

NOR-MAN Regional Health Authority



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,

A handwritten signature in blue ink, appearing to read 'V. McKenzie', written in a cursive style.

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 be 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,

A handwritten signature in black ink, appearing to read 'A. Lockhart', written in a cursive style.

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
- Tanis Campbell, Regional Care Advocate, Men's Team
- Don Gamache, Regional Community Health Developer
- Deanna Johnson, Regional Community Health Developer
- Fran Labarre, Regional Community Health Developer
- Christa McIntyre, Regional Community Health Developer
- Lesa Nordick, Regional Community Health Developer
- Jamie Simard, Decision Support, Administrative Data 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

- Corliss Patterson
- Pat Bilquist
- Tanis Campbell

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 or call Catherine Hynes at (204) 687-1338.

Principal Authors:

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Regional Manager, Decision Support

Susan Lockhart
Executive Director, Planning, Research and
Development

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

Teal Boxes - represent definitions



Teal Call Outs - comparisons from the last CHA



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 tell 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.

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

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.



NRHA DISTRICTS

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 3 - What does the NOR-MAN region look like?

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

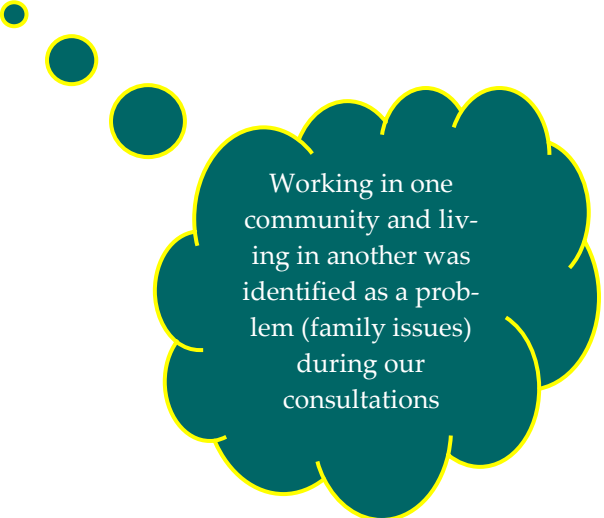
- District I
Flin Flon
Cranberry Portage
Snow Lake
- District II
The Pas
Opaskwayak Cree Nation (CN)
Rural Municipality (RM) of Kelsey
- District III
Cormorant
Sherridon / Cold Lake
Easterville
Chemawawin Cree Nation (CN)
Grand Rapids
Misipawistik Cree Nation (CN)
Moose Lake
Mosakahiken Cree Nation (CN)
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



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

- 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


- 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.

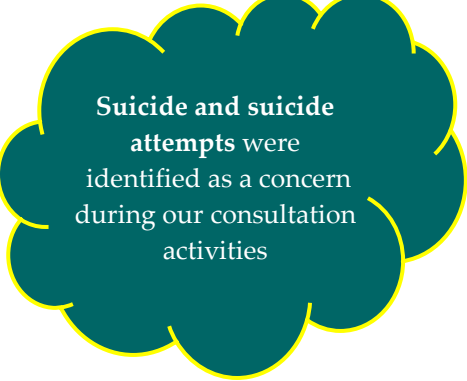
Chapter 5 - How Healthy are the people of the NOR-MAN region?

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)



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

- 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 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**


- 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

The top diseases of concern identified by our staff, physicians and partners were:


- Diabetes
- Obesity
- Heart Health
- Cancer
- Mental Health

Heart Health was identified as a major health concern during all our consultation


Diabetes was identified as health concern during all our consultation



Cancer was identified as a major health concern during all our consultations



Lack of recreational opportunities was identified as a concern during our consultations



Mental health issues were identified as health concern during all our consultation

- **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%**






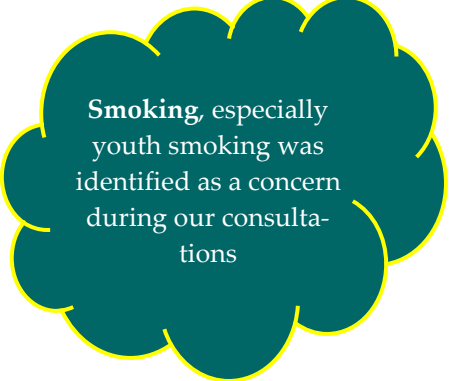
Limited housing options was identified as a concern during our consultations

- 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
- 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**



Teen pregnancy was identified as a concern during our consultations



Smoking, especially youth smoking was identified as a concern during our consultations



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

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

- 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**) than 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

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%**




Lack of access to physician services was identified by most communities during our consultation activities



Costs related to seeing a Specialist - especially if required to travel to Winnipeg identified as a concern during our consultation

- 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

Communication Focus Groups:

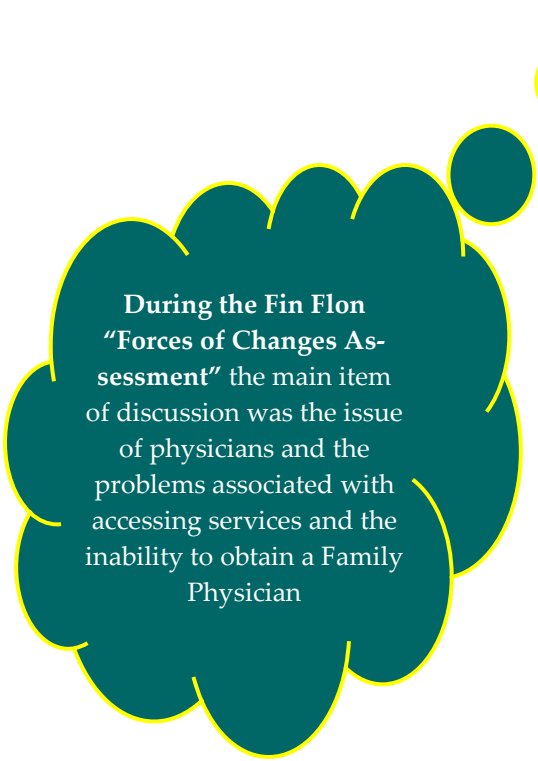
- Regular All Staff Meetings
- Email Notice of New Hires
- Access to Email Off-Site
- Groupwise Directory Update
- NRHA IntraNet.

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



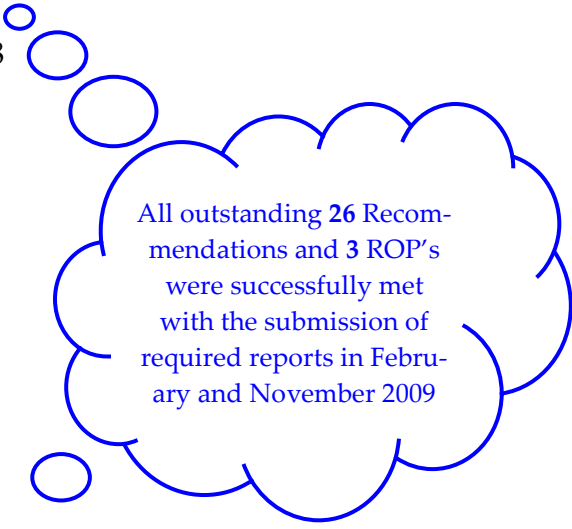
During the Fin Flon
“Forces of Changes Assessment” the main item of discussion was the issue of physicians and the problems associated with accessing services and the inability to obtain a Family Physician

- 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

- 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 participate 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

- 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 **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 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.”**

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Chapter 1

What is a Community Health Assessment?

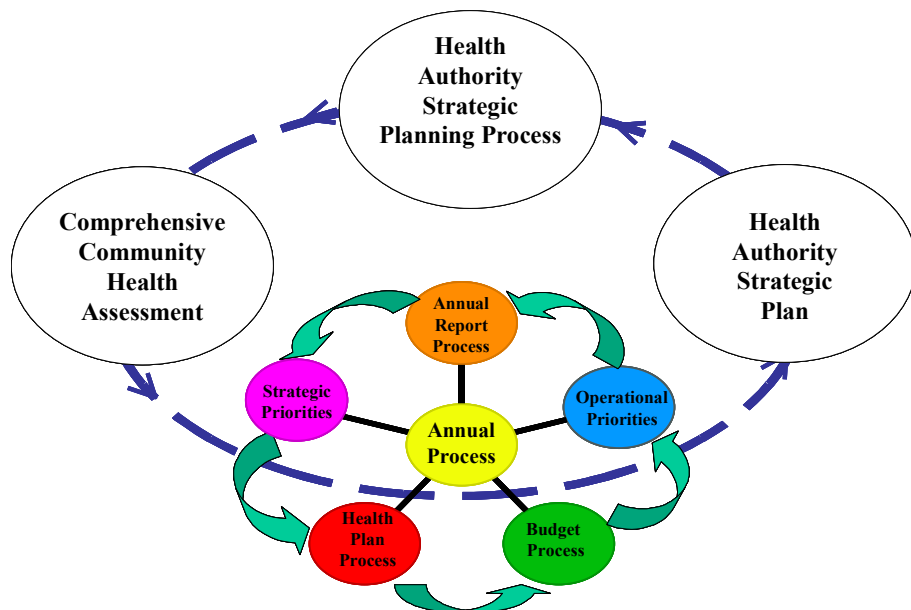
Our Community Health Assessment is the cornerstone to all planning in the region. According to Manitoba Health's *Community Health Assessment Guidelines, 2009*, a well-planned and thorough Community Health Assessment (CHA) will provide health authorities with evidence required to set priorities, choose 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.

Five Year - Health Planning Cycle



YEAR 1 - YEAR 5

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.

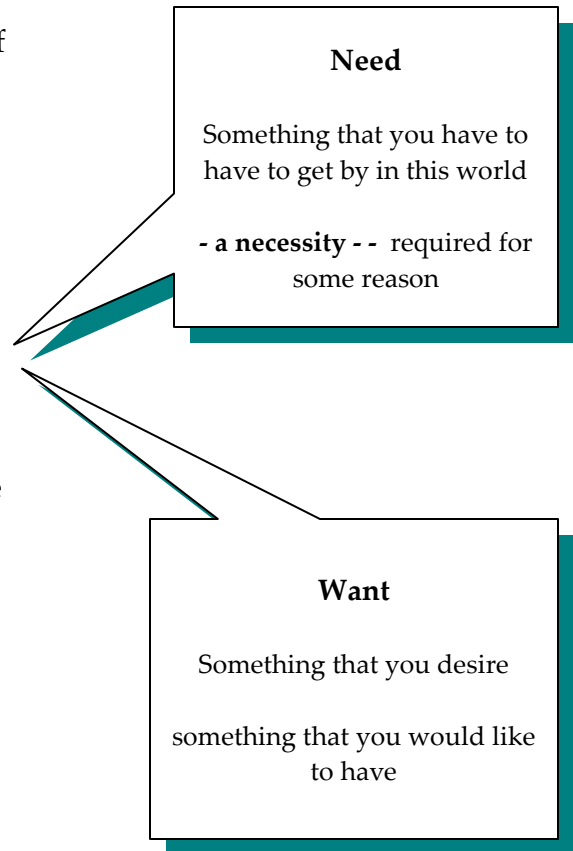
A joint **facts-based** method that gives direction to long-term health planning.

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 of 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.

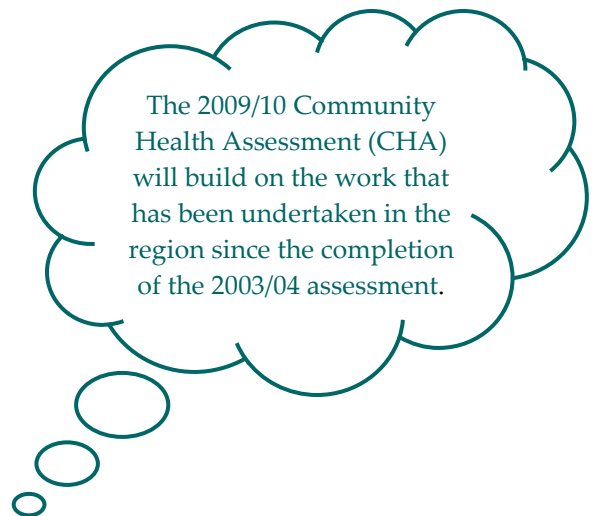
The role of CHAN is intended for Manitoba Health and the RHA's to work together to coordinate a standardized Community Health Assessment (CHA) process for Manitoba. Over the past several years, CHAN has been building

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.

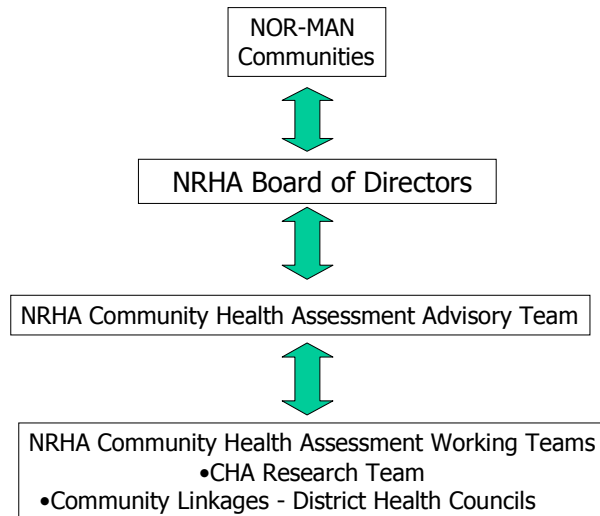
Our process was built on the premise that for a Community Health Assessment to be successful, it should not be done in isolation and needs to be done with the community rather than to the community.

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



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:

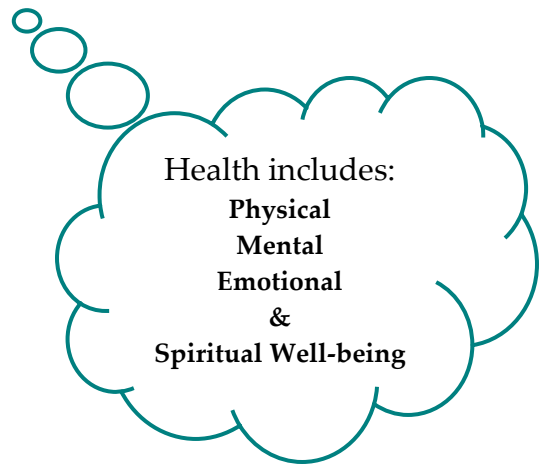
- To provide a third baseline of information from which the NRHA can compare and contrast health status changes over time
- To present initial findings to community residents and other stakeholders in order to better understand reasons for health status changes and potential new emerging health care 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)
 - Manitoba Child Health Atlas Update (2008)
 - What Works? A First Look at Evaluating Manitoba's Regional Health Programs and Policies at the Population Level (2008)
 - 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)
 - Manitoba Population Report (2009)
 - Manitoba Provincial Injury Data Report (2009)
 - H1N1 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)
-

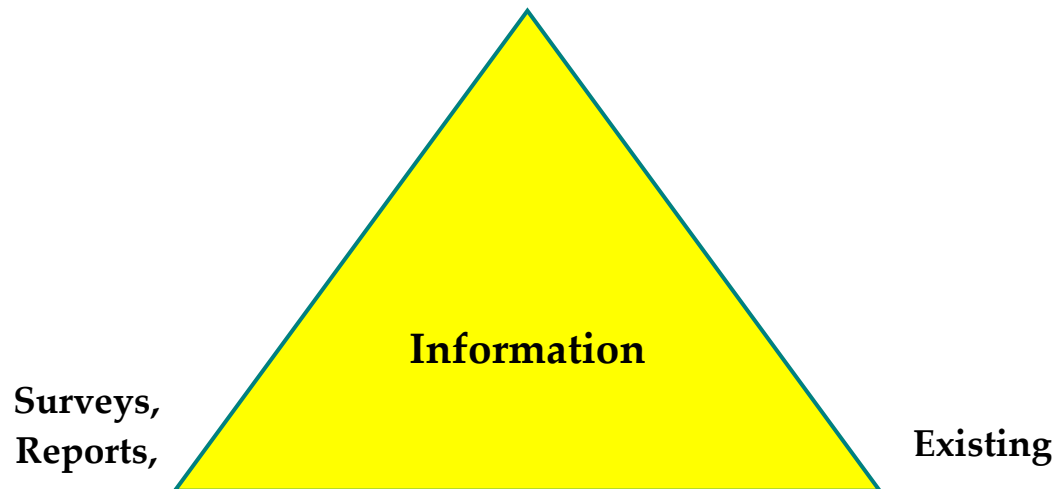
- **Health System Performance and Health Priorities Partners Survey** - was distributed to 168 partner organizations - (33% response rate)

(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.”**

Chapter 2

Who is the NOR-MAN Regional Health Authority?

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

- Executive Director, Community and Long Term Care
- Executive Director, Finance and Support Services
- Executive Director, Planning, Research and Development
- Executive Director, Human Resources
- Executive Director, Communications
- Medical Officer of Health
- Executive Director, Clinical Services, Flin Flon General Hospital
- Executive Director, Clinical Services, St. Anthony's General Hospital

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.



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



All Primary Health Care Services are coordinated through four (4) multi-disciplinary teams:

1. Infant/Child
2. Women/Youth
3. Men
4. Seniors

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

St. Anthony's Hospital has an **eight (8) bed** Psychiatric Inpatient Unit

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

The Pas has a **20 bed** residential Addictions centre - Rosaire House

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

Flin Flon has **65 Long Term Care beds** and **1 Respite bed**
The Pas has **59 Long Term Care beds** and **1 Respite bed**
Snow Lake has **4 Long Term Care beds**

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

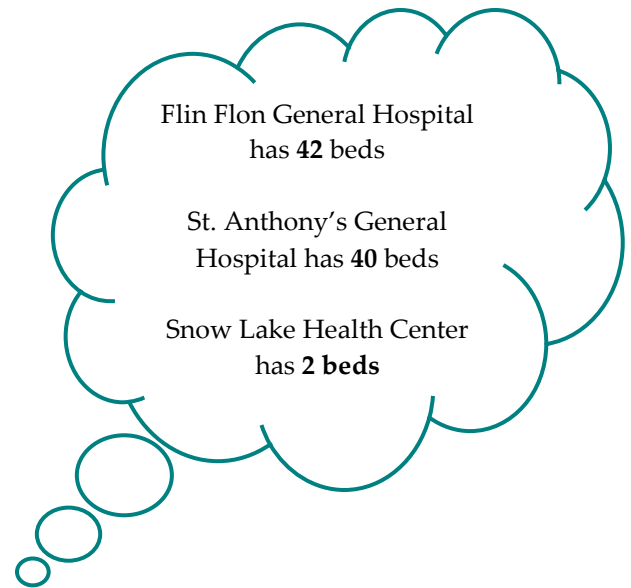
We publish a NRHA Services Overview document annually which provides a comprehensive listing of NRHA services and programs offered by service area and community.

(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:



NRHA **Acute Care** Services include the following:

Acute Inpatient Units (Medical, Pediatric, Surgical)
Aboriginal Services
Chemotherapy
Dialysis
Emergency Department/ Special Care Unit
Infection Control/ Staff Health
Dietitian Services
Laboratory Services
Medivac Services
NPTP
Palliative Care
Pharmacy Services
Physiotherapy
Psychiatric Unit
Obstetrics
Occupational Therapy
Operating Room/ Surgery
Respiratory Therapy
Social Work
Spiritual Care
Telehealth

NRHA 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

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

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

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 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.

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 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.

The NOR-MAN region covers a vast area of land spanning approximately 72,000 square kilometers in the central western part of the province.

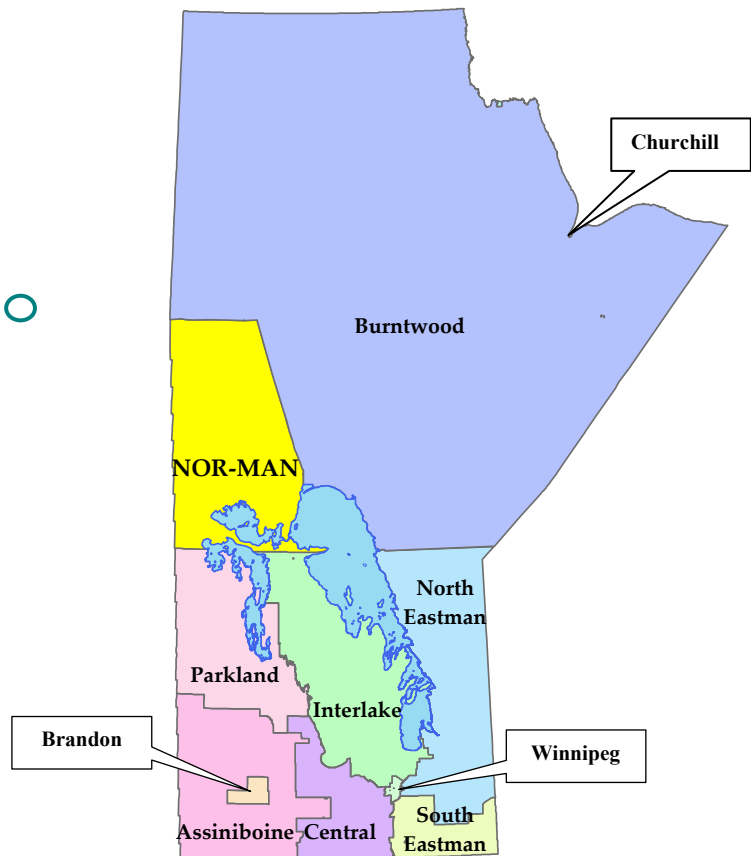


Figure 3.1 Manitoba Regional Health Authorities
Source: RHAM (Regional Health Authorities of Manitoba)

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.



Figure 3.2 Northern Regional Health Authority Regions
Source: Manitoba IGA, Community Profiles

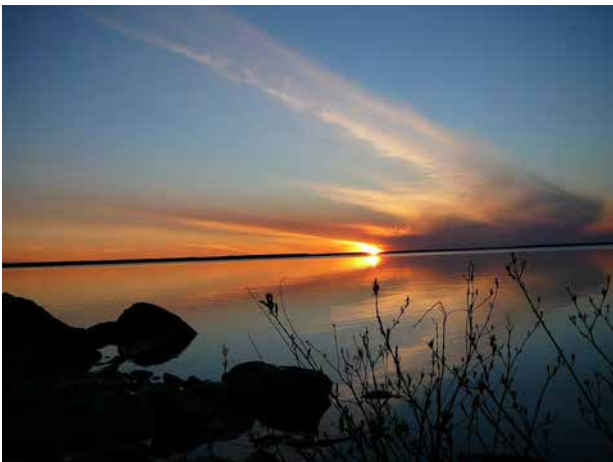
The NOR-MAN RHA region extends from Grand Rapids and Misipawistik Cree Nation in the southeast to Flin Flon in the west to Pukatawagan/Mathias Colomb Cree Nation in the north. The Mamawetan Churchill River Health Region is our neighbor to the west along the Manitoba/Saskatchewan border. Figure 3.3 shows 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.

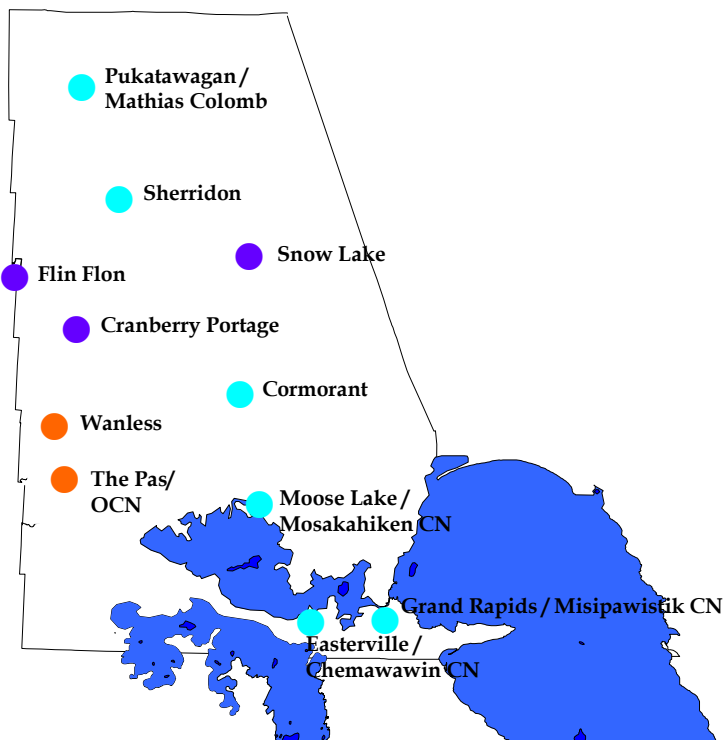


Figure 3.4 NOR-MAN Regional Health Authority Districts by Community
Source: NOR-MAN Regional Health Authority

NOR-MAN Communities

The NRHA region has three distinct types of communities: (1) First Nations Communities; (2) 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.

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

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.

In August 2007
Cranberry Portage
became the home of
the World's Largest
Tipi at approximately
2800 square feet

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.

The Chemawawin Cree Nation is a signatory to Treaty 5 signed in 1875

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





of city in 1970. A Mayor and Council govern the City of Flin Flon.

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 work force 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.

Population statistics for Flin Flon include:
5,594 Manitoba residents and 242 Saskatchewan residents

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.

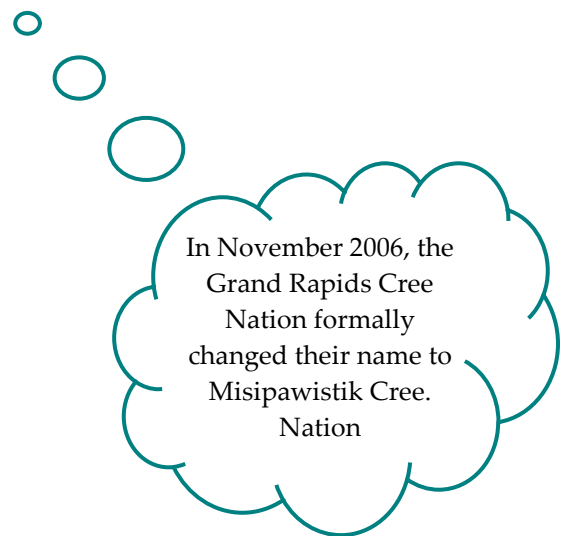
Geographically, Grand Rapids and Misipawistik Cree Nation are adjacent to one another, separated by the Saskatchewan River, on the north western shore of Lake Winnipeg, downstream from Manitoba Hydro's Grand Rapids hydroelectric station.

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.





Mosakahiken Cree Nation is a signatory to Treaty 5 signed in 1875

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.

