snow Lake
---|---|---|---
GP | 9 | 6 | 2
GP/ Surgeon | 1 | 0 | 0
GP/ OBS | 1 | 1 | 0
GP/ Anesthesia | 0 | 2 | 0
Radiology | 1 | 0 | 0

Regional Physicians:
*Internal Medicine -1
*Psychiatry -1
*Medical Officer of Health -1

Average Age of Employees
NRHA = 45.42 years
MB Healthcare Average = 43.89 years

Average Years of Service
NRHA = 9.6 years
MB Healthcare Average = 9.17 years

Perfect Attendance Award 2006
33 employees = 4.7%
700 eligible employees

Avg. Vacation/Employee = 4.92 weeks

Regional Retirement Profile
116 potential retirements = 11.8%
975 eligible employees

Volunteer Hours = 3,288
(Flin Flon & The Pas)
Accreditation Canada

1. The organization adopts client safety as a written, strategic priority or goal.

2. The organization develops and implements a plan and process to assess client safety issues within the organization, and to carry improvement plan

3. The organization has established a reporting system for actual and potential adverse events that meets any applicable legislation and includes a no-blame culture of reporting, an appropriate follow-up.

4. The organization has a formal and transparent policy and process of disclosure of adverse events to patients/ families, including support mechanisms for patients, family and care/services providers.

5. The organization carries out one client safety-related prospective, analytic process per year (e.g. FMEA) and implement appropriate improvements/ changes.

6. The Organization monitors client safety using the “Patient Safety Culture Instrument”

7. Provide quarterly reports to the Board on patient/ client safety, including changes/ improvements following incident investigation & follow-up.

8. Inform and educate patients/ clients and/or family about their role in patient safety, using both written and verbal communication.

9. Employ effective mechanisms for transfer of information at interface points, including shift changes, discharge, and patient/ client movement between health care services and sectors; and implement improvements

10. Implement verification processes & other checking systems for high risk care/ service activities, including ordering & receiving results of critical tests; administering surgical or other invasive procedures; diagnostic testing; medication use; and implement improvements.
11. Reconcile the patient’s/ client’s medications upon admission to the organization, and with involvement with the recipient of the patient/client.

12. Reconcile medications with the patient/ client at referral or transfer, and communicate the patient’s/ client’s medications to the next service provider of service at referral or transfer to another setting, service, service provider, or level of care within or outside the organization.

13. Remove concentrated electrolytes (including, but not limited to potassium chloride, potassium phosphate, sodium chloride>0.9%) from patient/ client care units.

14. Standardize and limit the number of drug concentrations available in the organization.

15. Provide ongoing, effective training for service providers on all infusion pumps.

16. Deliver at least one annual education/ training on patient safety to all staff, including targeted patient safety focus areas within the organization.

17. Delineate clearly the roles, responsibilities and accountabilities of staff and other providers for patient/ client care and safety.

18. Implement an effective preventative maintenance program for all medical devices, equipment and technology.

19. Adhere to federal and/or provincially-developed infection control guideline such as Health Canada’s Infection Control Guidelines: Hand washing, Cleaning, Disinfection and Sterilization in Health Care.

20. Deliver education and training for staff, other providers and volunteers on hand washing/ hygiene.

21. Monitor infection rates and share this information throughout the organization.

22. Examine, and where indicated, improve processes for sterilization of equipment and facilities.
23. Implement and evaluate a falls prevention strategy to minimize the impact of client falls.

24. Use at least 2 client identifiers prior to the provision of any service or procedure.

25. Develop and implement an organizational policy and protocol for administration of the influenza vaccine.

26. Develop and implement an organization policy and protocol for administration of the pneumococcal vaccine.
Sample Size

- 1763

Physical Activity

- 51% of female students and 63% of male students participate in the recommended amount of physical activity
- 63% of students are activity in grade 9, but the physical activity rate decreases to 49% by grade 12
- Students are most active after school followed by at lunch

Nutrition

- Only 7% of students in NOR-MAN eat the recommended servings of fruits and vegetables per day (males and female % is the same)

Body Mass

- 63% of males and 68% of females fall within the recommended height weight category
- 52% of males and 49% of females students perceive their body weight as healthy

Smoking

- 33% of males and 41% of female students in grades 9 – 12 reported that they are current smokers
- 14% of students in grades 6 to 8 smoke and this rate increasing to 37% of students in grades 9 to 12
- 38% of males and 42% of females have plans to quit smoking sometime in the future

Alcohol and Illegal Drugs

- 44% of grade 9 students had a least one drink of alcohol in the last 30 days, but this increases to 75% of grade 12 students
- 28% indicated that they had 5 or more drinks of alcohol within a couple of
hours on at least one of the past 30 days
- 22% of students used illegal drugs in the past 30 days.
- 29% of grade 9 students used illegal drugs in the last 30 days, but this increases to 32% of grade 12 students

School Connectedness

- 66% of students feel close to people at their school
- 69% of students feel they are part of their school
- 66% of students are happy to be at their school
- 67% of students feel safe in their school
- 45% of students stated that they have felt so sad or hopeless in the past 12 months that they stopped doing some usual activities for a while