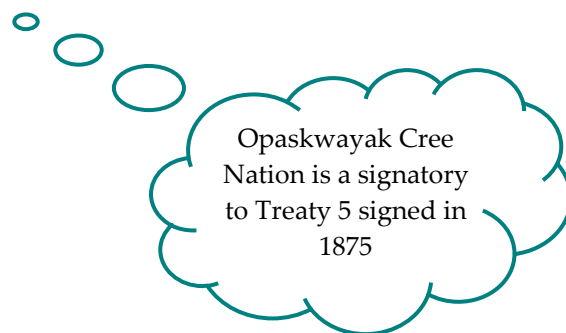
Pukatawagan/Mathias Colomb Cree Nation

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 Omnitrac), 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



Carrot Valley produces on average 800,000 bushels of grain



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.

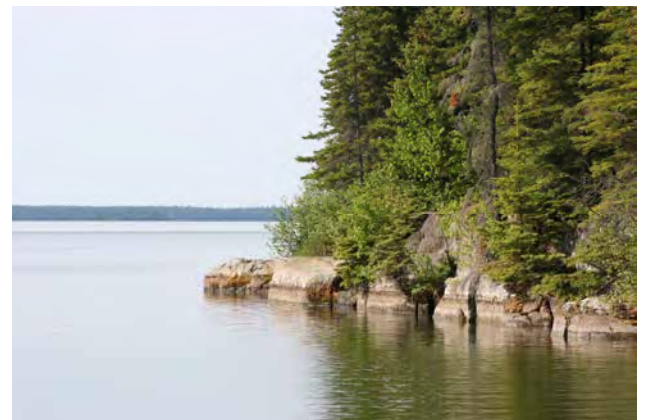
Wanless is a small village of 194 people (Statistics Canada, 2006 Census), that is located approximately 50 kilometers north of the Town of The Pas. Situated on the shores of Rocky Lake, are also homes to both year round and summer cottages of people who appreciate the great outdoors.

Sherridon/Cold Lake

Sherridon/Cold Lake is located on Kississing Lake, north of the 54th 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.

Lalor Lake deposit is believed to be the largest VMS deposit found in the region to date

Snow Lake

Snow Lake is a mining community situated mid-way 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.**

NRHA DISTRICTS

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)

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

Table 4.1 NOR-MAN RHA Population Trends
Source: Manitoba Health, Population Report – June 2008

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.

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)

NOR-MAN Aboriginal Profile

Figure 4.1 show 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%.

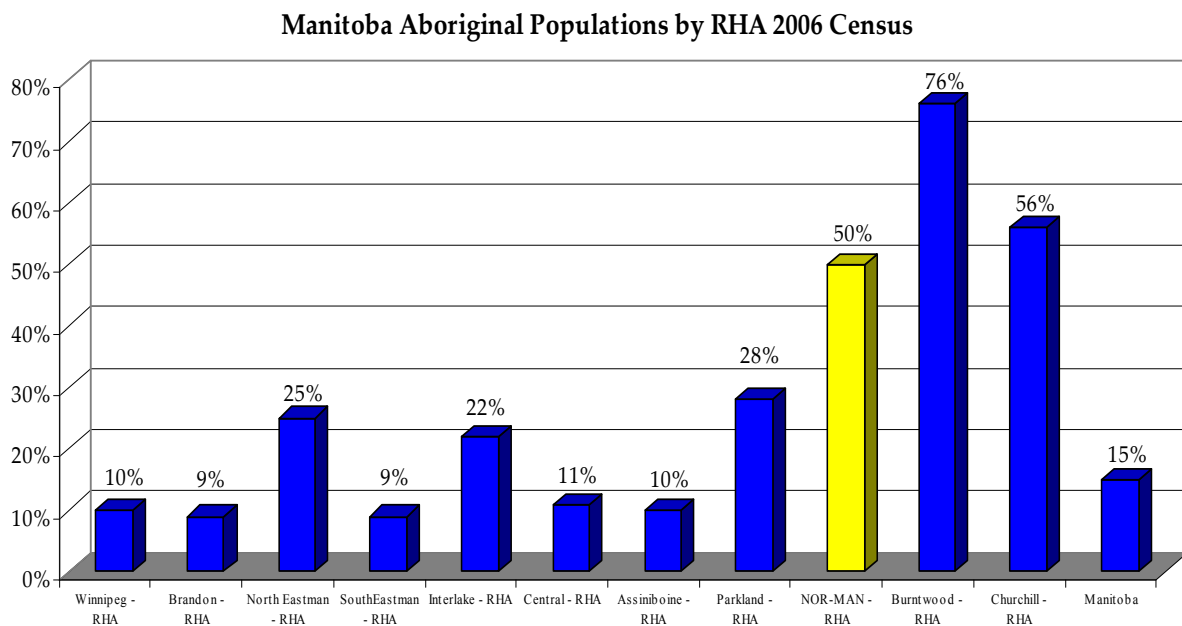


Figure 4.1: Provincial Aboriginal Population Percentages by RHA, 2006 Census
 Source: Manitoba Health, NRHA Profile Document, 2008/09

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%

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

(Department of Indian Affairs and Northern Development)

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

(Department of Indian Affairs and Northern Development)

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)

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.

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

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

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

Table 4.3: Registered Indian Populations by Type of Residence, 2006
Source: 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.

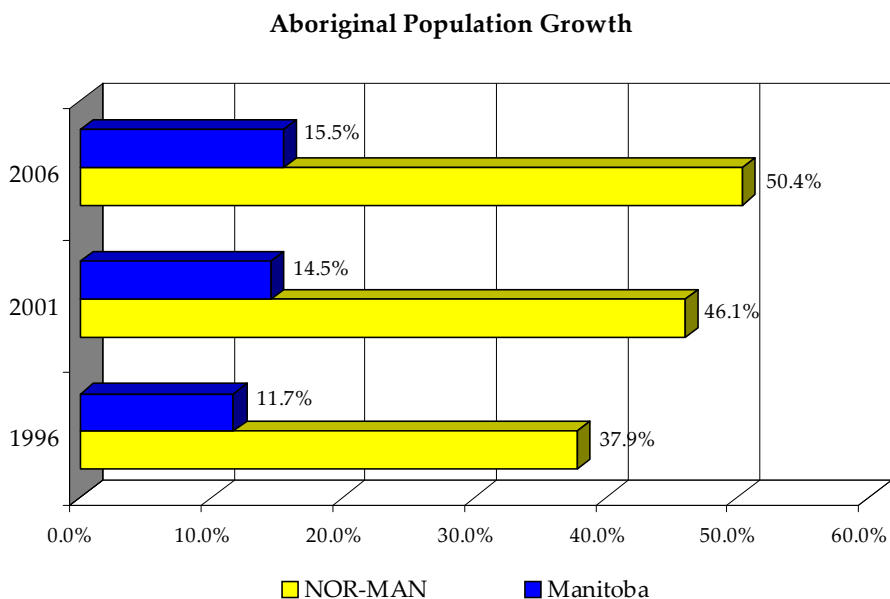


Figure 4.2: Provincial Aboriginal Population Percentages, 2006 Census
Source: Manitoba Health, NRHA Profile Document, 2008/09

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)

Since our last CHA report: the registered Métis population in the NOR-MAN region has increased from 2,764 or 11% to 3,157 or 13%.

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

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

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

Northeastern Saskatchewan residents account for 38% of ER visits, 53% of hospital discharges and 68% of newborns delivered

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.

Community	Population Numbers	Community	Population Numbers
Flin Flon, SK	305	Pelican Narrows	2121
Creighton	1784	Sandy Bay	1287
Denare Beach	840	Peter Ballantyne Cree Nation	1925
Sturgeon Landing	60	Totals	8322

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%).**

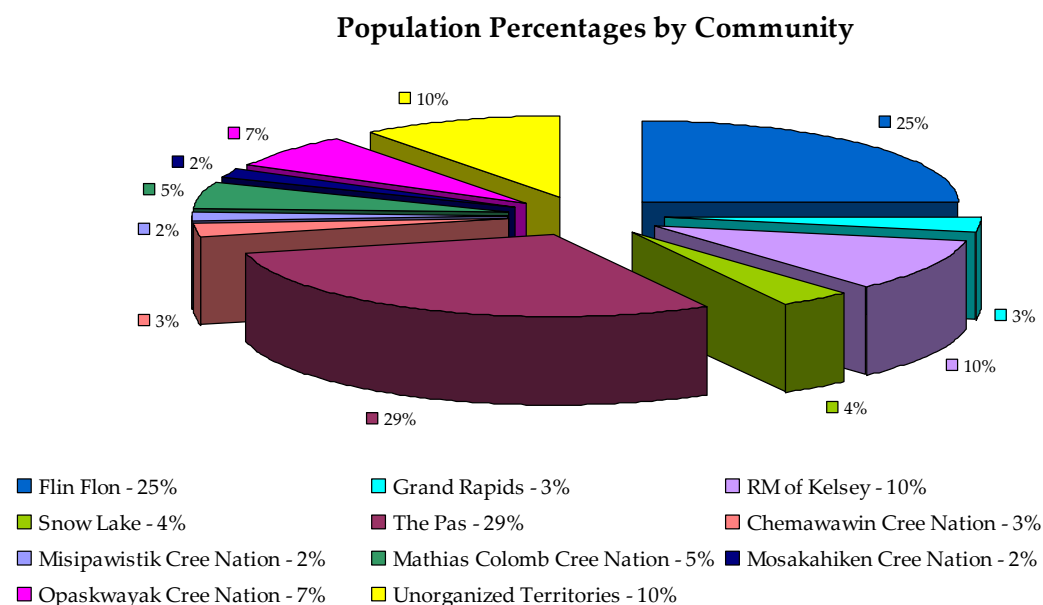


Figure 4.3: NOR-MAN Population Percentages by Community
Source: Manitoba Health Population Report - June 2008

Population Density

refers to the number of people living in a square kilometer of a particular region.

(Manitoba Health)

In short, we have less people living in our region - meaning more square kilometers per person

Our district level service area coverage is:
 District I = 2,684 km²
 District II = 1,159 km²
 District III = 37,628 km²

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 km². Excluding water, our service area coverage is approximately 41,471km².

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 km² in 2006.

RHA	Population Density			Population		
	1996	2001	2006	1996	2001	2006
Manitoba	2.09	2.11	2.15	1,144,643	1,152,982	1,178,457
Burntwood	0.13	0.13	0.14	44,229	44,806	46,163
NOR-MAN	0.61	0.60	0.59	25,401	25,012	24,340
Parkland	1.51	1.46	1.43	44,150	42,551	41,725
N. Eastman	0.94	0.97	0.99	38,093	39,320	40,157
Assiniboine	2.08	2.01	1.94	73,360	70,957	68,375

Table 4.6: Population Density

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

RHA	Population Density			Population		
	1996	2001	2006	1996	2001	2006
District I	3.47	3.19	2.89	9,320	8,560	7,754
District II	9.66	9.52	9.33	11,193	11,027	10,806
District III	0.13	0.14	0.15	4,888	5,425	5,780

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 a rural area - a rural population is defined as having a minimum of 400 people per square kilometer

(Manitoba Health)

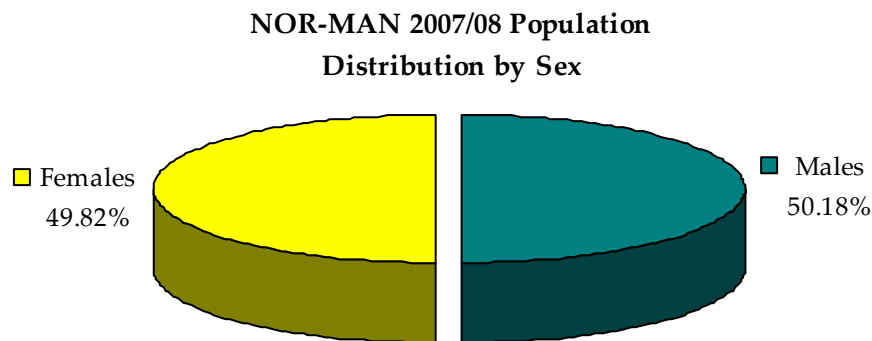


Figure 4.4: NOR-MAN Population Breakdown by Sex
Source: Manitoba Health Population Report - June 2008

Figure 4.5 compares the NOR-MAN and Manitoba population pyramid for the 2007/08 time period.

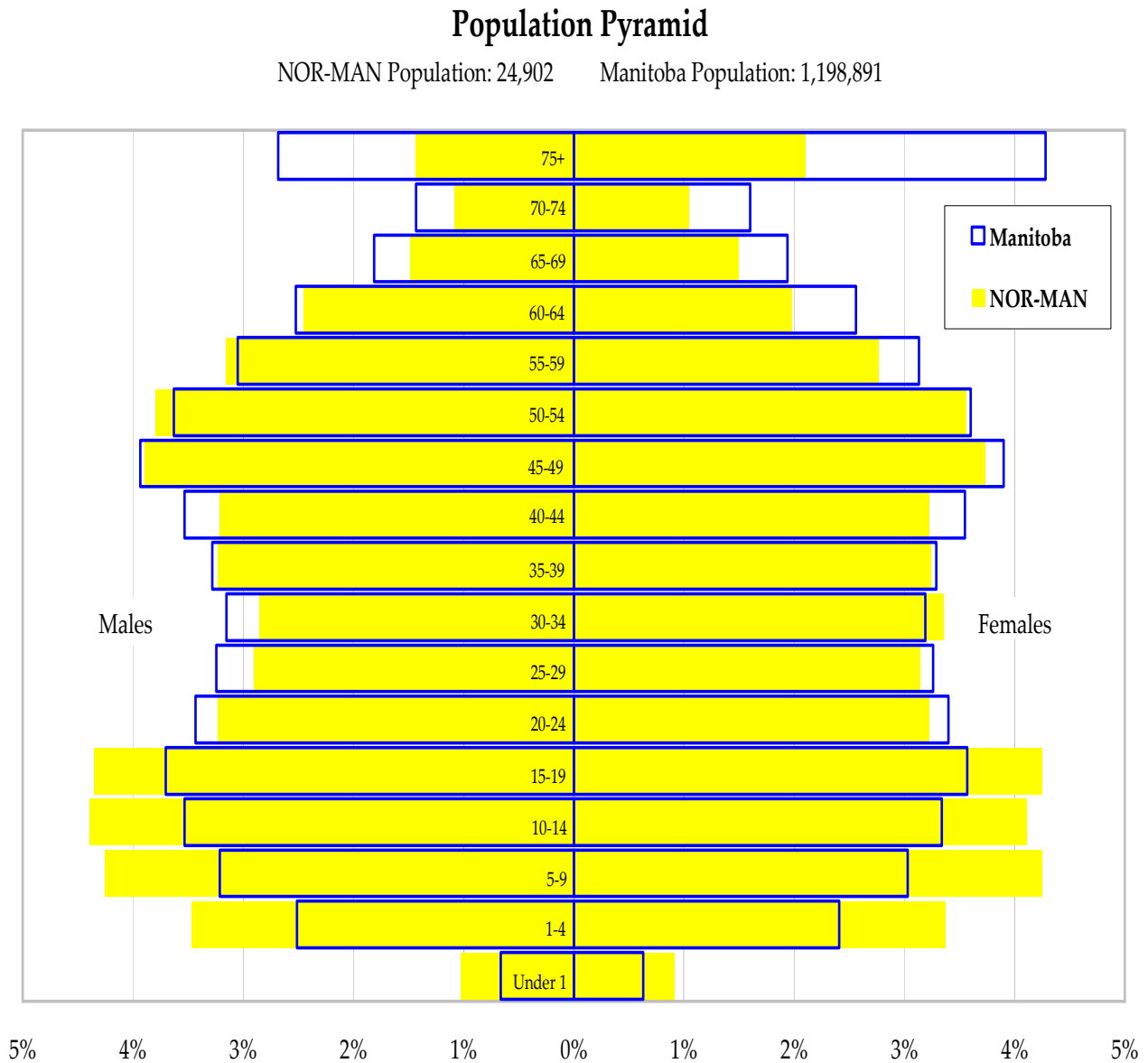
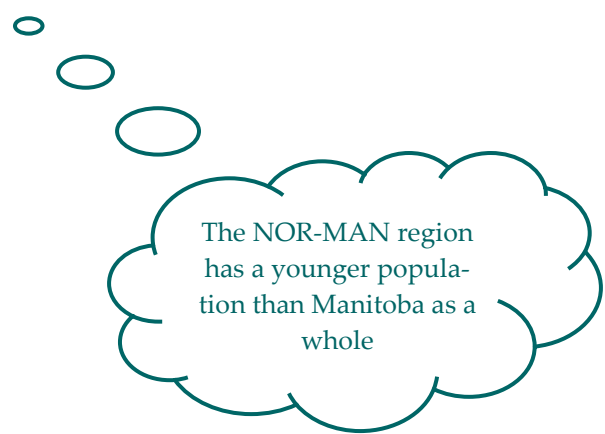


Figure 4.5: NOR-MAN Population Breakdown by Age and Sex
 Source: Manitoba Health Population Report - June 2008

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



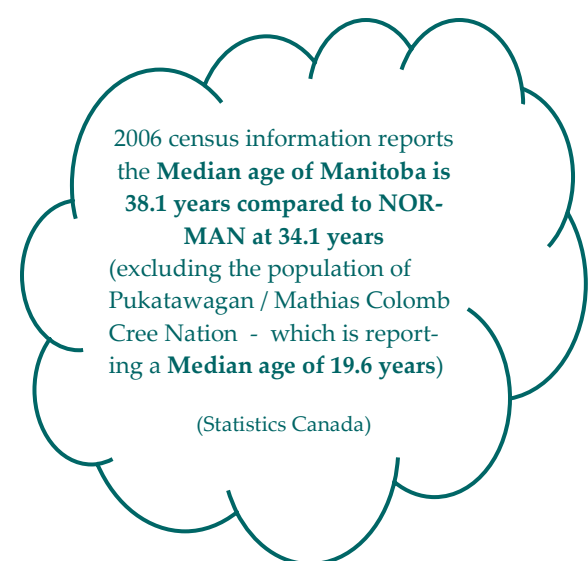
NOR-MAN Population by Community

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.**



Community	Children Ages 0-9		Youth Ages 10-19		Adult Ages 20-29		Adult Ages 30-44		Adult Ages 45-64		Seniors Ages 65+		Total	
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)
Flin Flon	648	(11)	809	(13)	732	(12)	1069	(18)	1967	(33)	788	(13)	6013	(25)
Grand Rapids	127	(19)	133	(19)	91	(13)	141	(21)	154	(22)	39	(7)	685	(3)
RM of Kelsey	347	(14)	387	(15)	303	(12)	414	(17)	798	(32)	259	(10)	2508	(10)
Snow Lake	35	(4)	188	(21)	93	(10)	167	(18)	317	(35)	115	(13)	915	(4)
The Pas	1131	(16)	1137	(16)	862	(12)	1499	(21)	1822	(26)	609	(9)	7060	(29)
Chemawawin Cree Nation	196	(29)	175	(26)	81	(12)	135	(20)	62	(9)	22	(3)	671	(3)
Misipawistik Cree Nation	109	(26)	99	(23)	65	(15)	68	(16)	68	(16)	16	(4)	425	(2)
Mathias Colomb Cree Nation	368	(30)	313	(25)	165	(13)	204	(16)	142	(11)	50	(4)	1242	(5)
Mosakahiken Cree Nation	125	(29)	99	(23)	66	(15)	78	(18)	51	(12)	14	(3)	433	(2)
Opaskwayak Cree Nation	418	(25)	350	(21)	227	(14)	329	(20)	292	(18)	54	(3)	1670	(7)
Unorganized Territories	602	(24)	486	(20)	327	(13)	498	(20)	435	(18)	120	(5)	2468	(10)
Totals	4162	(17)	4120	(17)	3012	(13)	4602	(19)	6108	(25)	2086	(9)	24090	

Table 4.8: 2007/08 NOR-MAN Populations by Age and Community Type
Source: Manitoba Health Population Report - June 2008

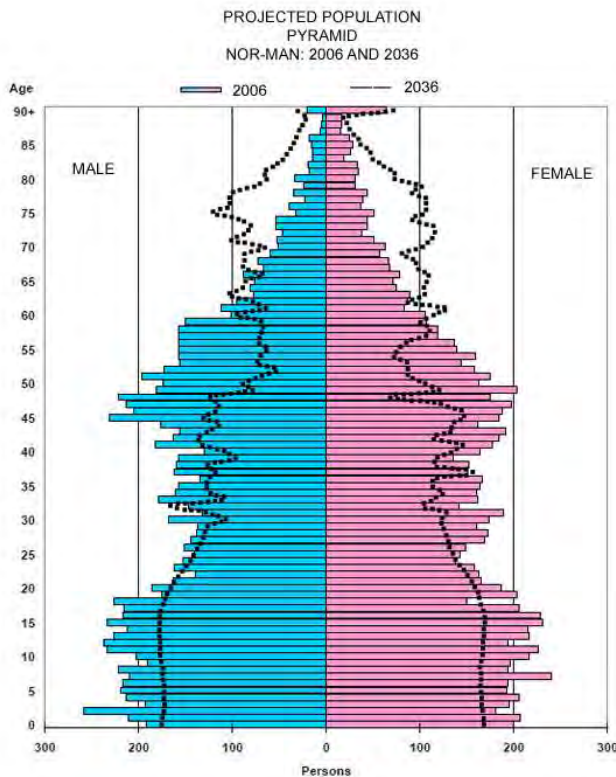


Figure 4.6: Projected Population Pyramid - NOR-MAN
Source: Manitoba Bureau of Statistics

NOR-MAN Population Projections

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

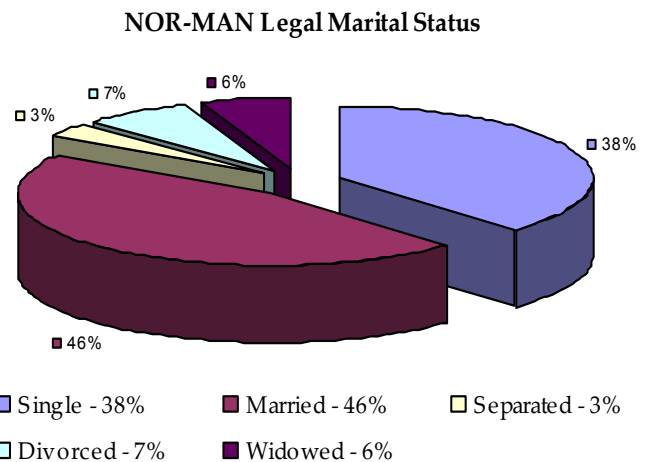
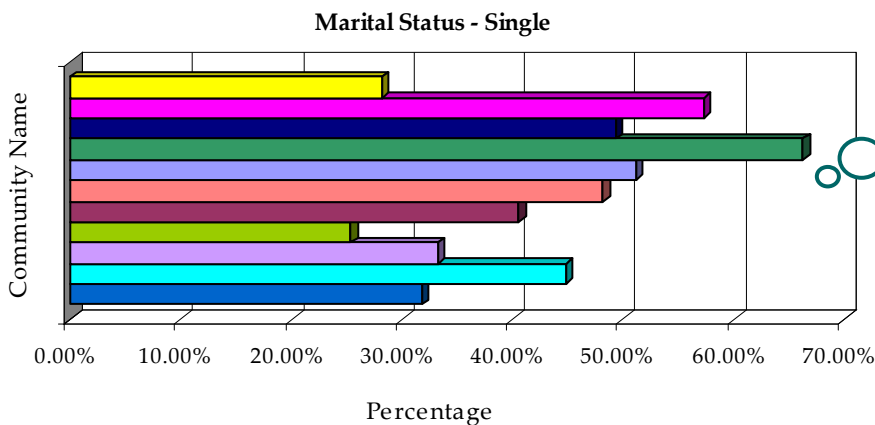


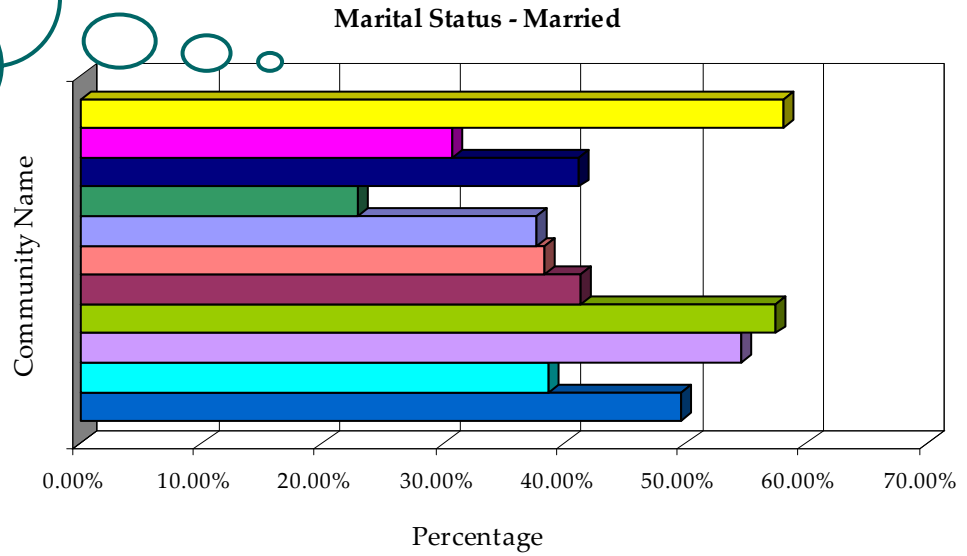
Figure 4.7: Legal Marital Status
Source: Statistics Canada, 2006 Community Profile



Mathias Colomb Cree Nation has the highest percentage of single individuals in the NOR-MAN region at 66.3%

Figure 4.8: Legal Marital Status - Single by Community
Source: Statistics Canada, 2006 Community Profile

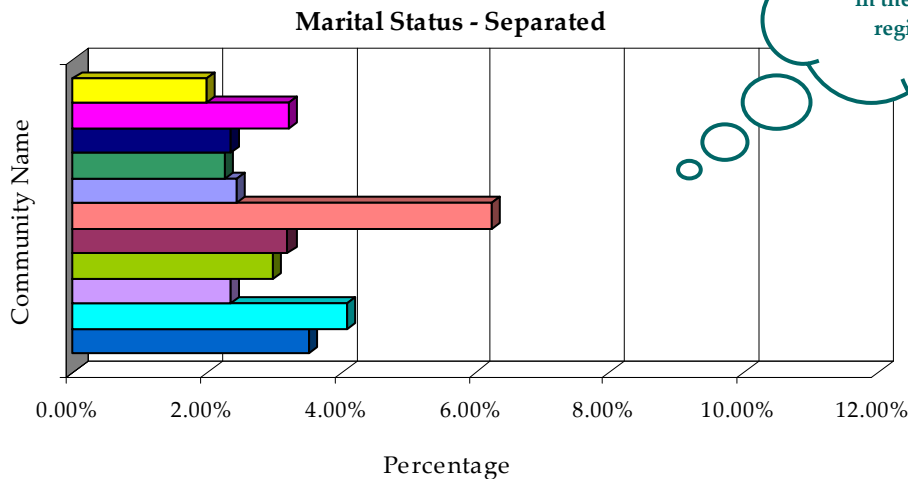
The Unorganized Territory has the highest percentage of married individuals in the NOR-MAN region at 58.1%



- Flin Flon - 49.7%
- Snow Lake - 57.5%
- Misipawistik CN - 37.8%
- Opaskwayak CN - 30.8%
- Grand Rapids - 38.8%
- The Pas - 41.4%
- Mathias Colomb CN - 23%
- Unorganized Territory - 58.1%
- RM of Kelsey - 54.7%
- Chemawawin CN - 38.4%
- Mosakahiken CN - 41.2%

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%



- Flin Flon - 3.5%
- Snow Lake - 3.0%
- Misipawistik CN - 2.4%
- Opaskwayak CN - 3.2%
- Grand Rapids - 4.1%
- The Pas - 3.2%
- Mathias Colomb CN - 2.2%
- Unorganized Territory - 2.0%
- RM of Kelsey - 2.4%
- Chemawawin CN - 6.3%
- Mosakahiken CN - 2.4%

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

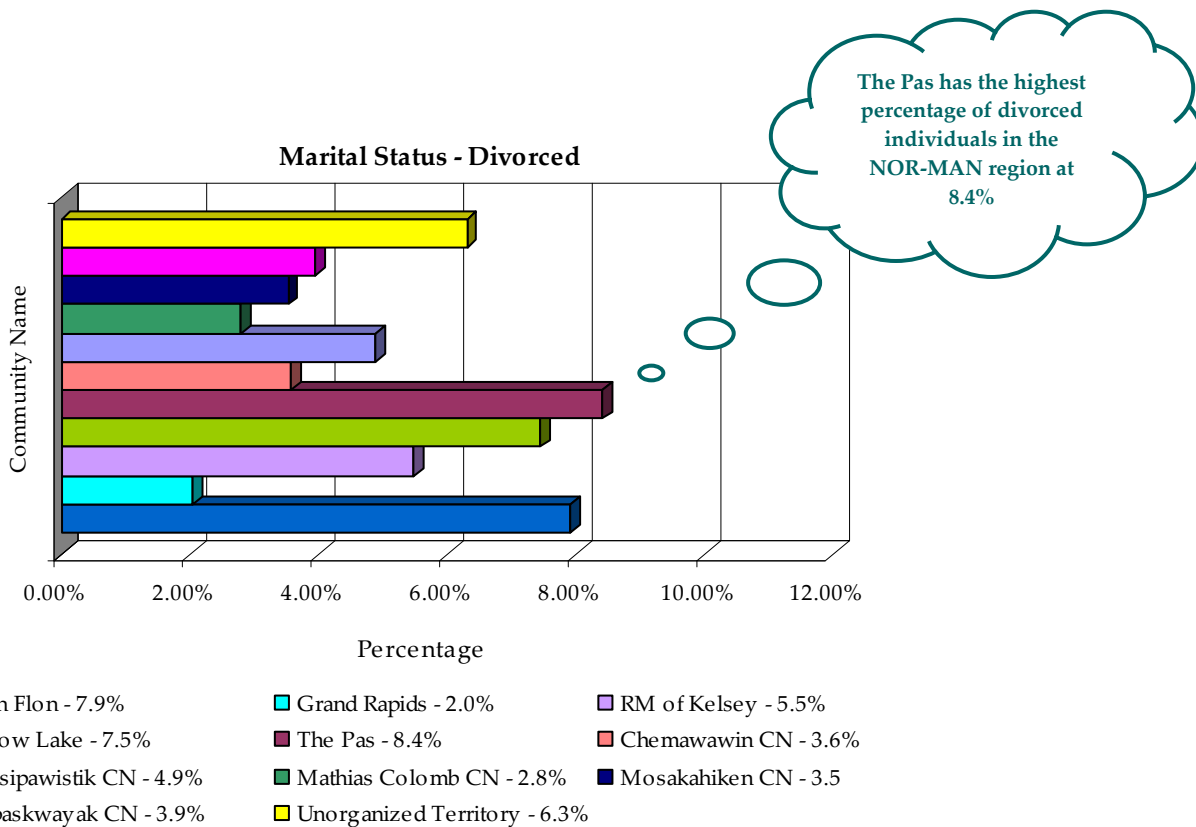


Figure 4.11: Legal Marital Status - Divorced by Community
Source: Statistics Canada, 2006 Community Profile

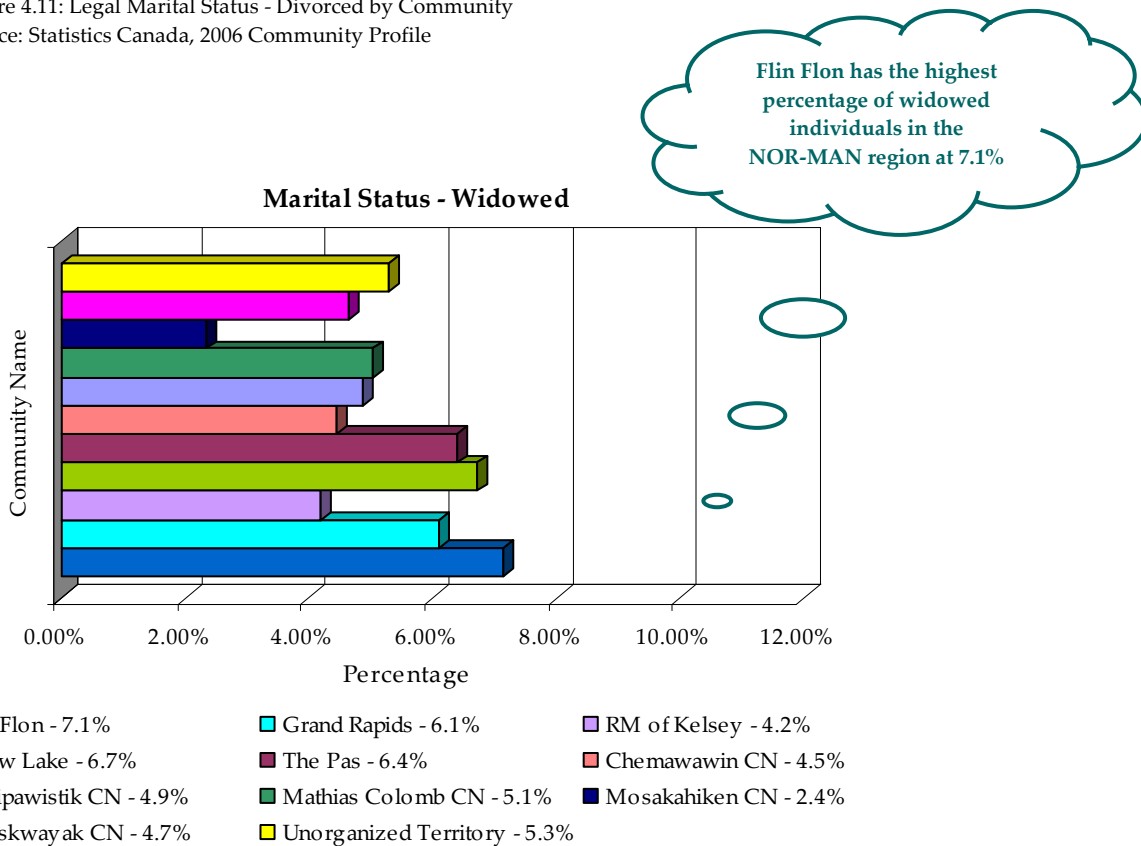


Figure 4.12: Legal Marital Status - Widowed by Community
Source: Statistics Canada, 2006 Community Profile

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.

Mobility Status refers to whether a person lived in the same residence on Census Day as he or she did one year before—one year mobility status or five years before—five year mobility status

(Statistics Canada)

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%**.

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

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 than 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.

NOR-MAN Communities	Mobility Status - Place of Residence					
	Totals	Same within 5 year	Changed within 5 years (same census subdivision)	Changed within 5 years (from another census subdivision)	Different Province	Different Country
		# (%)	# (%)	# (%)	# (%)	# (%)
Flin Flon	5,225	3,150 (60)	1,010 (19)	440 (8)	610 (12)	10 (0)
Grand Rapids	300	135 (45)	40 (13)	65 (22)	30 (10)	30 (10)
RM of Kelsey	2,315	1,465 (63)	440 (19)	225 (10)	180 (8)	0 (0)
Snow Lake	745	515 (69)	60 (8)	135 (18)	15 (2)	20 (3)
The Pas	5,055	2,730 (54)	1,480 (29)	585 (12)	225 (4)	30 (1)
Chemawawin CN	840	625 (74)	170 (20)	40 (5)	10 (1)	0 (0)
Misipawistik CN	575	560 (97)	0 (0)	10 (2)	0 (0)	0 (0)
Mathias Colomb CN	1,285	970 (75)	210 (16)	60 (5)	50 (4)	0 (0)
Mosakahiken CN	620	530 (85)	65 (10)	25 (4)	0 (0)	0 (0)
Opaskwayak CN	1,890	1,340 (71)	405 (21)	100 (5)	40 (2)	10 (1)
Unorganized Territories	1,795	1,170 (65)	305 (17)	280 (16)	40 (2)	10 (1)
NOR-MAN Totals	20,645	13,190 (64)	4,185 (20)	1,965 (10)	1,200 (6)	110 (0.5)

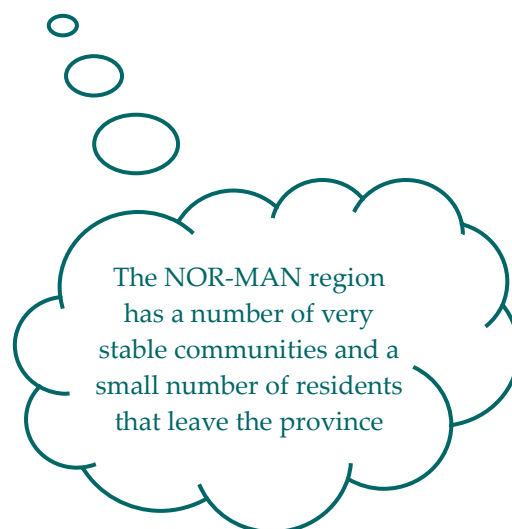
Table 4.9: Five Year Mobility Status - Place of Residence
Source: Statistics Canada, 2006 Community Profile

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:

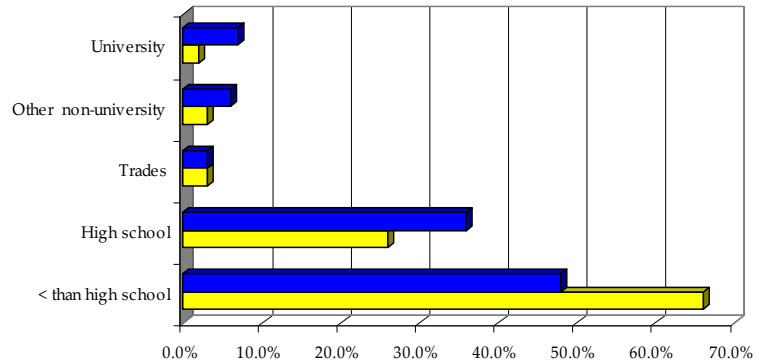
- District I - 39%,
- District II - 24%
- District III - 15%.

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

Our district high school completion rates are:

- District I - 28%,
- District II - 21%
- District III - 13%.

Highest Levels of School Ages 15 - 24 years



	<than high school	High school	Trades	Other non-university	University
■ Manitoba	48.0%	36.0%	3.0%	6.0%	7.0%
■ NOR-MAN	66.0%	26.0%	3.0%	3.0%	2.0%

Figure 4.13: Highest Level of Schooling Attainment – Ages 15 – 24
Source: Manitoba Health, NRHA Profile Document, 2008/09

Figure 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%**.

Highest Level of Schooling - Ages 25 - 64 Years

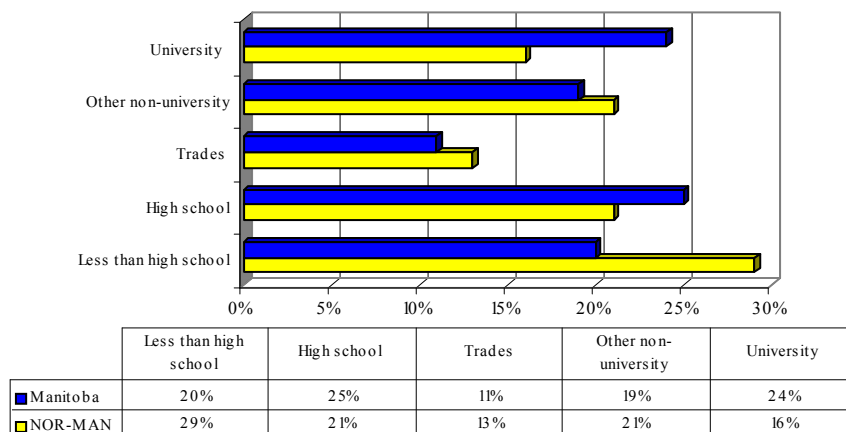
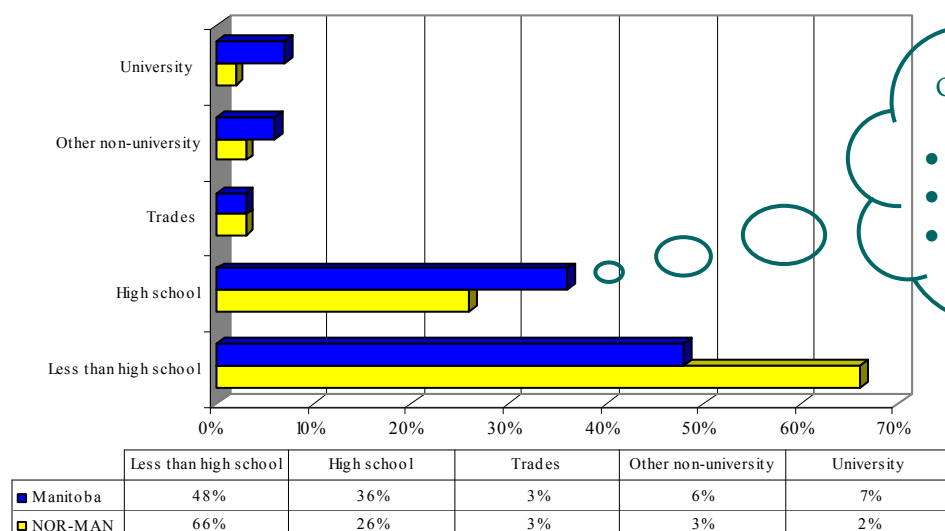


Figure 4.14: Highest Level of Schooling Attainment – Ages 25 – 64
Source: Manitoba Health, NRHA Profile Document, 2008/09

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

Highest Level of Schooling - Ages 65+ Years



Our district high school completion rates are:

- District I - 18%,
- District II - 10%
- District III - 15%.

Figure 4.15: Highest Level of Schooling Attainment – Ages 65+ Years
 Source: Manitoba Health, NRHA Profile Document, 2008/09

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%**.

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

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.

NOR-MAN has a total of 2071 individuals aged 15 - 19 years of age living in the region

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

Education is an important determinant of health and our overall low levels of education is a concern

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

	Total Pop	Less than grade 12	High school diploma or equivalent	Apprenticeship or trades certificate or diploma	College, CEGEP, or other non-university certificate or diploma	University certificate or diploma below the bachelor level	University certificate, diploma or degree
Flin Flon	4490	33%	28%	13%	16%	3%	7%
Grand Rapids	245	29%	14%	12%	6%	27%	12%
Kelsey	1890	29%	24%	14%	19%	4%	8%
Snow Lake	665	25%	35%	17%	17%	2%	5%
The Pas	4145	30%	22%	11%	22%	4%	11%
Chemawawin CN	560	79%	9%	2%	6%	2%	2%
Misipawistik CN	415	67%	19%	2%	2%	6%	0%
Mathias Colomb CN	890	70%	10%	7%	6%	3%	6%
Mosakahiken CN	425	74%	14%	4%	5%	0%	2%
OCN 21E	1365	60%	14%	7%	13%	2%	4%
Unorganized Territory	1510	29%	16%	14%	20%	7%	15%
Totals	16,660	39%	22%	11%	16%	4%	8%

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.

Youth Health Survey reported on hours per week spent reading:

- 1 hour = 61%
- 1 - 6 hours = 29%
- 7+ hours = 9%

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

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

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

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

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

Aboriginal Educational Attainment Levels

The majority of NOR-MAN individuals who have claimed Aboriginal identity have not completed high school.

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.

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

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

Education is an important determinant of health and our overall low levels of education is a concern

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.

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

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

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%.

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

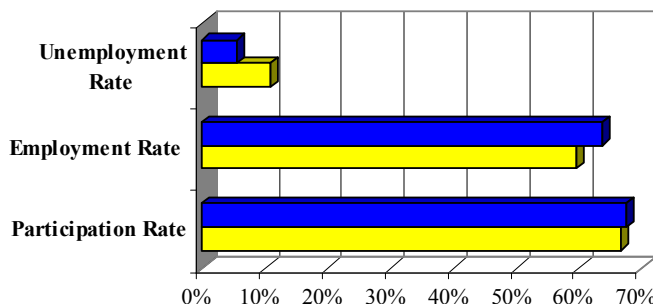
Employment Rate - refers to the number of people employed expressed as a percentage. . .

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)

Labour Force Indicators



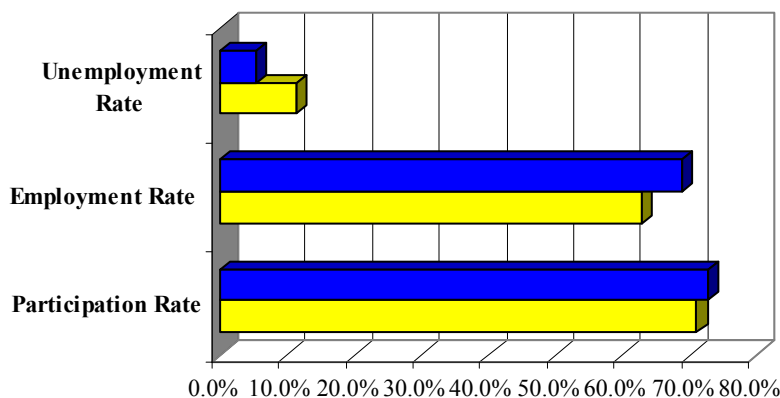
	Participation Rate	Employment Rate	Unemployment Rate
■ Manitoba	67.3%	63.6%	5.5%
■ NOR-MAN	66.6%	59.5%	10.8%

Figure 4.16: Labour Force Indicator
Source: Statistics Canada, 2006 Community Profile—Division No. 21

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 Indicators - Males



	Participation Rate	Employment Rate	Unemployment Rate
■ Manitoba	72.8%	68.8%	5.5%
■ NOR-MAN	71.1%	63.0%	11.5%

Figure 4.17 Labour Force Indicators - Males
Source: Statistics Canada, 2006 Community Profile – Division No. 21

- 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 Indicators - Female

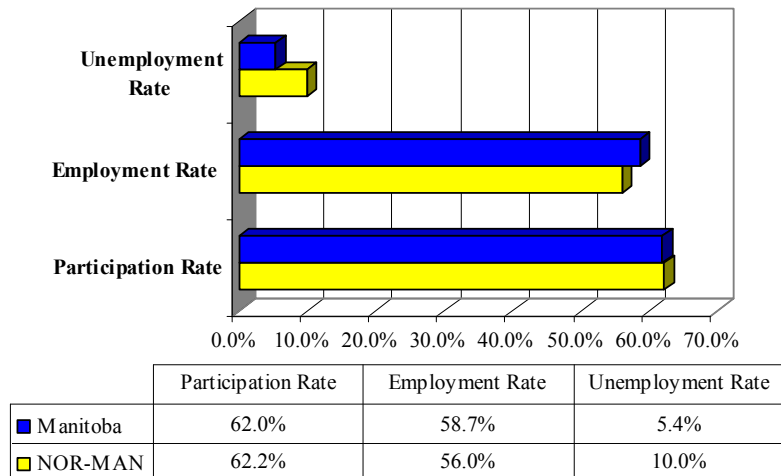
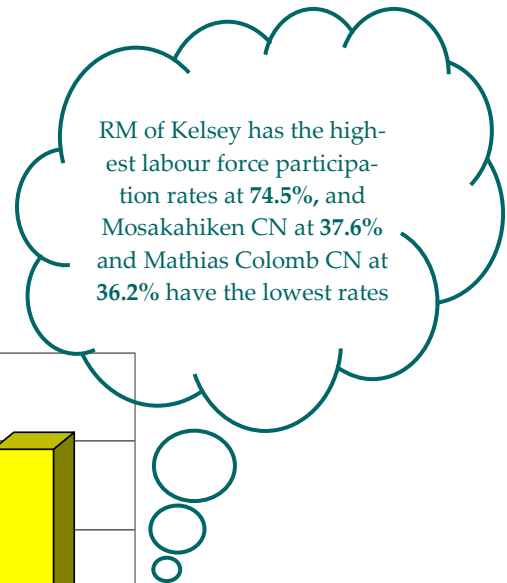


Figure 4.18: Labour Force Indicators - Females
Source: Statistics Canada, 2006 Community Profile – Division No. 21

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.



Labour Force Participation Rates by Community

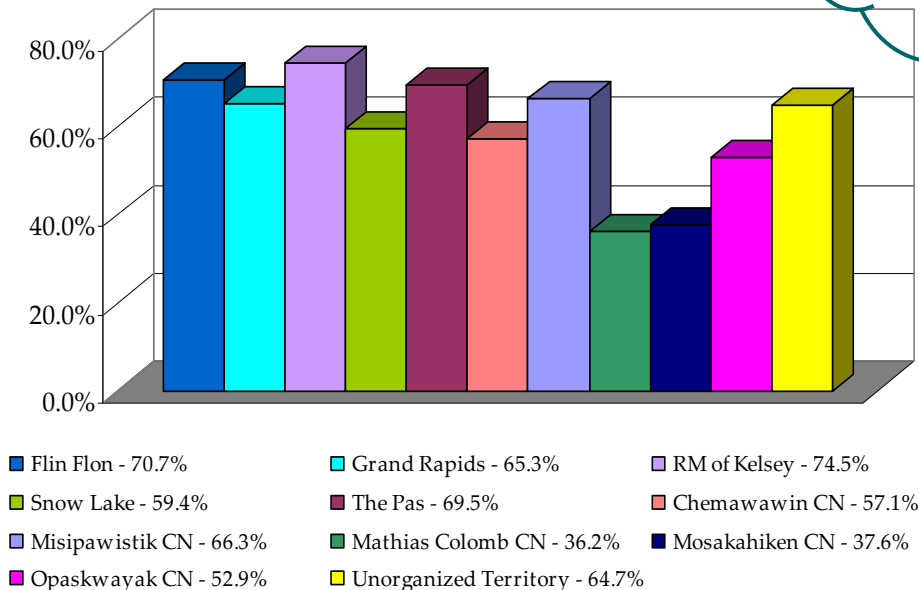


Figure 4.19: Labour Force Indicators by Community - Participation Rate
Source: Statistics Canada, 2006 Community Profile

The communities of Flin Flon (**70.7%**), RM of Kelsey (**74.5%**) and The Pas (**69.5%**) have the

Flin Flon has the highest employment rates at 67.5% and Mathias Colomb CN at 29.4% and Mosakahiken CN have the lowest rates at 27.1%

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.

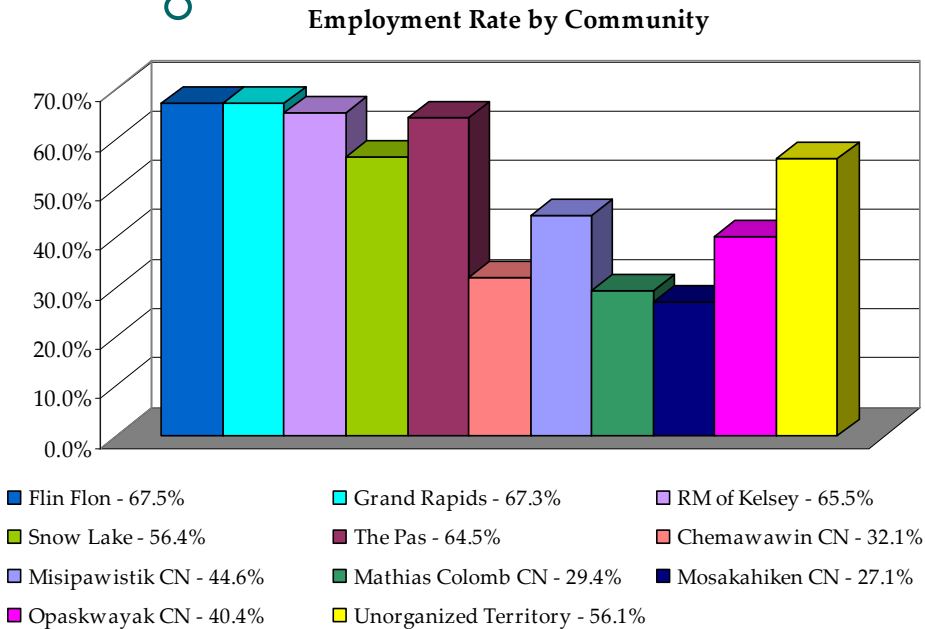


Figure 4.20: Labour Force Indicators by Community - Employment Rate
Source: Statistics Canada, 2006 Community Profile

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.

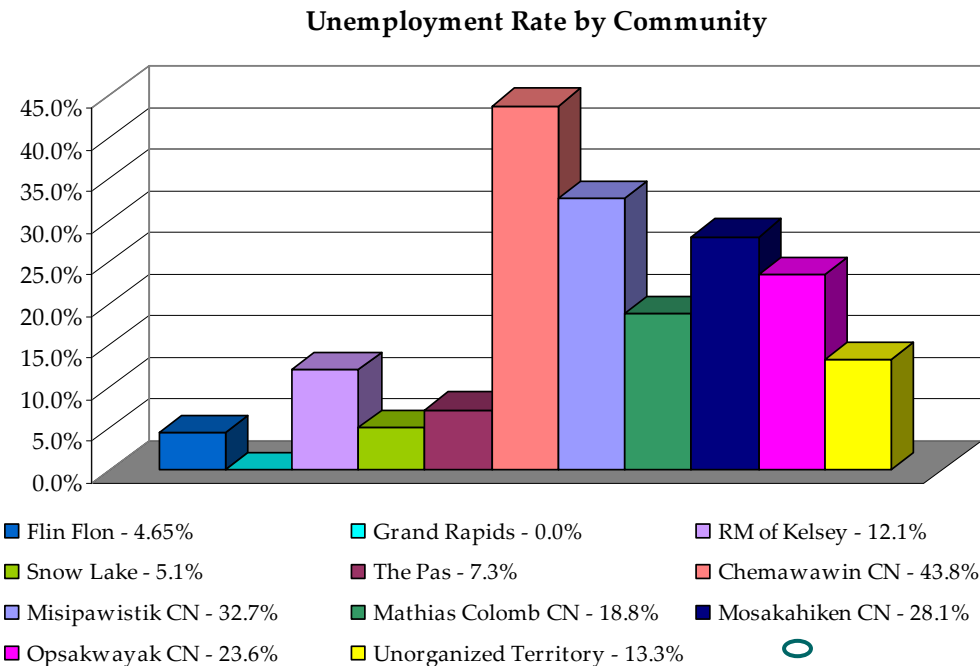


Figure 4.21: Labour Force Indicators by Community - Unemployment Rate
Source: Statistics Canada, 2006 Community Profile

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

Chemawawin CN has the highest unemployment rates at **43.8%** and Grand Rapids has the lowest at **0%**

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

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)

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.

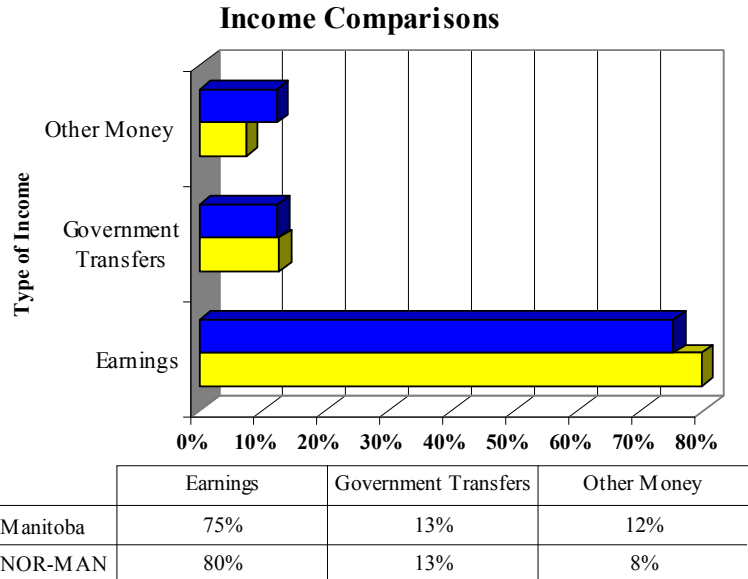


Figure 4.22: Composition of Total Income
Source: Statistics Canada, 2006 Community Profile

Compared to the 2001 census data, NOR-MAN has experienced an increase in our earnings of total income from 73% to 80% .

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.

Community	Earnings	Government Transfers	Other Money
Flin Flon	82.1% (80.2%)	11.1% (11.2%)	6.7% (8.6%)
Grand Rapids	88.4% (84.4%)	10.2% (13.5%)	1.1% (2.1%)
RM of Kelsey	81.9% (76.8%)	10.8% (10.7%)	7.4% (12.4%)
Snow Lake	78.4% (85.0%)	10.0% (8.4%)	11.9% (6.7%)
The Pas	81.4% (81.7%)	11.1% (10.1%)	7.5% (8.3%)
Chemawawin CN	64.9% (60.6%)	30.6% (37.4%)	5.5% (2.4%)
Misipawistik CN	69.0% (64.3%)	26.7% (33.5%)	5.1% (0.9%)
Mathias Colomb CN	63.1% (58.0%)	33.7% (40.8%)	3.4% (1.3%)
Mosakahiken CN	64.6% (57.0%)	34.3% (42.2%)	1.5% (0.6%)
Opaskwayak CN	70.8% (73.9%)	27.2% (25.4%)	1.8% (1.0%)
Unorganized Territory	74.2% (77.9%)	12.9% (10.5%)	13.0% (11.3%)

Table 4.15: Composition of Total Income for 2006 vs 2001
 Source: Statistics Canada, 2006 Community Profile

Median Income

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**.

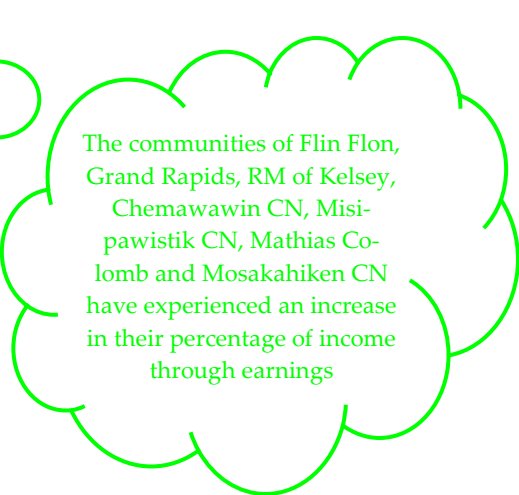


Table 4.16 compares the median total income by community for both the NOR-MAN region and Manitoba as a whole for the 2001 and 2006 census.

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**.

Median Income

is the dollar value at which half the people aged 15 and over who reported income have higher incomes than that dollar value and half have lower incomes.

(Statistics Canada)

Median Total Incomes have decreased for both the RM of Kelsey and Mathias Colomb CN between 2001 to 2006

(Statistics Canada)

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

Table 4.16: Median Total Income by Community
Source: Statistics Canada, 2006 Community Profile

When comparing the 2001 to the 2006 census data for average earnings by community it is important to remember that the NOR-MAN region lost a total of 275 residents with earnings

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.

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)

Average Earnings by Community

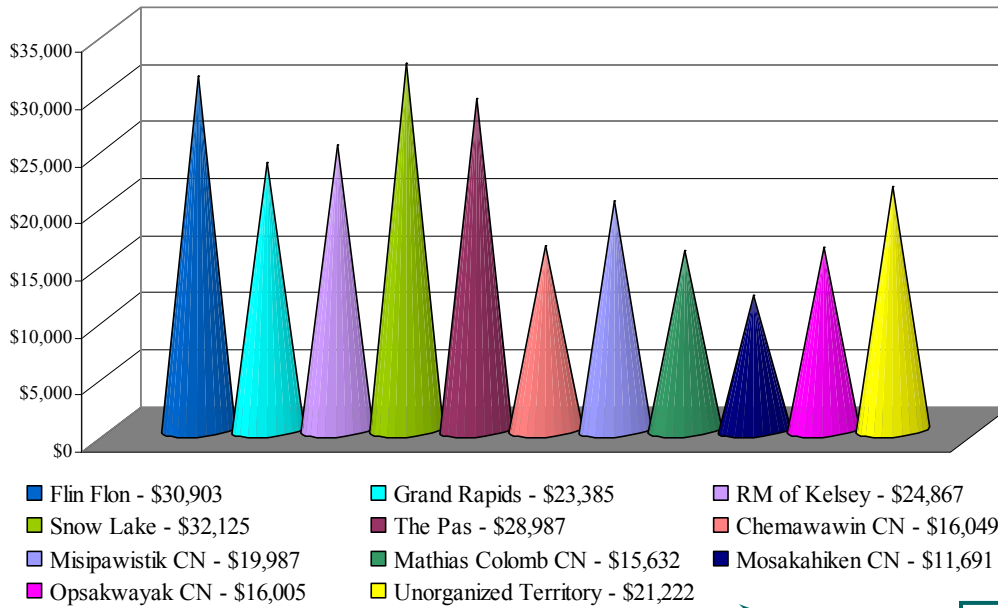


Figure: 4.23: Average Earnings by Community
Source: Statistics Canada, 2006 Community Profile

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.

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

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).

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)

Worked Full Time - Average Earnings

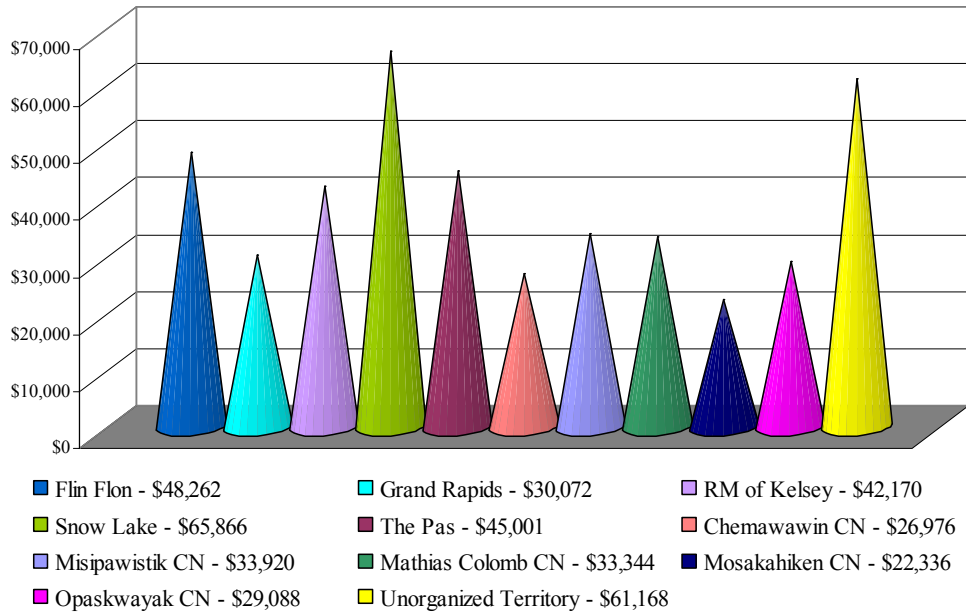


Figure: 4.24: Average Earnings – Worked Full-Time by Community
Source: Statistics Canada, 2006 Community Profile

2001 Worked Full Time - Average Earnings by community are:

- Flin Flon - \$45,787
- Grand Rapids - \$41,095
- Snow Lake - \$51,1661
- The Pas - \$40,670
- Chemawawin CN - \$25,464
- Misipawistik CN - \$29,456
- Mathias Colomb CN - \$29,309
- Mosakahiken CN - \$25,579
- OCN - \$27,418
- Unorganized - \$47,099

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%**)

Median Household Income

reflects the dollar value at which point half of the families have higher incomes and half have lower incomes. The median household income is calculated for all household units, whether or not they reported income.

(Statistics Canada)

- **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%**)

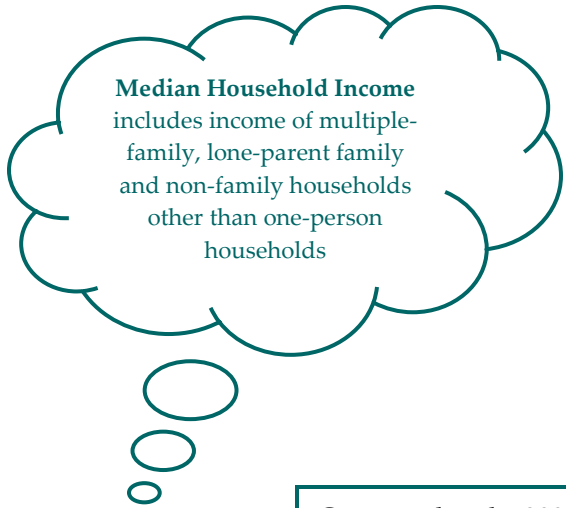
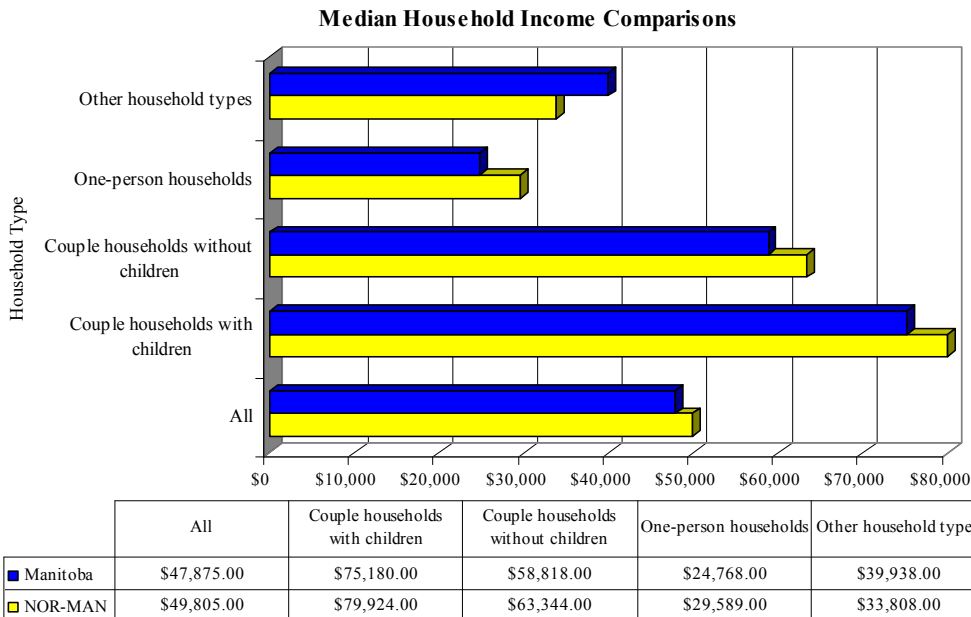


Figure 4.25 shows the median household incomes by family type for the NOR-MAN region (excluding the community of Pukatawagan / Mathias Colomb Cree Nation) compares to provincial incomes.



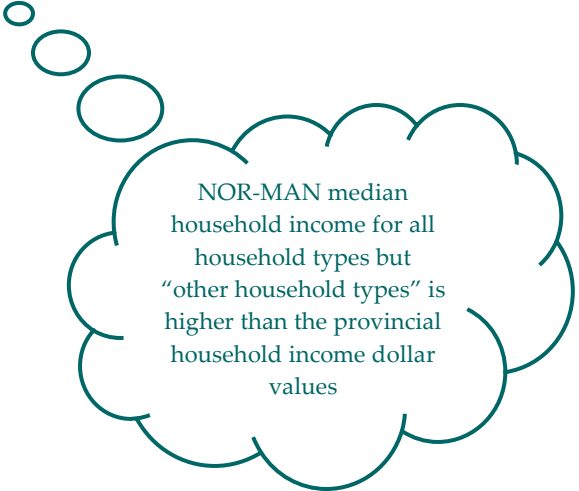
Compared to the 2001 census, NOR-MAN has experienced:

- A total loss of 570 private households
- An increase of 165 private household containing a couple without children

Figure 4.25: Median Household Income
Source: Statistics Canada, 2006 Community Profile – Division No. 21

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**.



Moose Lake, Easterville, Sherridon/Cold Lake and Cormorant are Northern Affairs communities

Athapap, Big Island, Clearwater, Bakers Narrows, Rocky and Schist are Lake Area communities

2001 census reported 6,475 families living in the NOR-MAN region - **decrease of 500 families**

The 2001 census shows a similar statistically picture for the NOR-MAN region:

- 63% or 4,065 married-couple families
- 16% or 1,010 common-law families
- 22% or 1,395 lone-parent families, of which:
 - 78% or 1,085 are female lone-parent families
 - 22% or 305 are male lone-parent families

(Statistics Canada)

- 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.

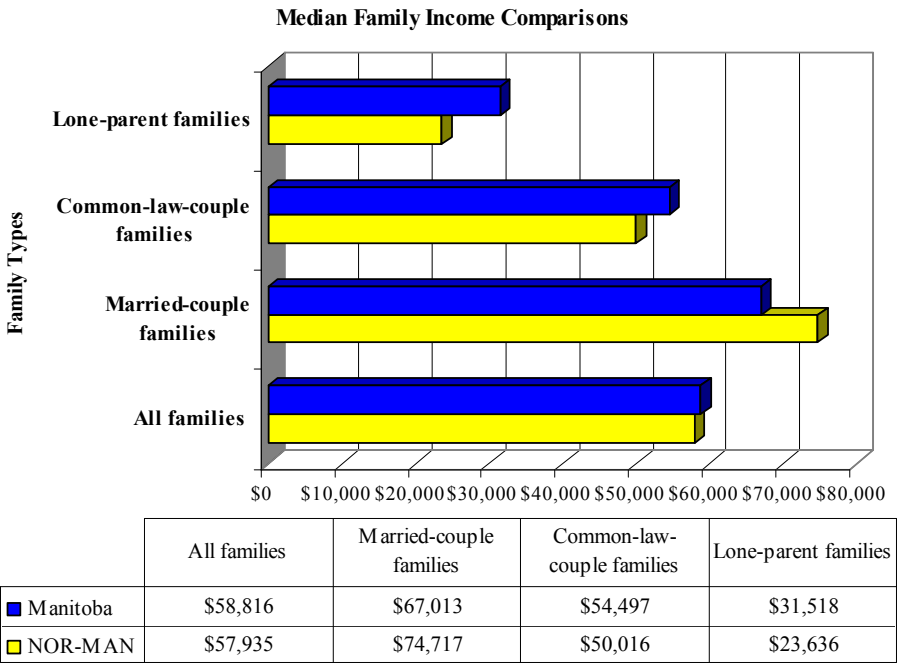


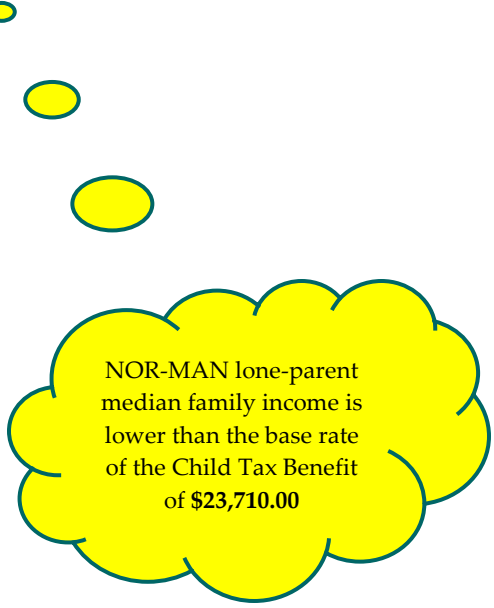
Figure 4.26: Median Family Income by Family Type
 Source: Statistics Canada, 2006 Community Profile - Division No. 21

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 times 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

The dependency ratio is the ratio of combined individuals in the non-working age groups (under 15 and over 65 years) to those of working age (15 to 65 years). The ratio is presented as the number of dependents for every 100 people in the working age population

(Manitoba Health, Health Information Branch)

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

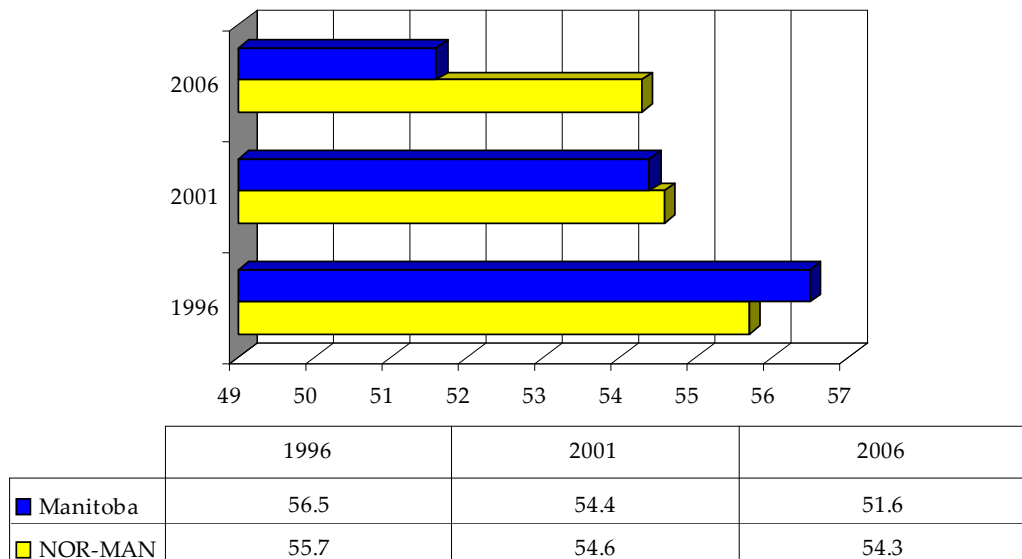


Figure 4.27: Population Dependency Ratio
Source: Statistics Manitoba Health Information Management, RHA Profile Document

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.

Languages	Male # (%)	Female # (%)	Totals # (%)
English Only	8,765 (82)	8,795 (82)	17,560 (82)
French Only	150 (1)	95 (1)	240 (1)
Both English & French	15 (0)	10 (0)	25 (0)
Other Languages	1795 (17)	1,810 (17)	3,605 (17)
Totals	10,725	10,710	21,430

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

The 2001 census data shows **34.6%** of Aboriginal identity population stating they have knowledge of Aboriginal Language(s)

(Statistics Canada—Aboriginal Community Profiles)

The 2001 census data shows **31.6%** of Aboriginal identity population stated that an Aboriginal Language(s) was their mother tongue

(Statistics Canada—Aboriginal Community Profiles)

The 2006 Aboriginal Population Profile does not provide information for the communities of Snow Lake and the Town of Grand Rapids.

with respect to Aboriginal language(s) spoken at home and as mother tongue.

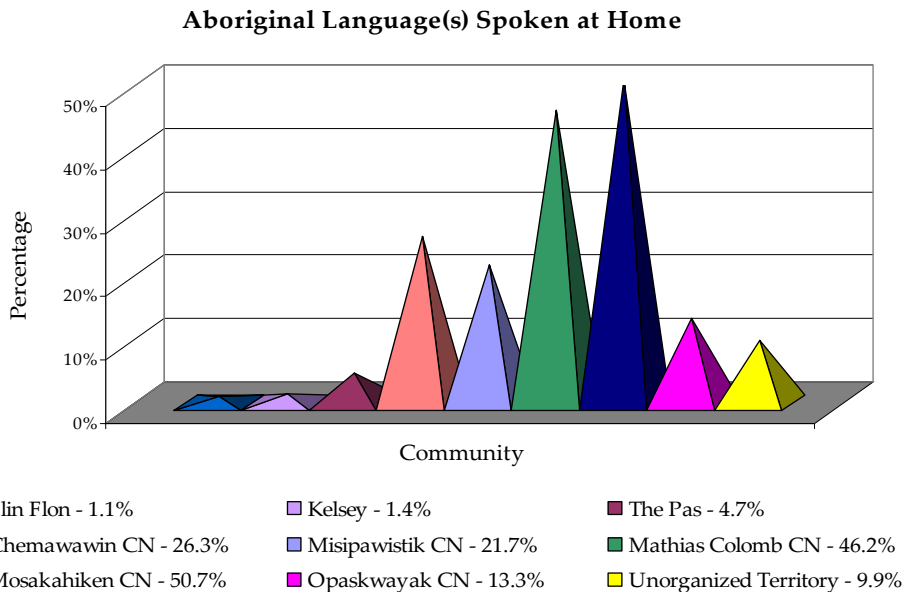


Figure 4.28: Aboriginal Language(s) Spoken at Home
Source: Statistics Canada, 2006 Aboriginal Community Profile

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.

Aboriginal language(s) spoken at home and as mother tongue appears to be declining in all First Nation Communities in the NOR-MAN region.

Figure 4.35 shows that Aboriginal language(s) spoken as their mother tongue. These rates 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.

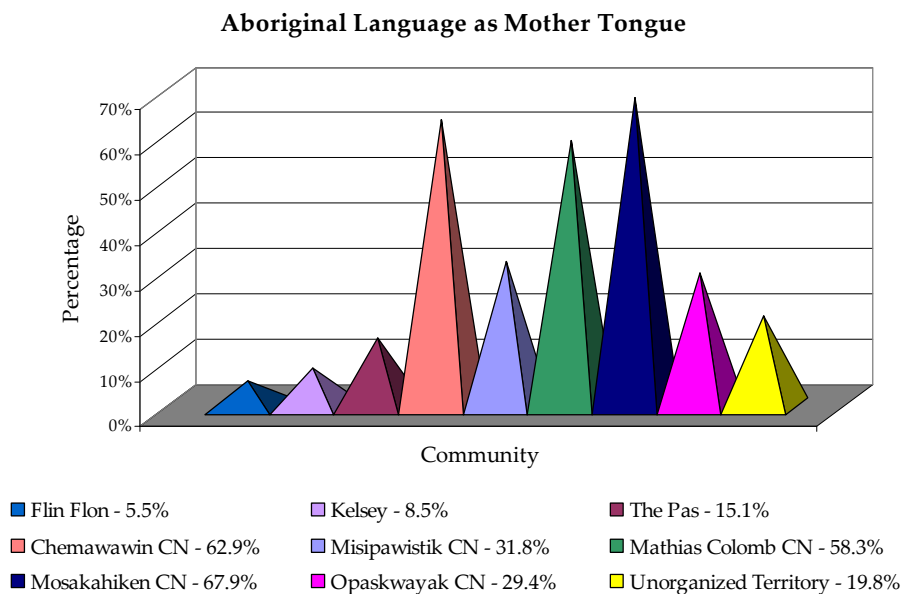


Figure 4.29: Aboriginal Language(s) as Mother Tongue
Source: Statistics Canada, 2006 Aboriginal Community Profile

Summary

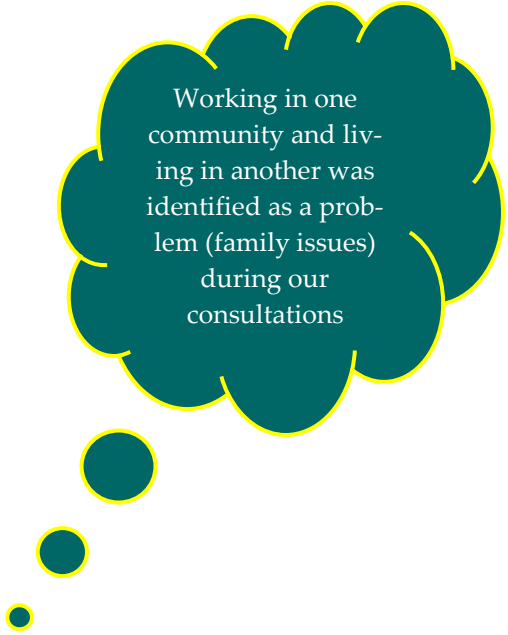
The NOR-MAN region covers a vast area of land spanning approximately 72,000 square kilometers in the central western part of the province. The people and the communities that make up the region display considerable diversity in origin, governance structure, economic base, service availability and interconnectedness.

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



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



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


- 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.



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



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

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

Health Status:

refers to the degree to which a person is able to function physically, emotionally and socially, with or without aid from the health system

(A Dictionary of Epidemiology, 4th Edition)

NRHA DISTRICTS

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)

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:

Mortality Rate

is the number of deaths per 1,000 area residents per year.

Mortality rates are reported over a five year period.

(Manitoba Centre for Health Policy)

- 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.**

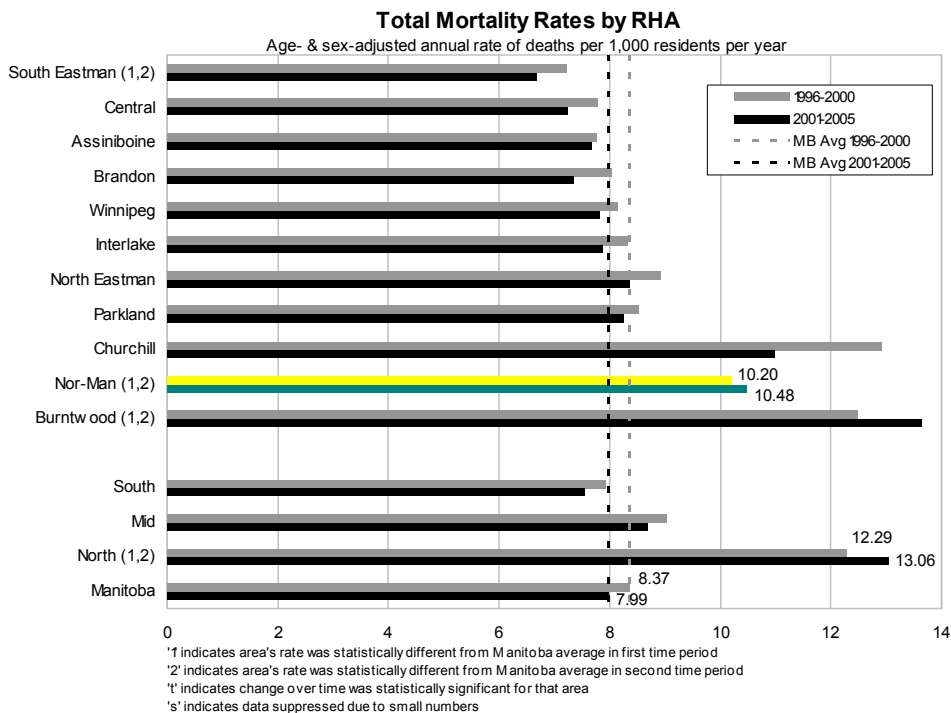


Figure 5.1: Total Mortality Rates by RHA

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.**

Premature Mortality Rate (PMR)

is a ratio calculated by the number of deaths occurring before the age of 75, divided by the number of individuals in the population who are younger than 75 years of age, over a specific period of time.

PMR is reported over a five year period.

(Manitoba Centre for Health Policy)

Time Period	Manitoba Rate (t)	NOR-MAN Rate (1, 2)	District I	District II (1,2)	District III (1,2)
1996 – 2000	3.48/1,000	4.55/1,000	3.16/1,000	5.15/1,000	6.45/1,000
2001 – 2005	3.29/1,000	4.40/1,000	3.44/1,000	4.42/1,000	6.51/1,000

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**.

Standardized Rates

Means that the rate has been adjusted to create a fair comparison among the regions with different age and sex population distributions

(Manitoba Centre for Health Policy)

Men are more likely than women to die before the age of 75 years

Life Expectancy (at birth)

Life Expectancy (at birth)

is the number of years a person would expect to live starting at birth if today's mortality rates remained the same throughout a person's life.

Life expectancy is reported over a five year period.

(Manitoba Centre for Health Policy)

NOR-MAN males again have seen an increase their life expectancy - they are living longer

Both our District II and III males and females rate is statistically lower than the provincial rate.

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**.

	Manitoba Males	NOR-MAN Males
1991 – 1995	75.4 years	70.6 years
1996 – 2000	75.9 years	72.9 years (1)
2001 – 2005	76.3 years (t)	73.4 years (2)

	Manitoba Females	NOR-MAN Females
1991 – 1995	81.3 years	77.1 years
1996 – 2000	81.3 years	77.9 years (1)
2001 – 2005	81.8 years (t)	77.6 years (2)

Table 5.2: Life Expectancy Chart

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

	NRHA Males	NOR-MAN Females
District I	75.9 years	79.7 years
District II	73.1 years (1,2)	77.2 years (1,2)
District III	69.6 years (2)	74.4 years (1,2)

Table 5.3: Life Expectancy Chart by NOR-MAN District

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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 difference 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

Potential Years of Life Lost (PYLL)

is a measurement used to calculate the number of years of life lost due to death before the age of 75 years

Anyone who dies at age 75 or older contributes zero (0) years to the PYLL total

(Manitoba Centre for Health Policy)

The District III PYLL rates for both time periods are statistically different (higher) than the Manitoba average

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 Rate

is the number of deaths per 1,000 area infants under the age of one year per year.

Mortality rates are reported over a five year period.

(Manitoba Centre for Health Policy)

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.

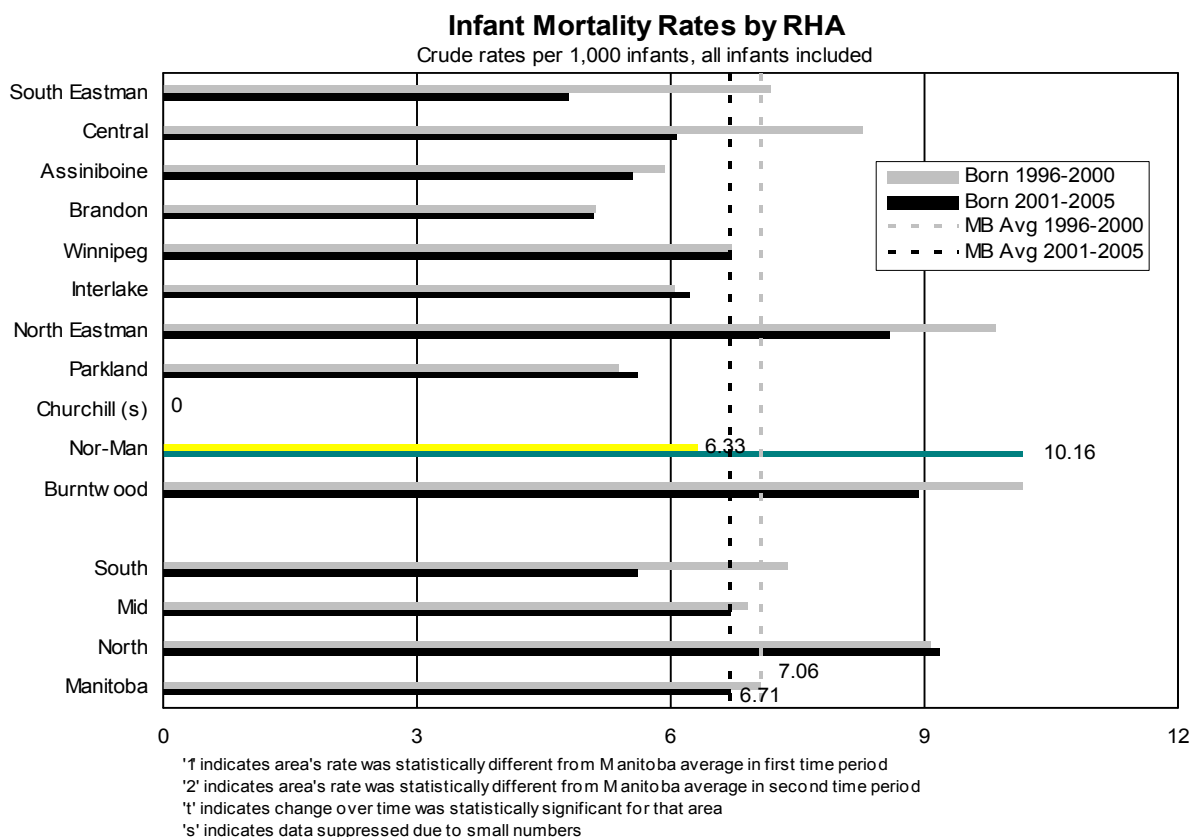


Figure 5.2: Infant Mortality Rates by RHA
 Source: Manitoba Centre for Health Policy, Child Health Atlas Update, November 2008

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
 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)

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.

No district level data is available due to low numbers

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,

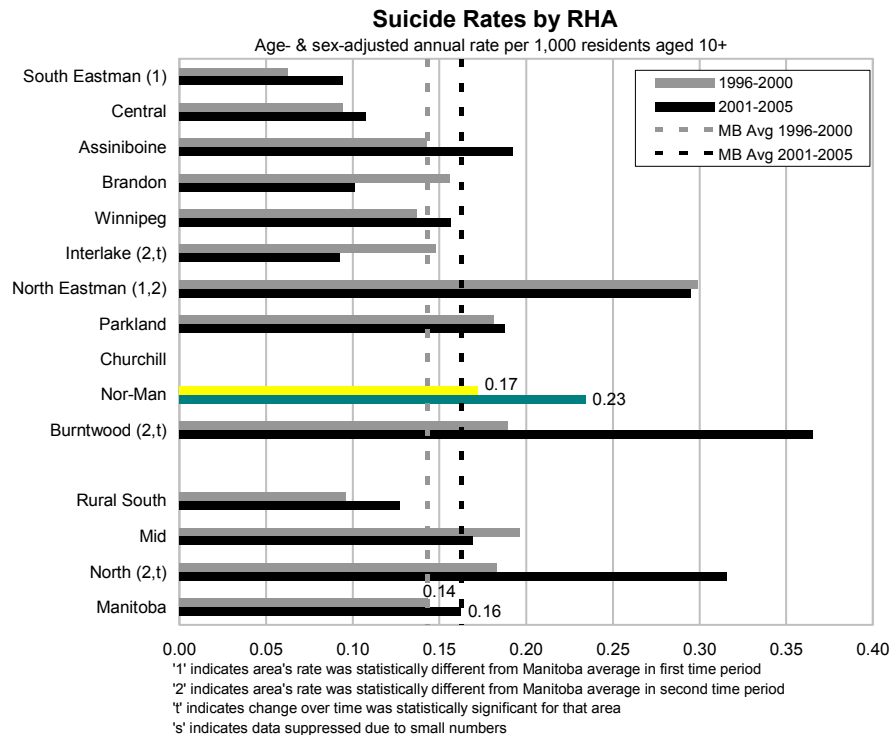


Figure 5.3: Suicide Rates by RHA
 Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

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

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.

Circulatory diseases includes heart disease and stroke

Since our last CHA report the proportion of our: Deaths due to **Circulatory Disease** have decreased from **30.2% to 26.3%**, our deaths due to **Cancer** have increased from **22.2% to 24.7%**, and our deaths due to Endocrine, Nutritional & Metabolism Conditions have increased from **6.1% to 9.8%**

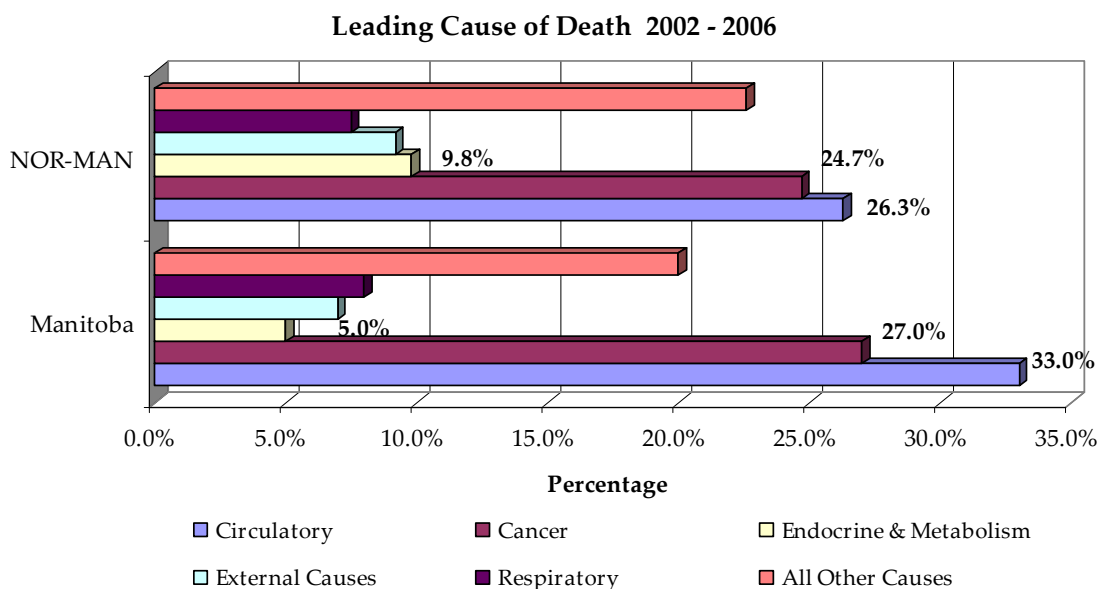


Figure 5.4: Leading Cause of Death
Source: Manitoba Health, NRHA Profile Document, 2008/09

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

NOR-MAN's leading cause of death for females is Circulatory and for males is Cancer

of death by sex.

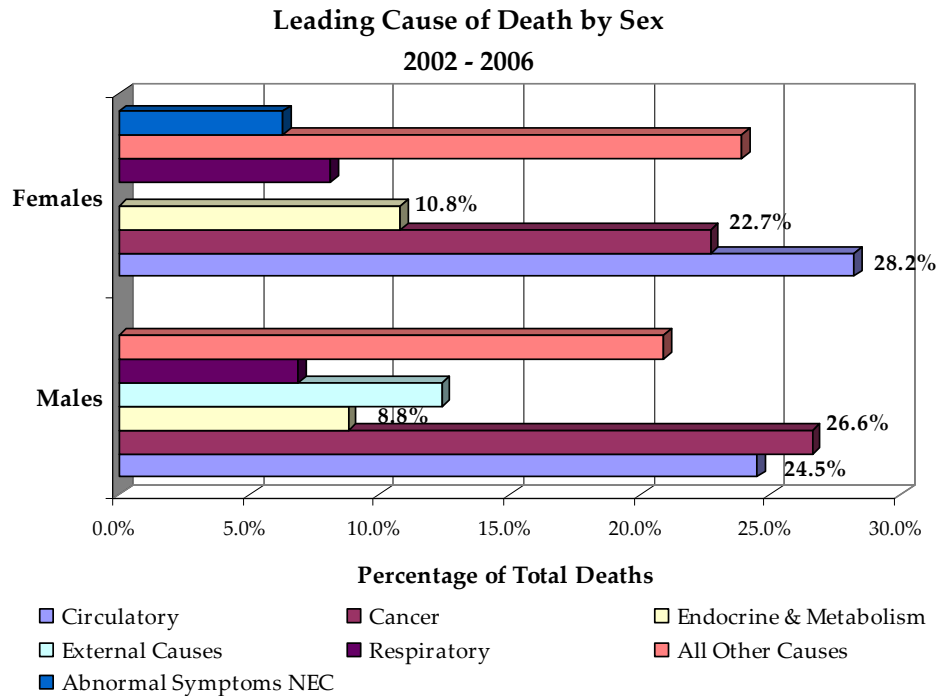


Figure 5.5: Leading Cause of Death by Sex
Source: Manitoba Health, NRHA Profile Document, 2008/09

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.



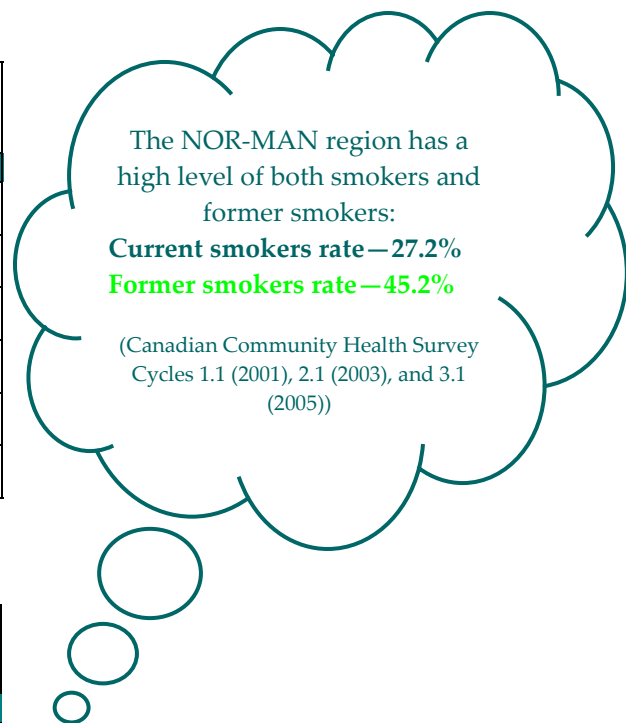
2000 – 2005 Top 5 Cancer Mortalities - Males and Females

Male Cause of Cancer Death	North	Manitoba
Lung	31.7%	28.9%
Colorectal	10.7%	11.6%
Prostate	11.2%	8.0%
Pancreas	2.2%	5.3%
Bladder	1.3%	3.7%
Other	42.9%	42.5%

Table 5.4: 2000-2005 Top 5 Cancer Mortalities - Males
Source: Manitoba Health, NRHA Profile Document, 2008/09

Female Cause of Cancer Death	North	Manitoba
Lung	28.7%	25.6%
Colorectal	10.3%	10.8%
Breast	14.4%	10.0%
Pancreas	6.9%	6.6%
Ovary	2.3%	2.0%
Other	37.4%	42.0%

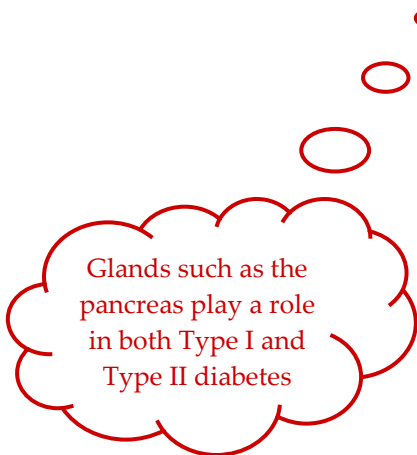
Table 5.5: 2000-2005 Top 5 Cancer Mortalities - Females
Source: Manitoba Health, NRHA Profile Document, 2008/09



Endocrine System

Is a collection of glands that produce and secrete hormones that regulate the body's growth, metabolism, and sexual development

(endocrineweb.com)



Endocrine, Nutritional and Metabolic Disease

The third leading of 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:

Injury

is defined as:

Any specific and identifiable bodily impairment or damage resulting from acute exposure to:

- Thermal Energy
- Mechanical Energy
- Electric Energy
- Chemical Energy

Or

Absence of essential energy
(heat or oxygen)

(Manitoba Provincial Injury Data Report)

1. **Suicide** at a rate of 12.1/100,00 (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 3.8/100,00 (1.5)
5. **Assaults** at a rate of 3.4/100,00 (2.3)

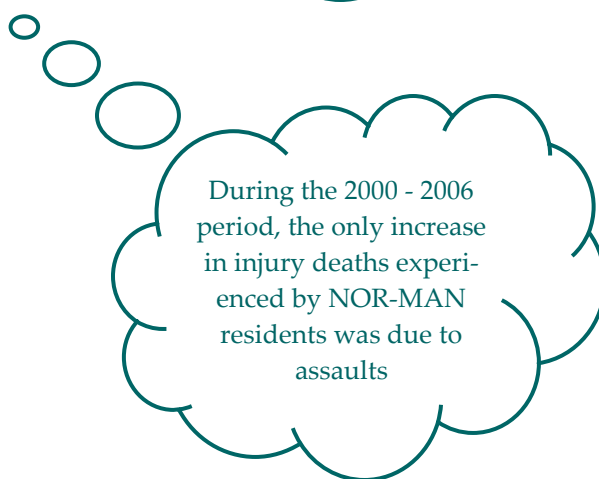
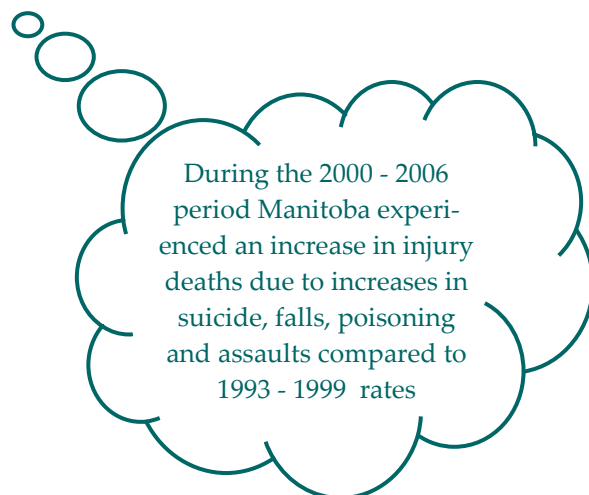
While, the leading causes of injury deaths in NOR-MAN for the same time period were:

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 **5.8/100,00** (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.

Cause of Injury Death 2000 - 2006	NOR-MAN Male	NOR-MAN Female
Motor Vehicle / Traffic	19.3/100,000	14.0/100,000
Suicide	22.7/100,000	9.3/100,000
Assaults	13.6/100,000	0.0/100,000
Fall	4.5/100,000	7.0/100,000
Drowning	10.2/100,000	1.2/100,000

Table 5.6: Leading Cause of Injury Deaths
Source: Manitoba Health, Manitoba Provincial Injury Data Report, 2009



Chronic Disease

Is a disease that has a prolonged course of illness, does not resolve spontaneously and for which a complete cure is rarely achieved

(American Public Health Association, 1988)

Incidence Rate

Refers to the number of **new cases** of a particular condition (relative to population size) reported in a given time frame (usually by calendar years)

(Manitoba Centre Health Policy)

Prevalence Levels

Describes the proportion of the population **living with** a particular condition at a given moment in time, regardless of when the condition was contracted, diagnosed or reported

(Manitoba Centre for Health Policy)

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%**

The top diseases of concern identified by our staff, physicians and partners were:

- Diabetes
- Obesity
- Heart Health
- Cancer
- Mental Health

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**).

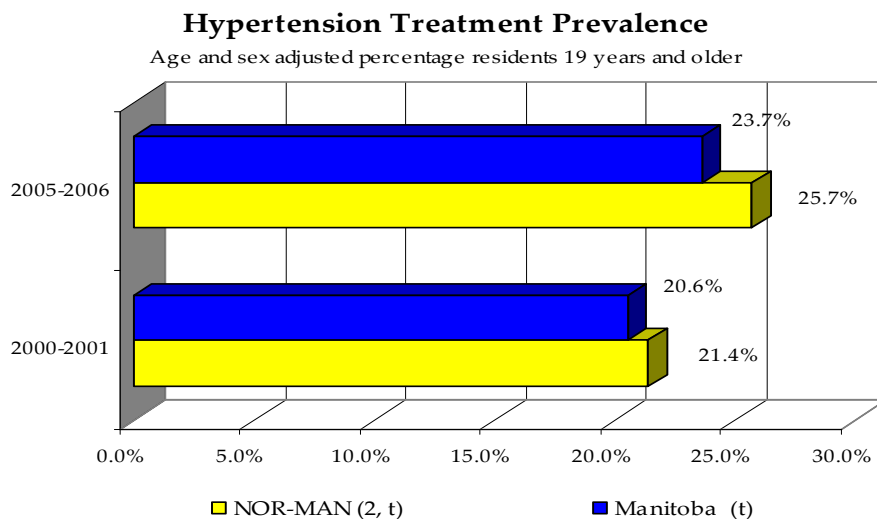
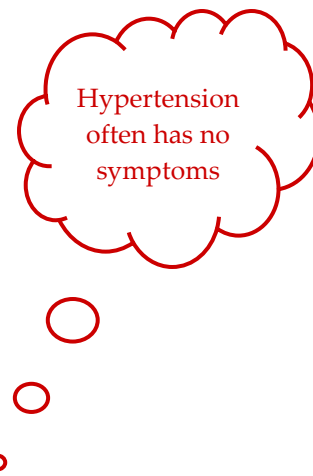


Figure 5.6 Hypertension Treatment Prevalence Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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).**

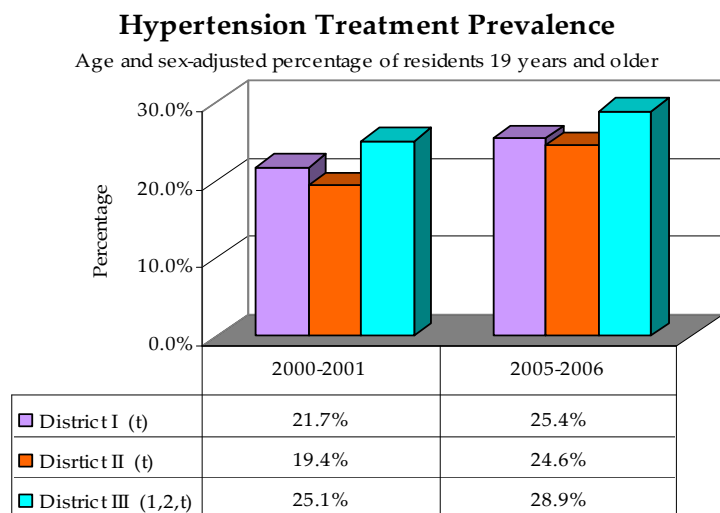


Figure 5.7 Hypertension Treatment Prevalence Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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.

Heart Health was identified as a major health concern during all our consultations

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.

Treatment Prevalence Ischemic Heart Disease (IHD)

Refers to individuals 19 and older who are diagnosed with having restriction of flow to coronary arteries defined by a combination of physician visits, hospitalization and prescription over a three year period

(Manitoba Centre for Health Policy)

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.

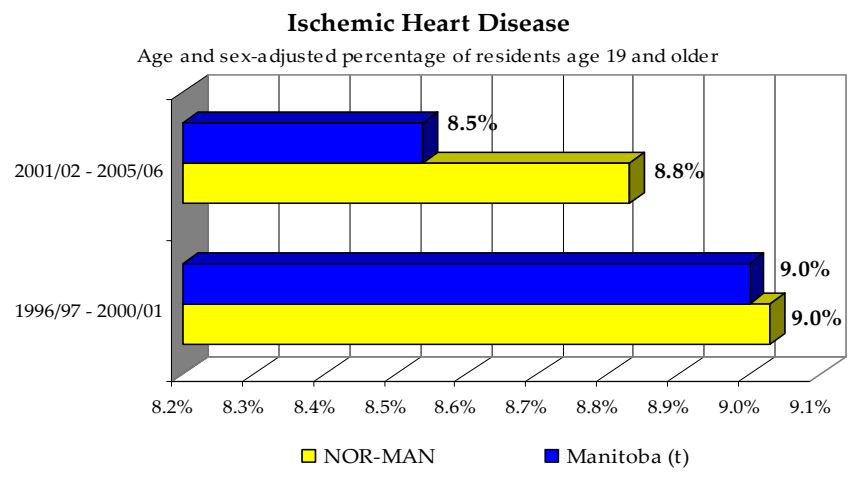


Figure 5.8 Ischemic Heart Disease Prevalence
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Ischemic Heart Disease by NOR-MAN District

Age and sex-adjusted percentage of residents age 19 and older

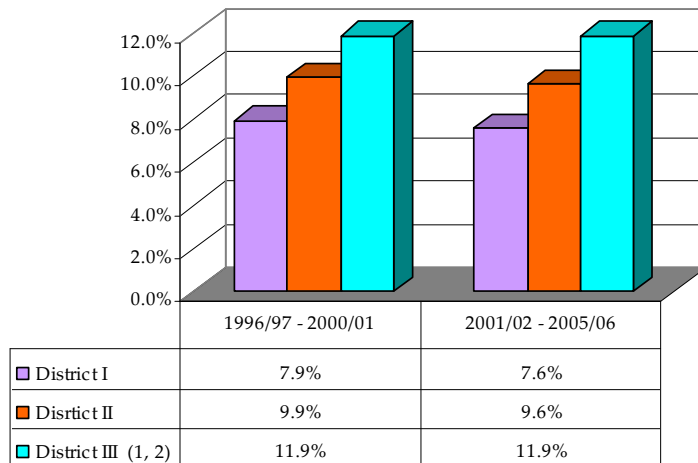


Figure 5.9: Ischemic Heart Disease by NOR-MAN District

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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 a 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

Stroke

a stroke occurs when there is a sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain.

Stroke rates are reported over a five year period

(Manitoba Centre for Health Policy)

Manitobans as shown in Figure 5.10.

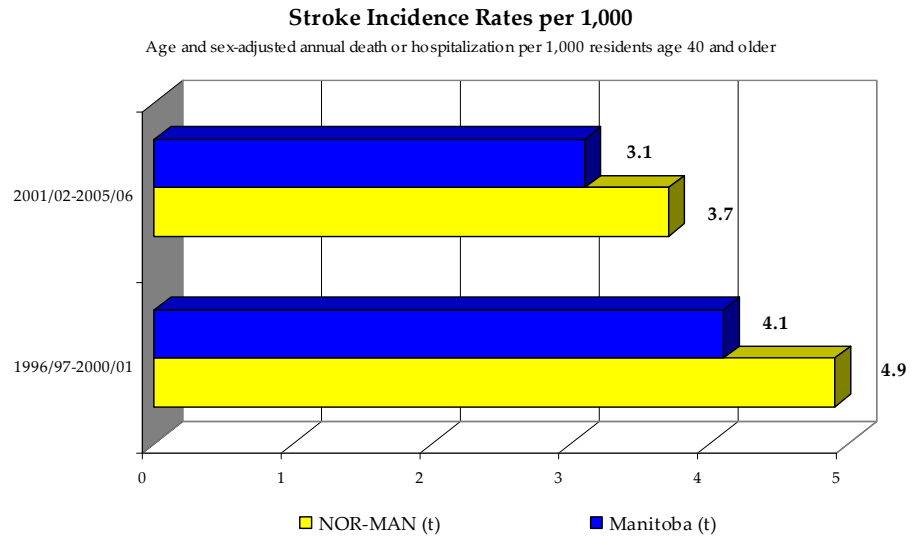


Figure 5.10: Stroke Rates per 1,000 Residents
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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 a **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

Stroke Rates by NOR-MAN District

Age and sex-adjusted annual death or hospitalization per 1,000 residents age 40

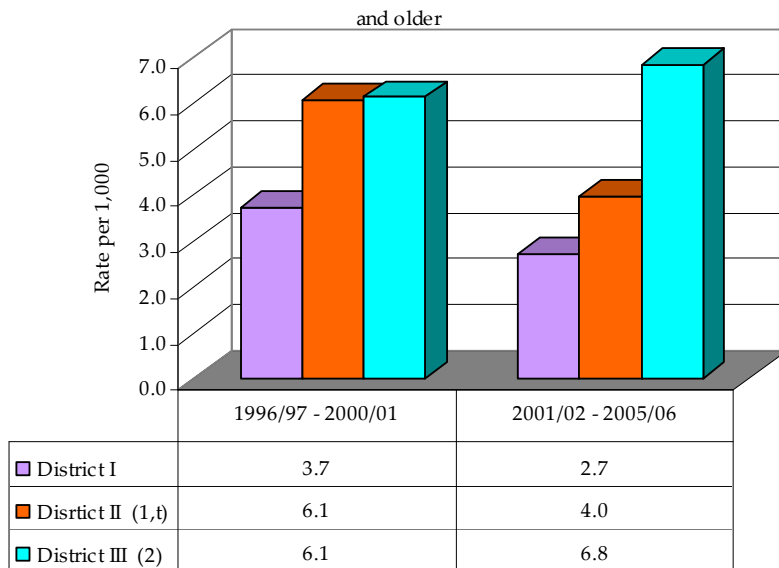


Figure 5.11: Stroke Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

(Manitoba Centre for Health Policy)

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

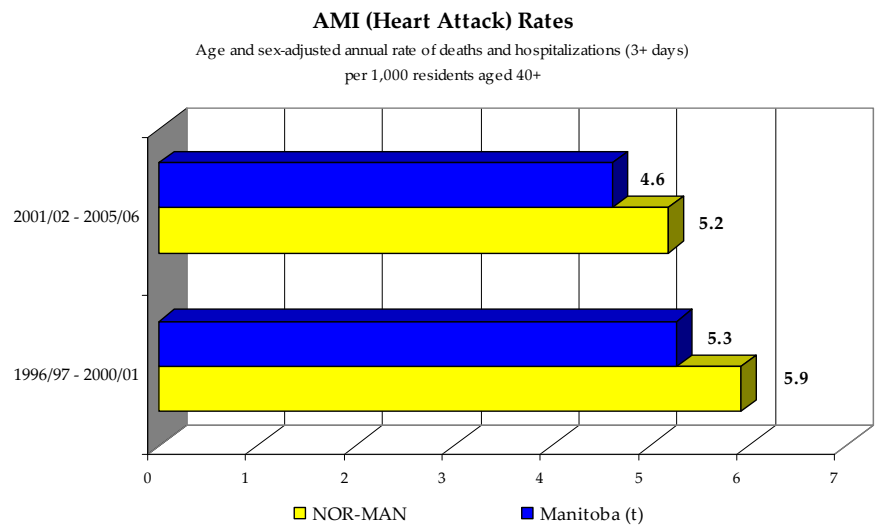


Figure 5.12: AMI (Heart Attack) Rates per 1,000 Residents
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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:

AMI(Heart Attack) rates by NOR-MAN District

Age and sex-adjusted annual rate of death and hospitalizations (3+ days) per 1,000 residents age 40+

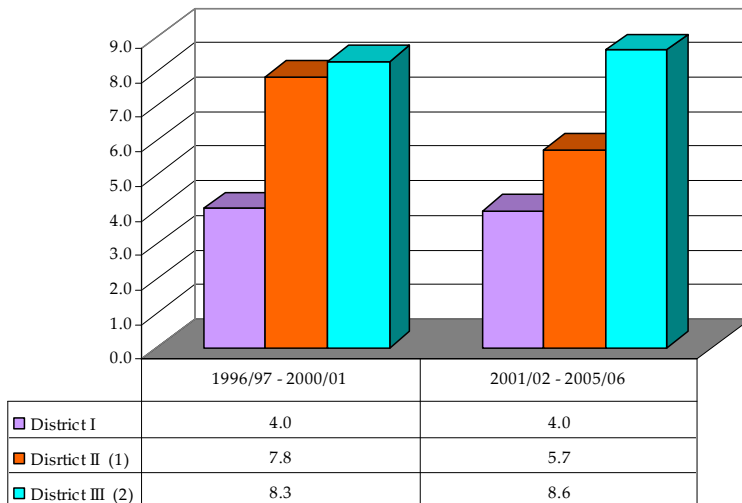


Figure 5.13: AMI (Heart Attack) Rates per 1,000 Residents by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

- 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 a **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.

Our diabetes rates continue to trend upward from 6.3% in 1986/87 to 1994/95 compared to today's rate of 13.0%

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.

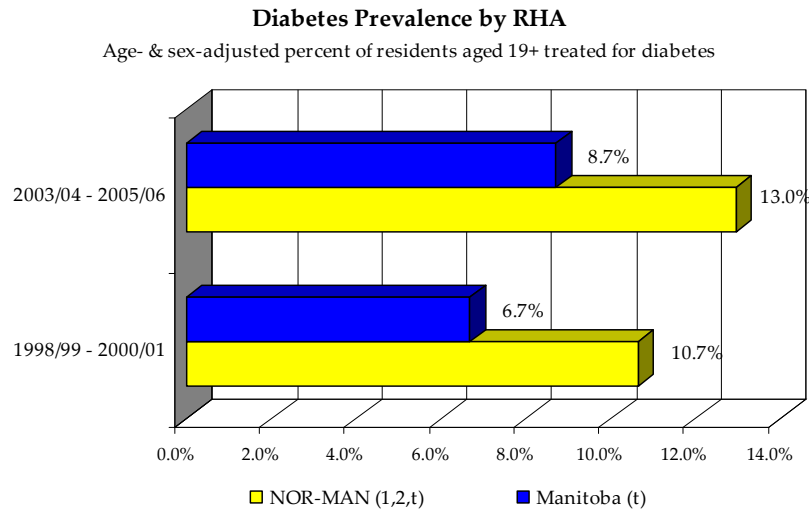
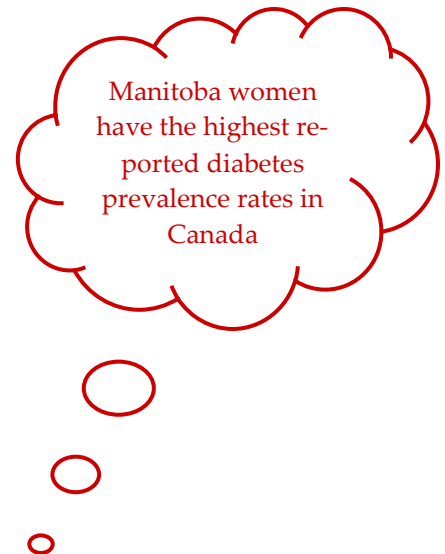


Figure 5.14: Diabetes Rate
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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:

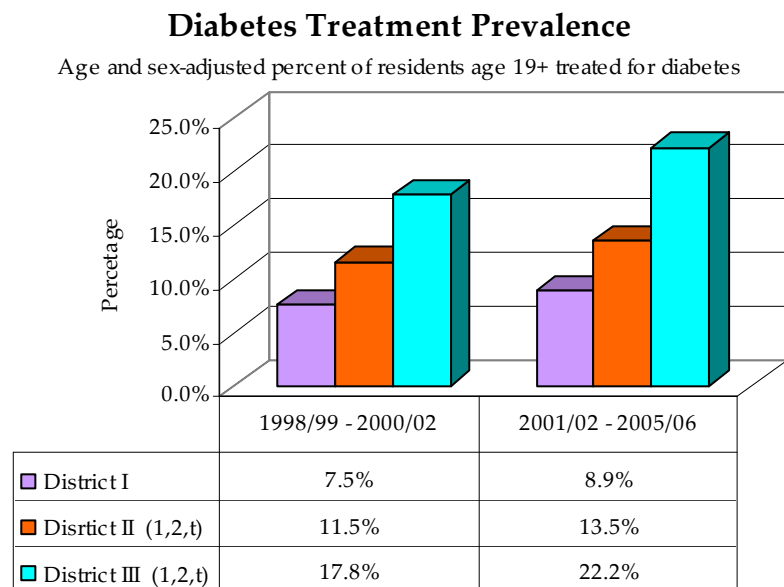


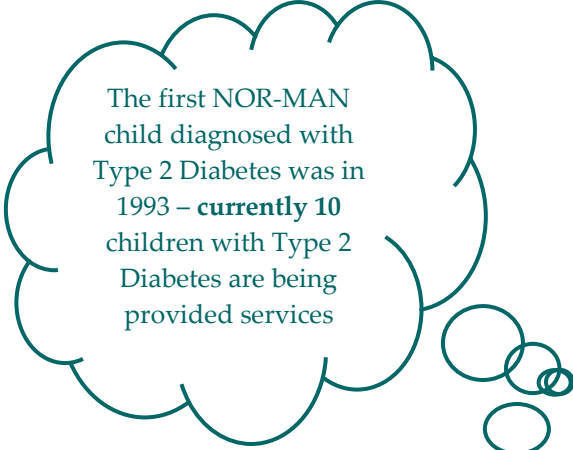
Figure 5.15: Diabetes Treatment Prevalence by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Diabetes

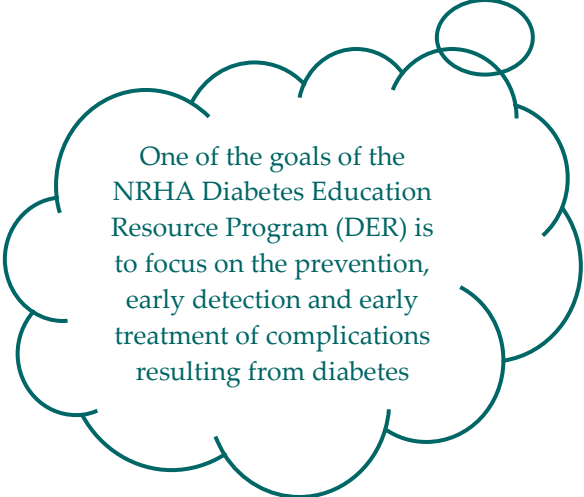
Diabetes mellitus is a chronic condition in which the pancreas no longer produces enough insulin (Type 1) or when cells stop responding to the insulin that is produced (Type 2) so that the glucose in the blood cannot be absorbed into the cells of the body.

Diabetes Treatment prevalence means having had two or more physician visits or one hospitalization in either or both of the three year time periods

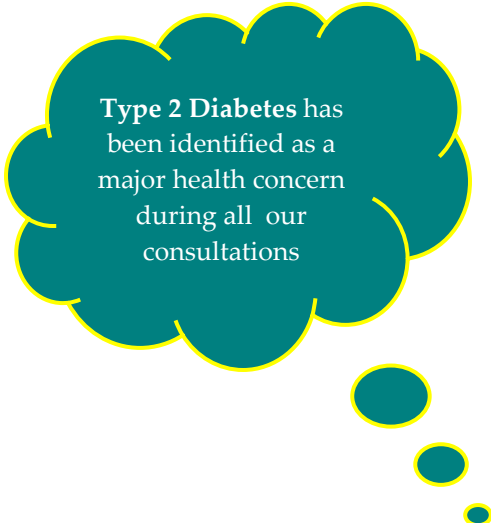
(Manitoba Centre for Health Policy)



The first NOR-MAN child diagnosed with Type 2 Diabetes was in 1993 – currently 10 children with Type 2 Diabetes are being provided services



One of the goals of the NRHA Diabetes Education Resource Program (DER) is to focus on the prevention, early detection and early treatment of complications resulting from diabetes



Type 2 Diabetes has been identified as a major health concern during all our consultations

- 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.

NOR-MAN experienced a decrease in our Lower Limb Amputations rates among residents with diabetes from 3.33% to 1.87% this change over time is statistically significant

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
 (Prairie Women’s Health Centre of Excellence)

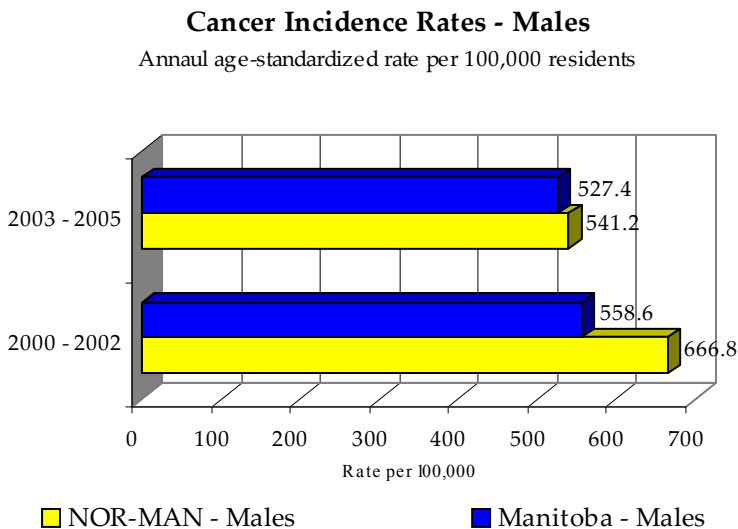


Figure 5.16: Cancer Incidence - Males
 Source: Manitoba Health, NRHA Profile Document, 2008/09

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

Figure 5.17 shows the rate of new cancers for NOR-MAN females in time period one is **507.2/100,000** compared to a provincial rate of

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.

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

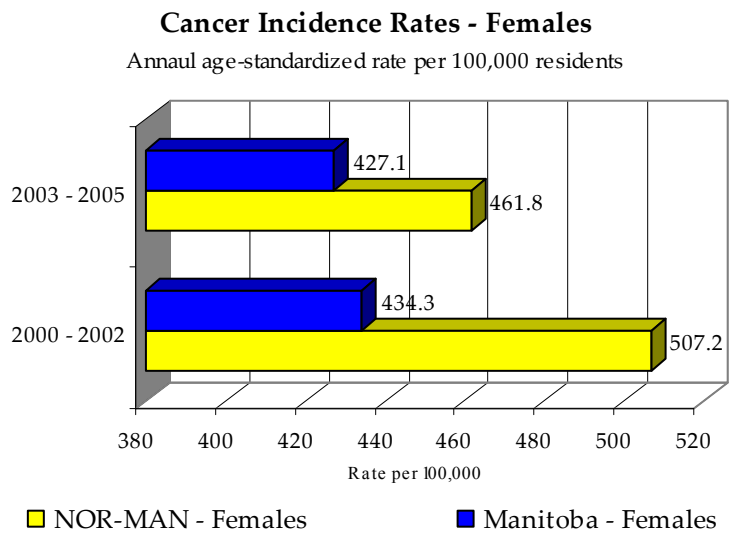


Figure 5.17: Cancer Incidence Rate - Females
Source: Manitoba Health, NRHA Profile Document, 2008/09

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:

	NOR-MAN 2000/2002 (per 100,000)		Manitoba 2000/2002 (per 100,000)		NOR-MAN 2003/2005 (per 100,000)		Manitoba 2003/2005 (per 100,000)	
	Male	Female	Male	Female	Male	Female	Male	Female
Breast		146		123		114		122
Cervical		7		9		15		9
Colorectal	87	88	82	55	71	51	51	52
Lung	131	74	87	60	142	98	85	63
Prostate	184		148		108		148	
Melanoma	11	suppressed	13	10	12	6	12	9

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 was identified as a major health concern during all our consultations

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

Cancer

Is a group of disease in which abnormal cells in some organ or tissue begins to grow in an uncontrolled manner.

Cancer prevalence rates refer to the number of people living with cancer at a certain point of time

(Prairie Women's Health Centre of Excellence)

prevalence rate of **5,145/100,000** compared to the provincial male rate of **4,811/100,000** in 2005.

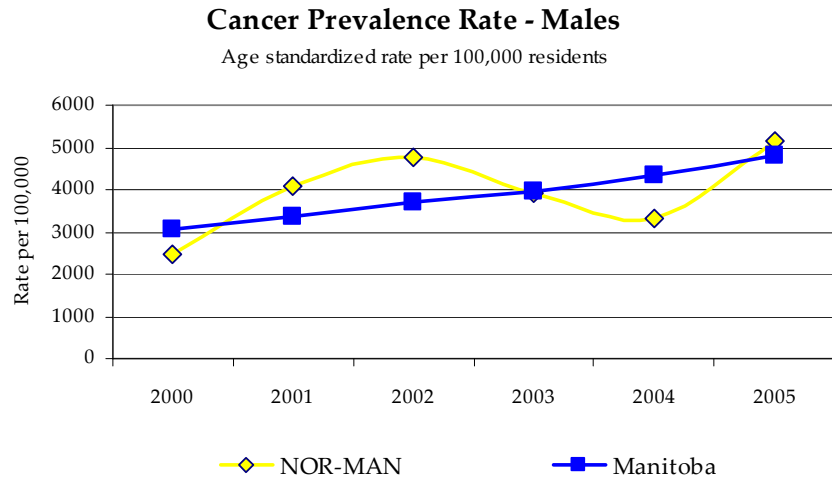


Figure 5.18: Cancer Prevalence—Males
Source: Manitoba Health, NRHA Profile Document, 2008/09

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**.

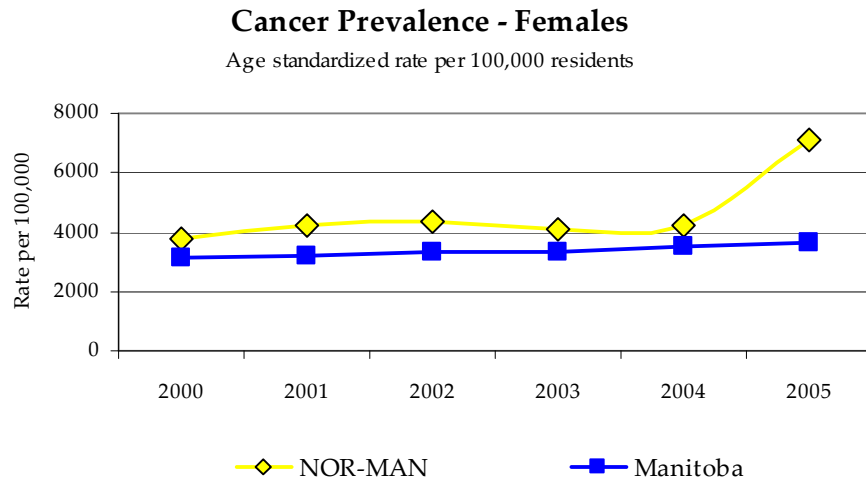
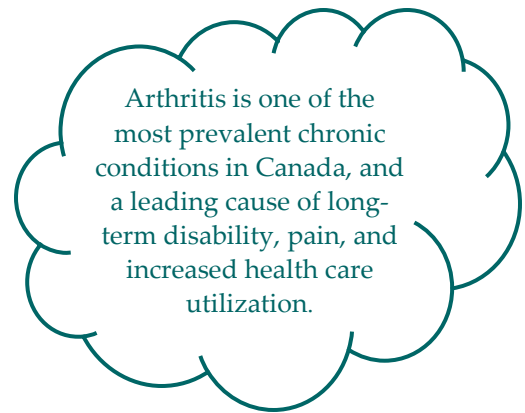


Figure 5.19: Cancer Prevalence—Females
Source: Manitoba Health, NRHA Profile Document, 2008/09

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 a group of disorders that affects joints and is often characterized by inflammation and joint or musculoskeletal pain. The most common forms of arthritis are osteoarthritis and rheumatoid arthritis

Arthritis rates are reported over a two year period

(Manitoba Centre for Health Policy)

Osteoarthritis (OA):

is caused by the breakdown of cartilage at a joint, often resulting from overuse or an injury

(Manitoba Centre for Health Policy)

Rheumatoid Arthritis (RA):

is an autoimmune disease that causes chronic inflammation in the lining of the joints

(Manitoba Centre for Health Policy)

People diagnosed with Arthritis have a substantially lower quality of life

- 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.

Total Respiratory Morbidity (TRM)

Is a measure of the burden of all types of respiratory illness in the population

TRM rates are reported a one year period

(Manitoba Centre for Health Policy)

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.

Osteoporosis

Is a disease that leads to a reduction in bone density, making bones more likely to break

Osteoporosis rates are reported over a two year period

(Manitoba Centre for Health Policy)

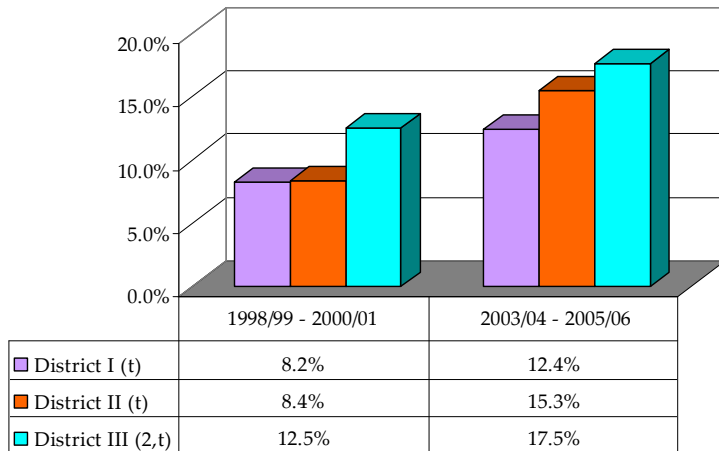
When reviewing Osteoporosis prevalence rate for 1998/99-2000/01 and 2003/04-2005/06 we have experienced an increase in our rates. During the second time period our rate of **14.6%** was statistically different (**higher**) than the provincial rate of **12.7%**.

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 underestimate 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



District III's Osteoporosis rate is statistically different (higher) at 17.5% than the provincial rate

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.

Injury Hospitalization

Is the number of hospital separations for which any injury code was included as one of the diagnoses per 1,000 residents

Injury hospitalization rates are reported over a five year period

(Manitoba Centre for Health Policy)

Injury Hospitalization Rates by RHA

Age- & sex-adjusted annual rate of hospitalizations for injury, per 1,000 residents

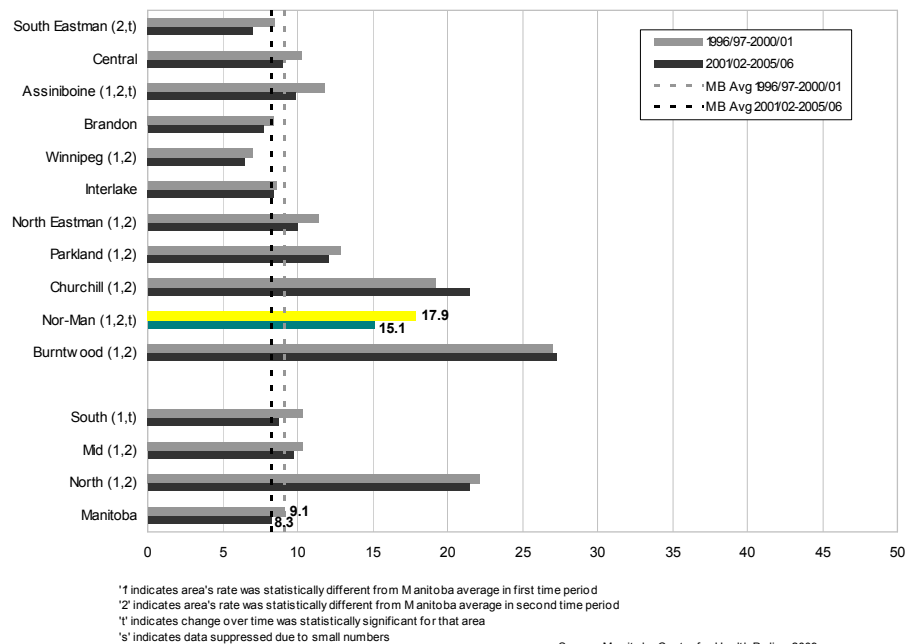


Figure 5.21: Injury Hospitalization Rates by RHA
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

The NOR-MAN males and females injury hospitalization rates have decreased over time

Table 5.8 highlights our top five injury hospitalization causes for two time periods.

	NOR-MAN 1993 - 1999		NOR-MAN 2000 - 2006	
	Male	Female	Male	Female
Falls	637.1/100,000	729.7/100,000	459.0/100,000	604.2/100,000
Assaults	324.8/100,000	93.6/100,000	267.9/100,000	75.8/100,000
Self Inflicted	107.9/100,000	329.3/100,000	79.5/100,000	236.8/100,000
Motor Vehicle / Traffic	153.3/100,000	158.7/100,000	110.1/100,000	110.8/100,000
Struck By/Against	212.4/100,000	37.9/100,000	112.4/100,000	23.3/100,000

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

Age- & sex-adjusted annual rate of hospitalizations for injury, per 1,000 residents

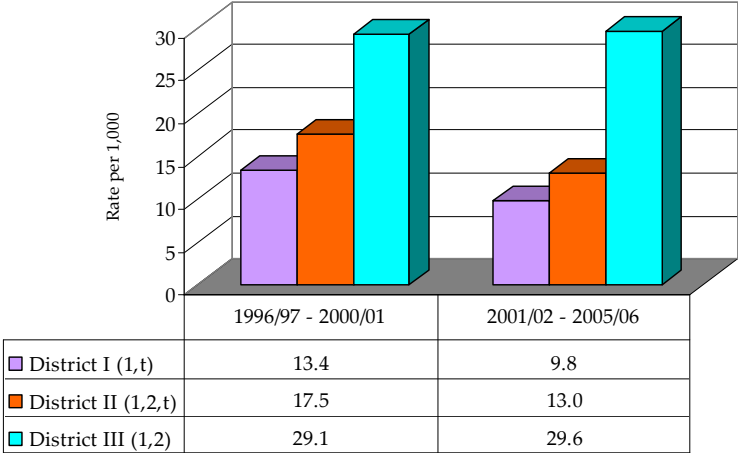


Figure 5.22 Injury Hospitalization Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Injury
is defined as:

Any specific and identifiable bodily impairment or damage resulting from acute exposure to:

Thermal Energy
Mechanical Energy
Electric Energy
Chemical Energy
Or the absence of essential energy (heat or oxygen)

(Manitoba Provincial Injury Data Report)

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%**.

Norman the Safety Moose



The NOR-MAN region experienced the **highest percentage decrease over time** of all regions for injury hospitalizations

CCHS data limitation is that surveying does not occur in First Nation Reserve Communities

54.2% of NOR-MAN males and **59.6%** of NOR-MAN females reported either excellent or very good self-rated health

Self-rate health question asked: "In general, would you say your health is ?"

Self-Rated Health

Age and sex-adjusted percentage of weighted sample age 12 and older

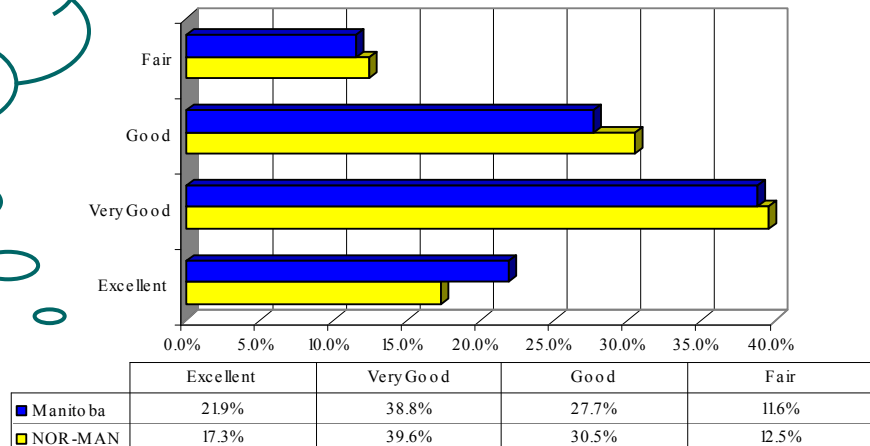


Figure 5.23: Self Rated Health - Canadian Community Health Survey
Source: Manitoba Centre for Health Policy, Manitoba RHA Indicator Atlas, 2009

54.0 % of youth and 38.0 % of adult respondents ranked their health as very good or excellent according to the Manitoba First Nations RHS

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

Functional Health
is an overall measure, based on the eight dimensions of functioning—vision, hearing, speech, mobility, dexterity, feelings, cognition and pain.

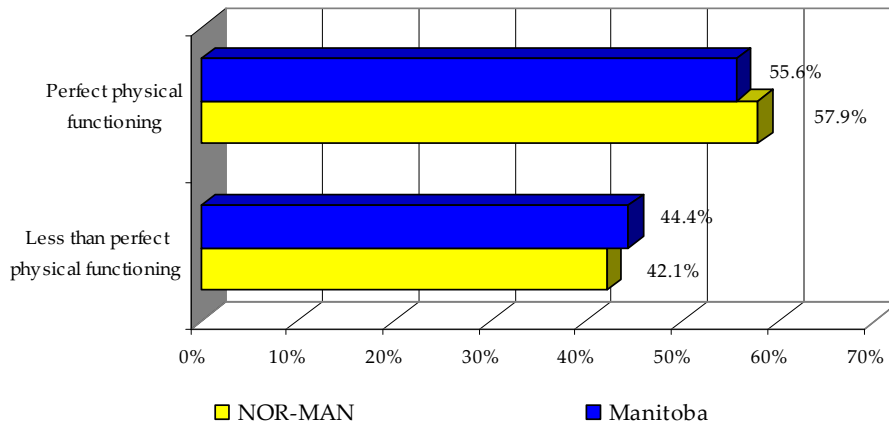
(Statistics Canada, Canadian Community Health Survey)

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).

SF-36 Perfect Physical Functioning

Age- & sex-adjusted percent of weighted sample aged 12+ with an index score of 100



62.1% of NOR-MAN males and 53.8% of NOR-MAN females reported perfect physical functioning

Figure 5.24: SF-36 Perfect Physical Functioning, Canadian Community Health Survey
Source: Manitoba Centre for Health Policy, Manitoba RHA Indicator Atlas, 2009

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.**

Lower response rates = poorer overall mental health

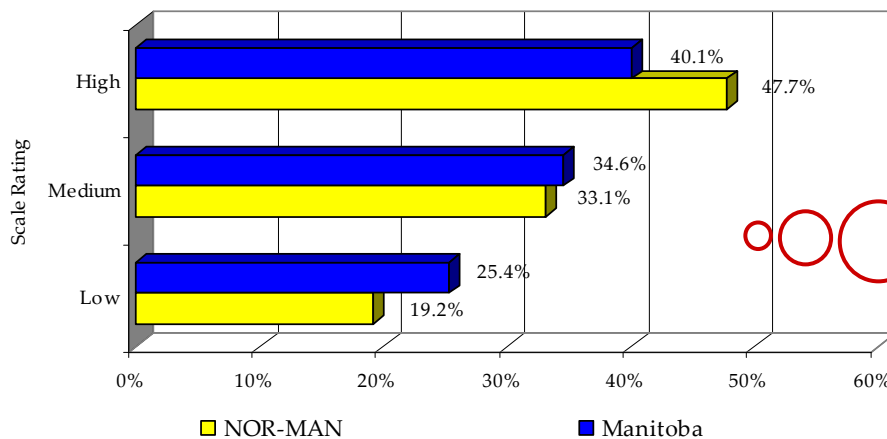
General Mental Health Scale

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.

Higher response rates = better overall mental health

SF-36 General Mental Health Scale

Age- and sex-adjusted percent of weighted sample aged 12+ within each group



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

Figure 5.25: SF-36 General Mental Health Scale, Canadian Community health Survey
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

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

Figure 5.26 shows the difference between the NOR-MAN and the provincial prevalence rates of cumulative 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)

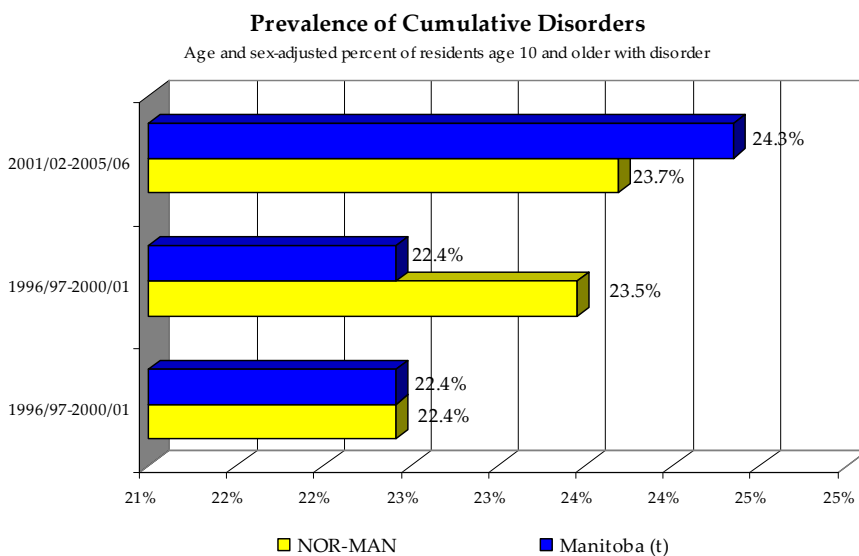


Figure 5.26: Treatment Prevalence of Cumulative Mental Health
 Source: Manitoba Centre for Health Policy, Manitoba RHA Indicator Atlas, 2009

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.

According to the Youth Health Survey 45% of NOR-MAN youth who responded that they has felt so sad in the past 12 months that they stopped doing some of their usual activities for a while

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**.

Depression

Is a mood disorder characterized by feelings of sadness, anger, frustration, and lack of interest in activities that persist to the point that they interfere with daily life for an extended period of time.

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)

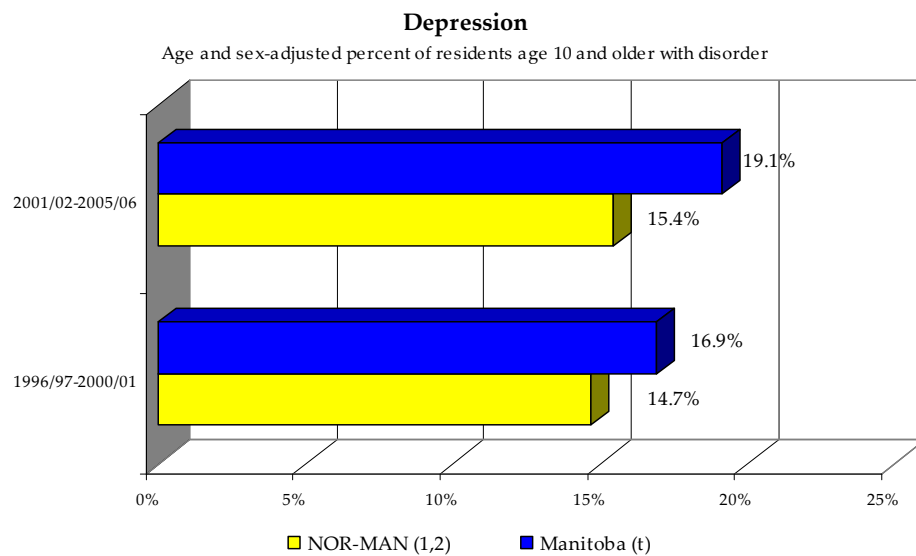


Figure 5.27: Treatment Prevalence of Depression
Source: Manitoba Centre for Health Policy, Manitoba RHA Indicator Atlas, 2009

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)

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)

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.

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.

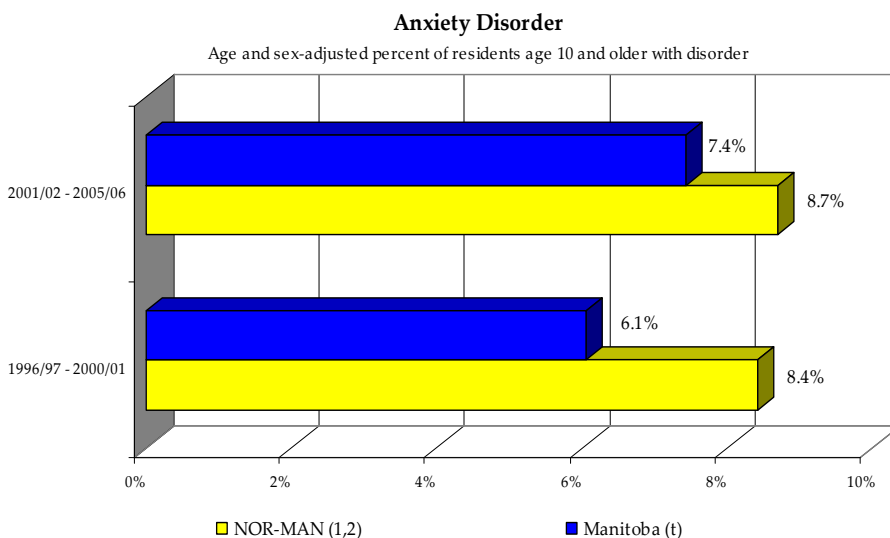


Figure 5.28: Treatment Prevalence of Anxiety Disorders
 Source: Manitoba Centre for Health Policy, Manitoba RHA Indicator Atlas, 2009

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.

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

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.

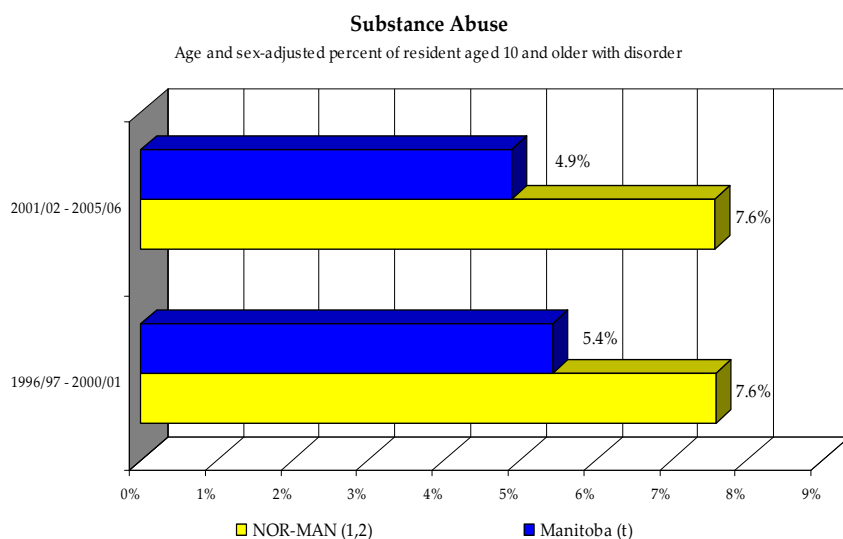
Figure 5.29 shows that the NOR-MAN prevalence rate for substance abuse in both time periods is **statistically different (higher) than the provincial rate.**

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)

Figure 5.29: Treatment Prevalence of Substance Abuse - Aged 10+
 Source: Manitoba Centre for Health Policy, Manitoba RHA Indicator Atlas, 2009



Alcohol and drugs were identified as major health concerns during all our consultations

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

Is a class of mental illness characterized by chronic behavioral and relationship patterns that often cause serious personal and social difficulties as well as general impairment of functioning

Rates are the proportion of residents age 10 and over diagnosed in hospital abstracts or physician claims over a five year period

(Manitoba Centre for Health Policy)

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

is a long term mental illness that affects how a person thinks, feels and acts

Rates are the proportion of residents age 10 and over diagnosed in hospital abstracts or physician claims over a five year period

(Manitoba Centre for Health Policy)

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.

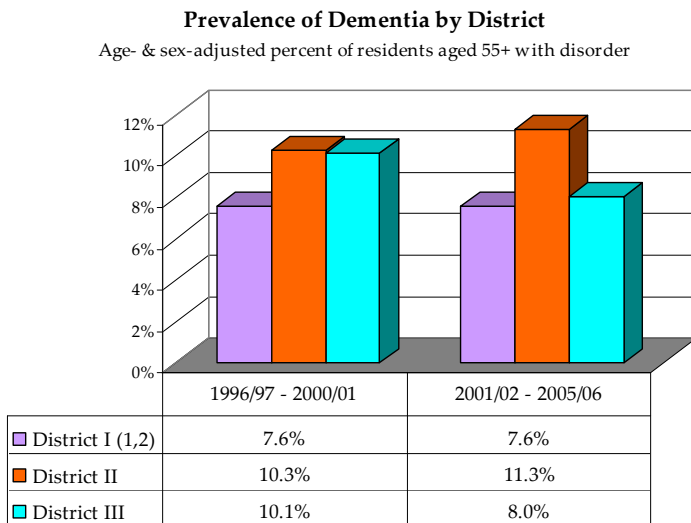


Figure 5.30: Dementia Prevalence Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

Dementia

is a loss of brain function, referring to a group of illness that involve memory, behaviour, learning, and communication problems which get worse over time

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)

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.

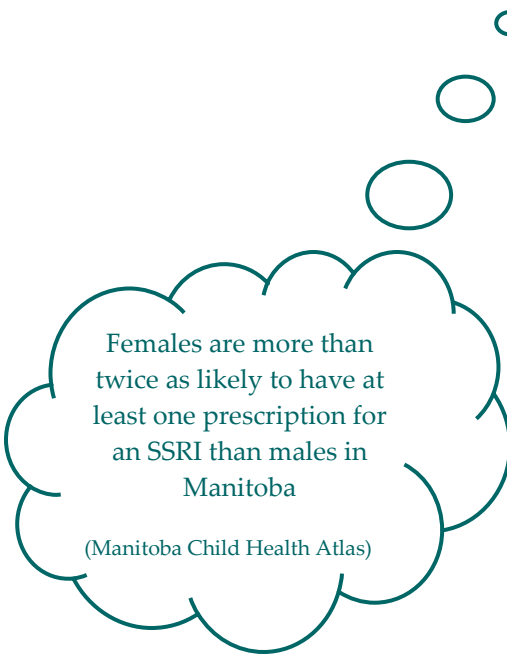
Adolescents/Teenagers on Antidepressants

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.



Females are more than twice as likely to have at least one prescription for an SSRI than males in Manitoba

(Manitoba Child Health Atlas)

Antidepressant

is a medication used for the treatment and prevention of depression

Rates are the proportion of children age 10 to 19 years who have had at least one antidepressant prescription in a one year period

(Manitoba Centre for Health Policy)

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 than the average Manitoba male (76.3 years)
- Females experienced a small decrease in life expectancy during the 2001 to 2005 time

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

One of our big concerns is the fact that 59.6% of the NOR-MAN population is under forty (40) years of age and has not yet reached the age when incidence and prevalence of Diabetes increase dramatically

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

The top diseases of concern identified by our staff, physicians and partners were:

- Diabetes
- Obesity
- Heart Health
- Cancer
- Mental Health

Heart Health was identified as a major health concern during all our consultations

Diabetes was identified as health concern during all our consultation

Cancer was identified as a major health concern during all our consultations

Lack of recreational opportunities was identified as a concern during our consultations

- 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)

- 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

Mental health issues were identified as health concern during all our consultation

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

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

NRHA DISTRICTS

District I

Flin Flon
Cranberry Portage
Snow Lake

District II

The Pas
Opaskwayak Cree Nation (CN)
Rural Municipality (RM) of Kelsey

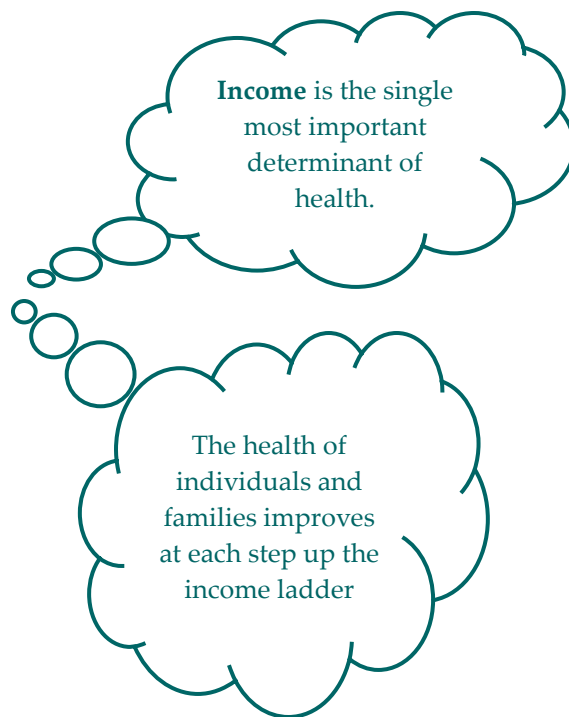
District III

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)

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.

Income Inequality: Low Income

Refers to the proportion of income (from all sources, pre-tax, post-transfer) held by households whose incomes fall below the median household income, by RHA and district.

A proportion of 50% would represent no inequality - the lower the percentage the higher the inequality

(Statistics Canada)

	1996		2001		2006	
	NOR-MAN	MB	NOR-MAN	MB	NOR-MAN	MB
Unattached Individuals	30%	45%	29%	40%	25%	38%
Private households	18%	21%	15%	18%	15%	17%
Economic households	15%	16%	12%	13%	12%	17%

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.

	District I	District II	District III
Unattached Individuals	20%	33%	13%
Private households	13%	16%	18%
Economic households	10%	13%	17%

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:

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)

- 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.

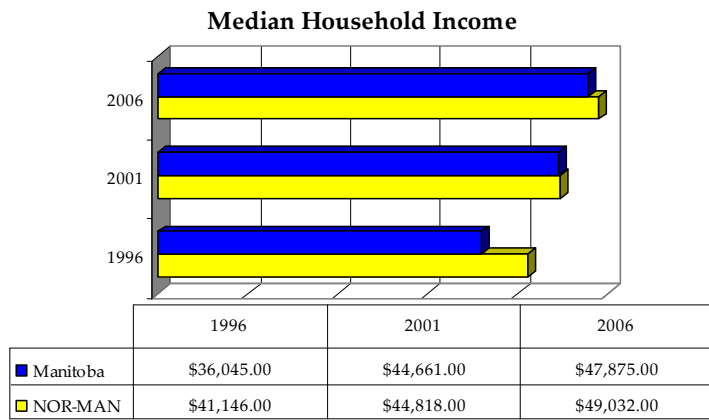


Figure 6.1: Income Inequality: Median Household Income
Source: Manitoba Health, NRHA Profile Document, 2008/09

Median Household Income

Refers to the dollar amount that marks the midpoint of a distribution of individuals, with income, ranked by size of income - median household income is calculated for all household units in the census of Canada, whether or not they report income

(Statistics Canada)

Table 6.3 shows the median household income by NOR-MAN districts for the time periods of 2001 and 2006.

	District I	District II	District III
2001	\$52,584.00	\$43,274.00	\$32,875.00
2006	\$57,887.00	\$47,172.00	\$40,518.00

Table 6.3: Income Inequality: Median Household Income by NOR-MAN Districts
Source: Manitoba Health, NRHA Profile Document, 2008/09

Gap between high and low income earners in District I is apparent given the fact that District I is experiencing more income inequality than NOR-MAN as a whole

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.

NOR-MAN rates are similar to Manitoba as a whole

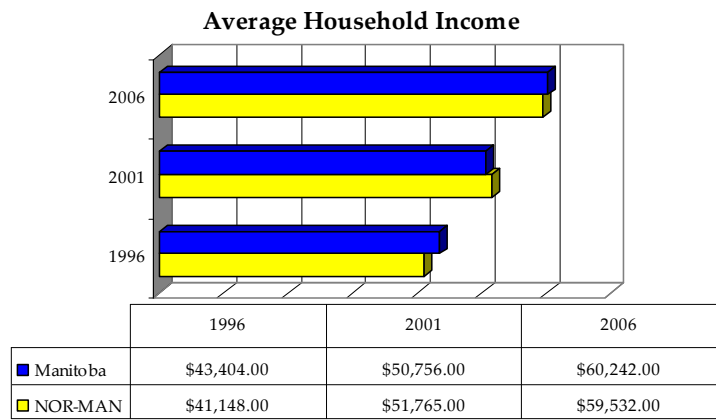


Figure 6.2: Income Inequality: Average Household Income
Source: Manitoba Health, NRHA Profile Document, 2008/09

Table 6.4 shows the average household income by NOR-MAN districts.

	District I	District II	District III
2001	\$56,646.00	\$51,208.00	\$44,427.00
2006	\$63,825.00	\$59,129.00	\$53,035.00

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.

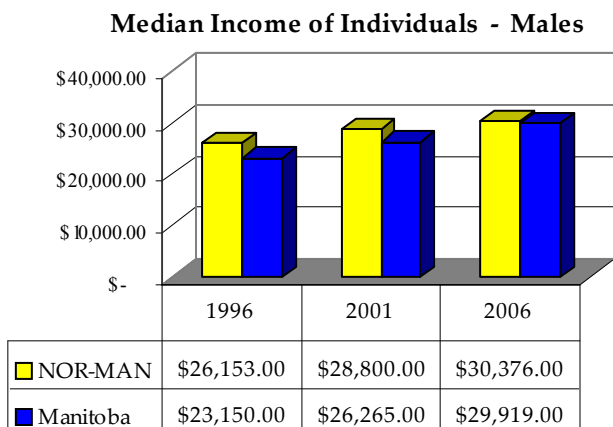
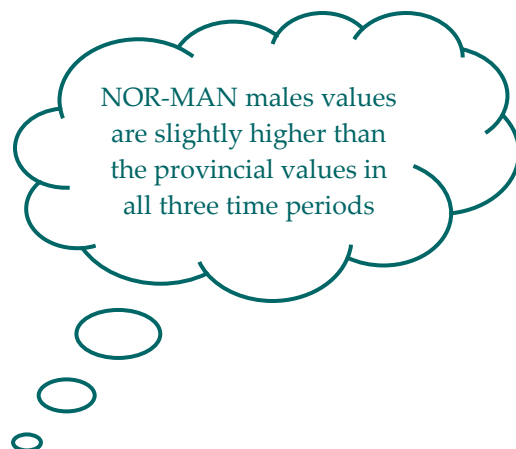


Figure 6.3: Income Inequality: Median Individual Income - Males
Source: Manitoba Health, NRHA Profile Document, 2008/09



When reviewing median individual - male income values for NOR-MAN districts as show in Table 6.5 , the following highlights are to be noted:

	District I	District II	District III
2001	\$42,487.00	\$26,057.00	\$14,376.00
2006	\$44,449.00	\$28,327.00	\$17,585.00

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



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.

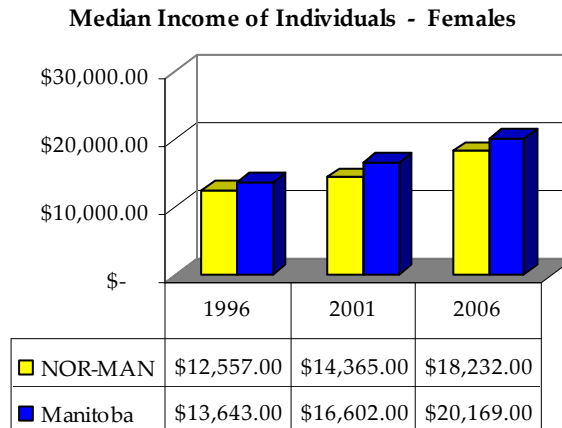


Figure 6.4: Income Inequality: Median Individual Income - Females
Source: Manitoba Health, NRHA Profile Document, 2008/09

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

NOR-MAN female values are slightly lower than the provincial values in all three time periods

When reviewing median individual - female income values by NOR-MAN districts as shown in Table 6.6, the following highlights are to be noted:

	District I	District II	District III
2001	\$14,833.00	\$15,750.00	\$11,885.00
2006	\$17,892.00	\$20,303.00	\$16,144.00

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.

Occupations

refers to the kind of work a person was doing during the reference week, as determined by their kind of work and the description of the main activities in their job

(Statistics Canada)

Top Six Occupation Comparisons

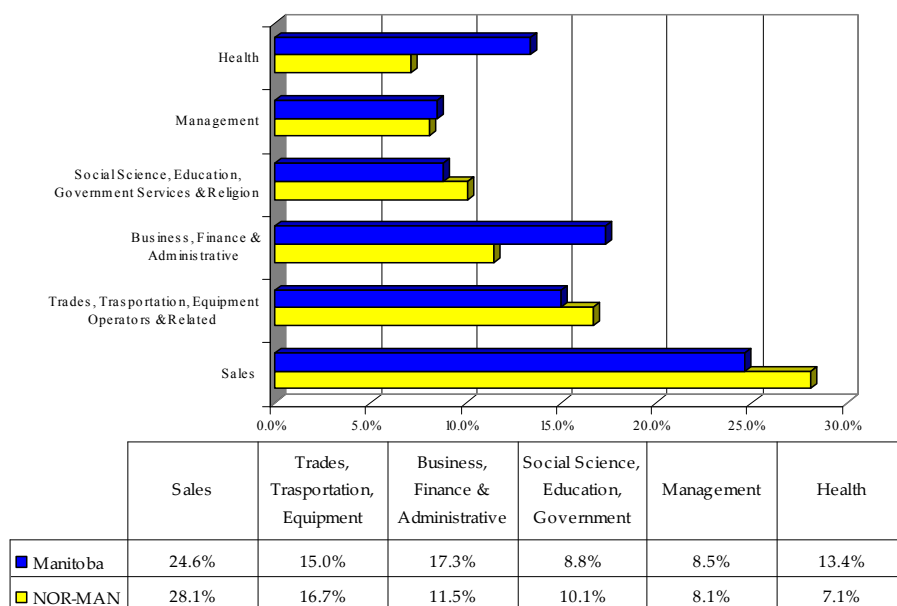


Figure 6.5: Top Six Occupation Comparisons
Source: Statistics Canada, 2006 Community Profile

Sales is the largest occupation type for both NOR-MAN residents at **28.1%** and Manitoba residents as a whole at **24.6%**.

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

NOR-MAN males have experienced an increase in our Unique to Primary Industry (jobs associated with primary resources) with rates from 11.2% in 2001 to 14.8% in 2006

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.

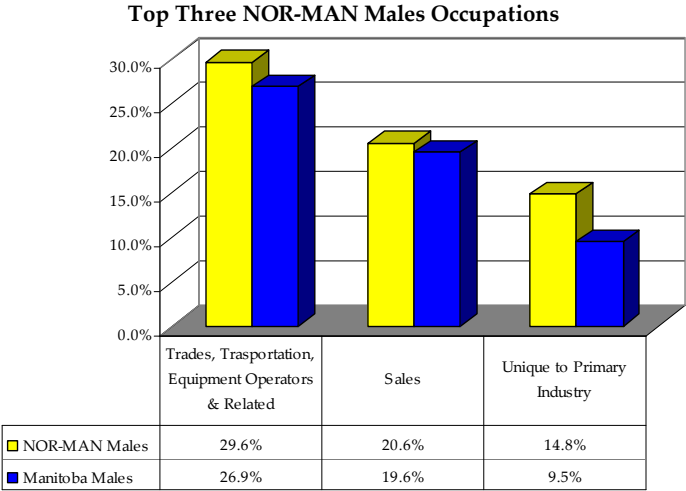
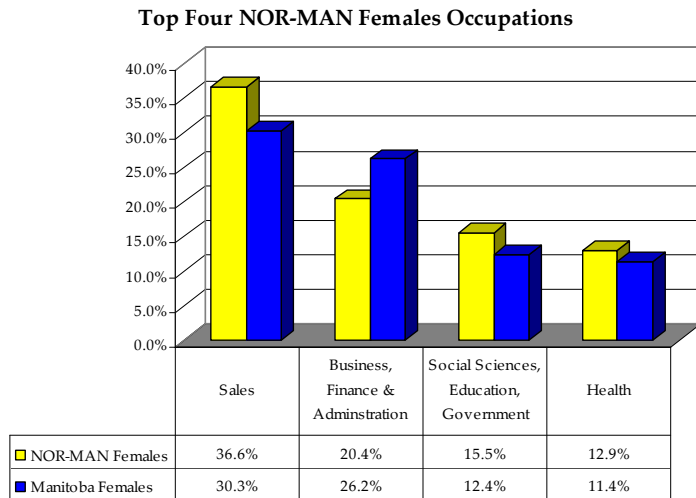


Figure 6.6: Top Three Occupation Comparisons - Males
Source: Statistics Canada, 2006 Community Profile

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.



NOR-MAN females have experienced a decrease in our Unique to Social Services, Education, Government service and religion rates from 19.5 % in 2001 to 15.5% in 2006

Figure 6.7: Top Four Occupation Comparisons - Females
Source: Statistics Canada, 2006 Community Profile

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.

NOR-MAN males have a higher youth unemployment rate than NOR-MAN females

Loss of employment opportunities for youth was identified as a concern during our consultations

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.

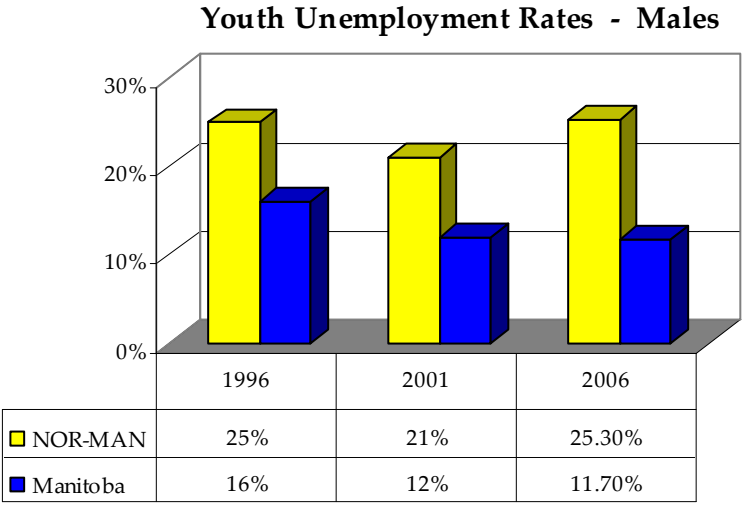


Figure 6.8: Youth Unemployment Rates - Males
Source: Manitoba Health, NRHA Profile Document, 2008/09

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%**.

Youth Unemployment Rates - Females

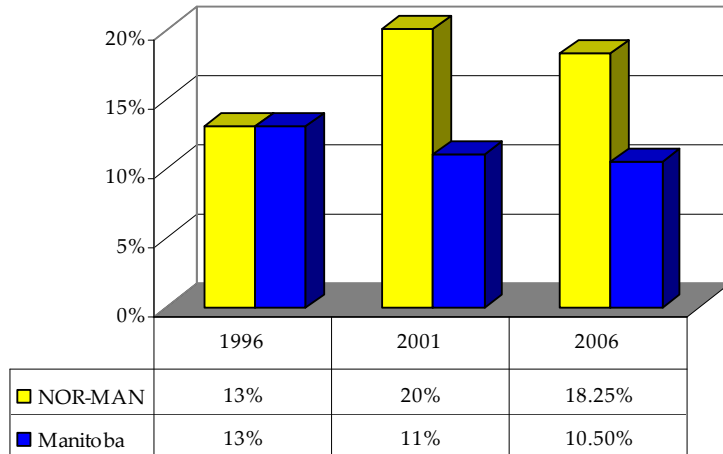


Figure 6.9: Youth Unemployment - Females
 Source: Manitoba Health, NRHA Profile Document, 2008/09

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.

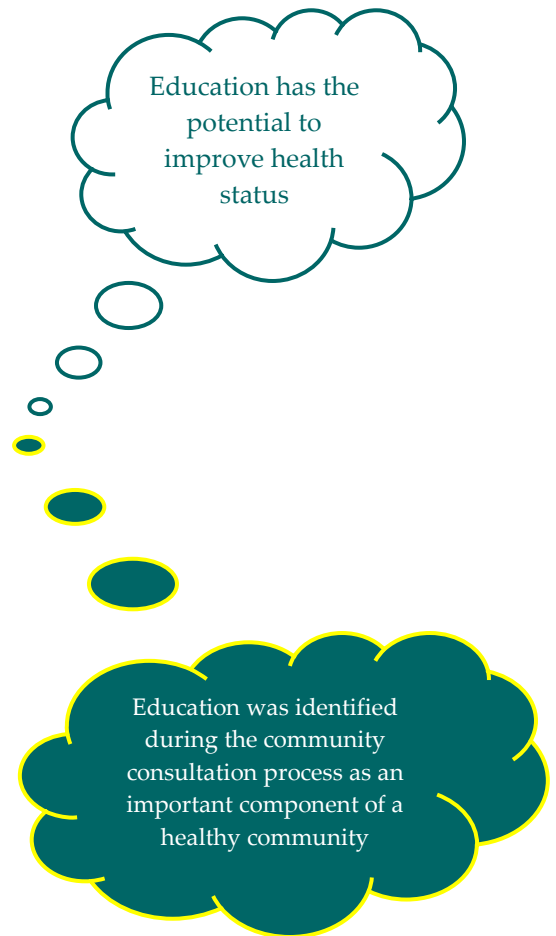
Education

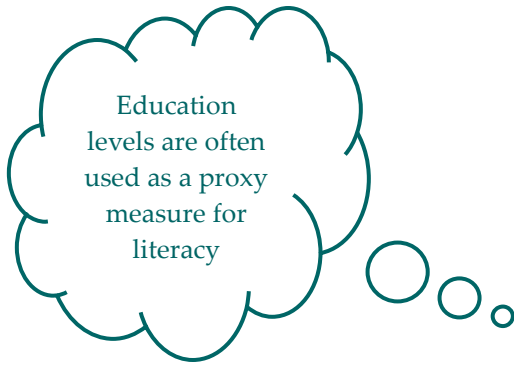
Education is an important determinant of health. Individuals with little schooling are more likely to have low paying jobs, have periods of unemployment or are on welfare, and have a higher probability of being functionally illiterate.

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

Is the percentage of grade three students with no school changes in a four year period

(Manitoba Centre for Health Policy)

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

Adjusted by sex: Percent of students that did not change schools in a four year period

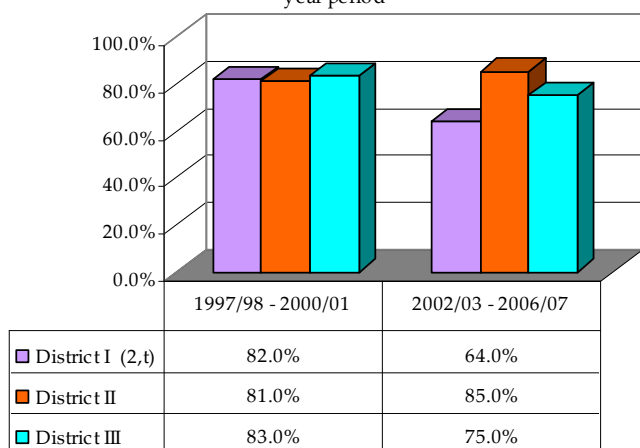


Figure 6.10: School Changes by NOR-MAN District
Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

Youth Health Survey results for school connectedness - Agree/strongly agree by NOR-MAN students were:

- Feel close to people at this school - 66%
- Feel I am part of the school - 69%
- Happy to be at school - 66%
- Feel safe in my school - 67%

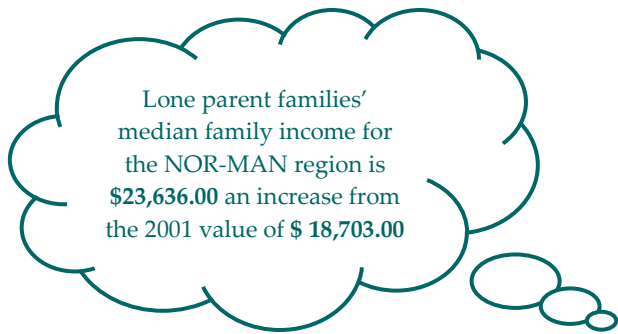
Living Conditions

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%.

We have slightly less people that are married at 46% compared to Manitoba and Canada at 50%



The 2001 Census reported a higher number of Lone Parent families with 1,395 or 22% compared to 2006

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)

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.

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.**

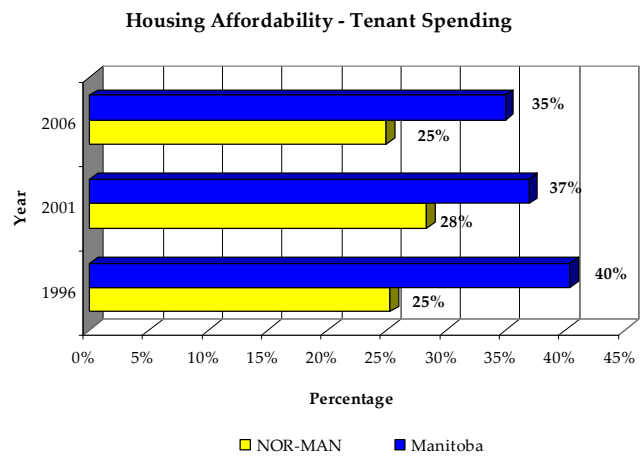


Figure 6.11: Housing Affordability - Tenant Spending
Source: Manitoba Health, NRHA Profile Document, 2008/09

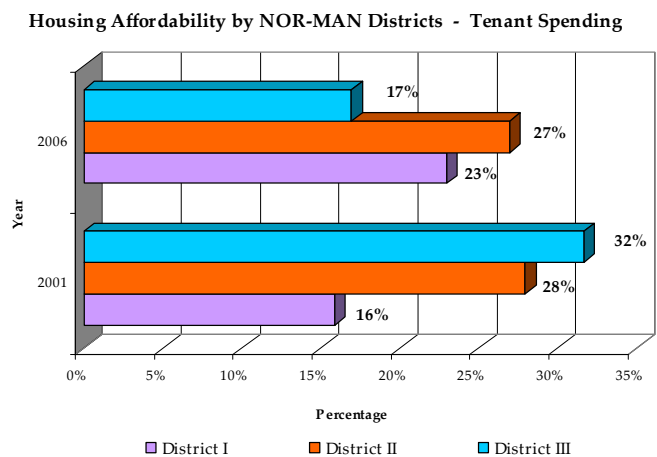


Figure 6.12: Housing Affordability by NOR-MAN District - Tenant Spending
Source: Manitoba Health, NRHA Profile Document, 2008/09

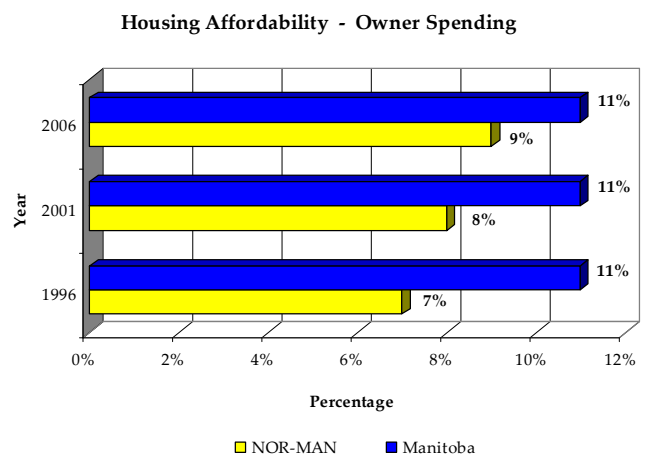


Figure 6.13: Housing Affordability - Owner Spending
Source: Manitoba Health, NRHA Profile Document, 2008/09

Average number of rooms per NOR-MAN dwelling is 6.2 rooms

Average household size in NOR-MAN is 2.7 individuals

Housing Affordability by NOR-MAN District - Owner Spending

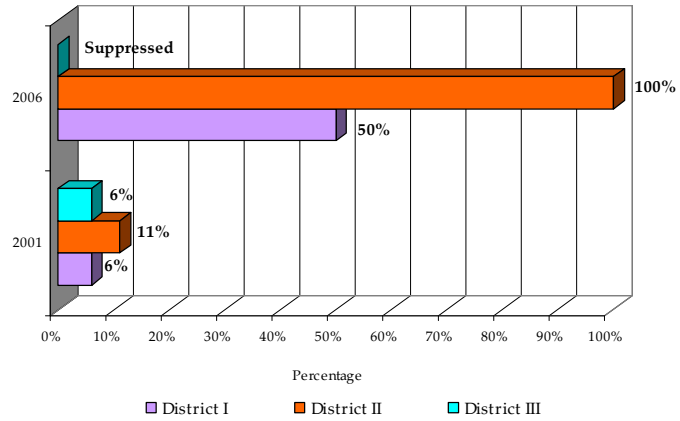


Figure 6.14: Housing Affordability by NOR-MAN District - Owner Spending
Source: Manitoba Health, NRHA Profile Document, 2008/09

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.

Dwellings With More Than 1 Person Per Room
% of total occupied private dwellings

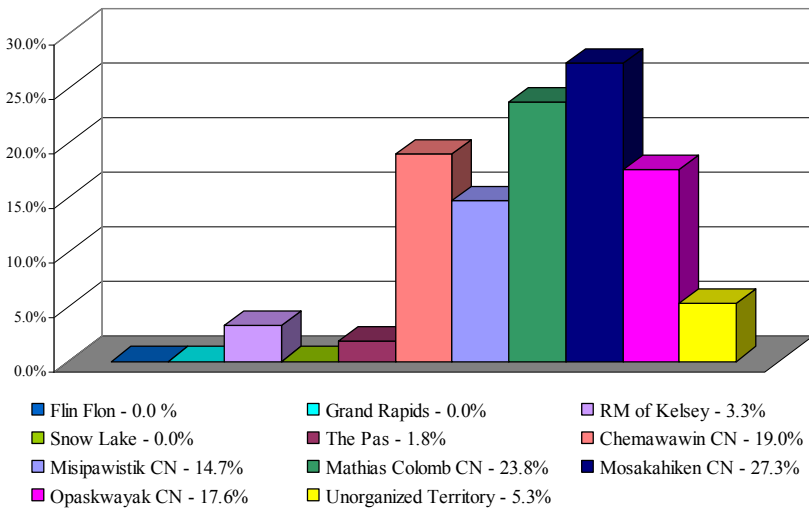


Figure 6.15: Dwellings with More than One Person Per Room
Source: Statistics Canada, 2006 Community Profile

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%.

84% of youth reported they currently live in an overcrowded home
(Manitoba First Nations Regional Longitudinal Survey)

48% of adults reported their home has a mold or mildew problem
(Manitoba First Nations Regional Longitudinal Survey)

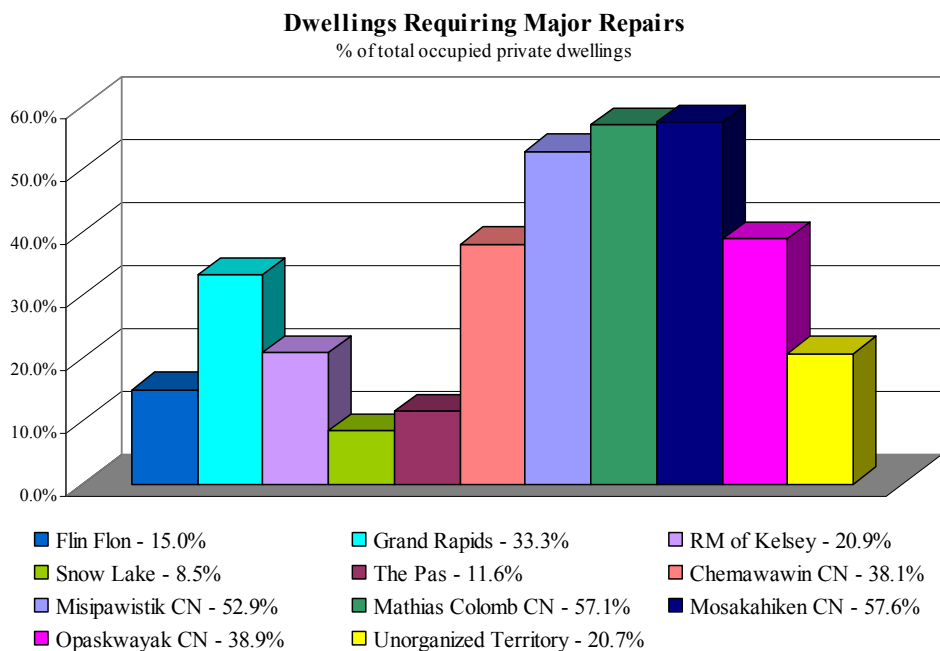


Figure 6.16: Dwellings Requiring Major Repairs
Source: Statistics Canada, 2006 Community Profile

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.

Limited housing options was identified as a concern during our consultations

Healthy Child Development

is a future predictor of how well children are :

- able to learn in school;
- able to cope with life experiences; and
- how healthy they will be as adults.

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

Total NOR-MAN Births by year are:

- 2003/04 = 434
- 2004/05 = 410
- 2005/06 = 389
- 2006/07 = 435
- 2007/08 = 458

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

Pre-term Birth Weights

Preterm birth has been identified as one of the most important perinatal health problem in industrialized nations and in Canada.

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**

Preterm Birth

Is a any live birth where the gestational age was less than 37 weeks.

(Manitoba Centre for Health Policy)

in five years that the NOR-MAN rate has been higher at 9.1% than the provincial rate at 8.2%.

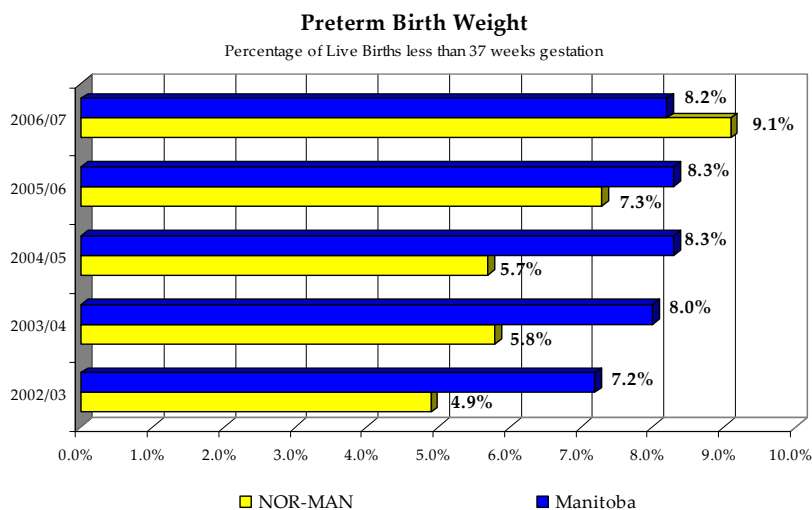
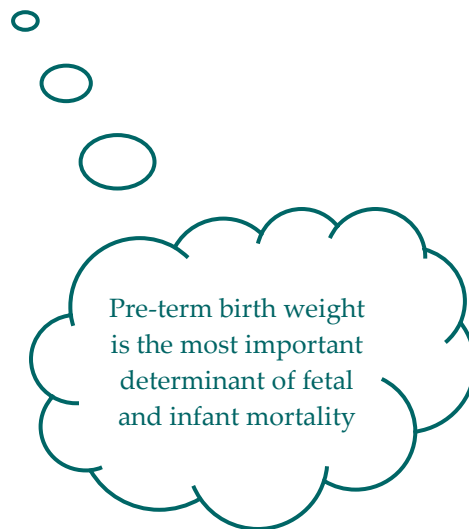


Figure 6.17: Preterm Birth Weight Rates
Source: Manitoba Health, NRHA Profile Document, 2008/09



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 a 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)

Teen Birth Rates - Ages 15-19 years

Age-adjusted rates per 1,000 females

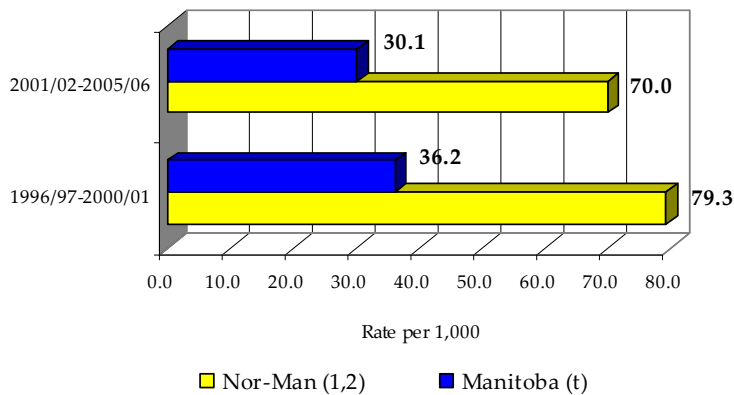


Figure 6.18: Teen Birth Rates - Ages 15-19 Years
Source: Manitoba Health, NRHA Profile Document, 2008/09



Teen Birth Rate of Women Aged 15-19 by NOR-MAN District

Age-adjusted rates per 1,000 females

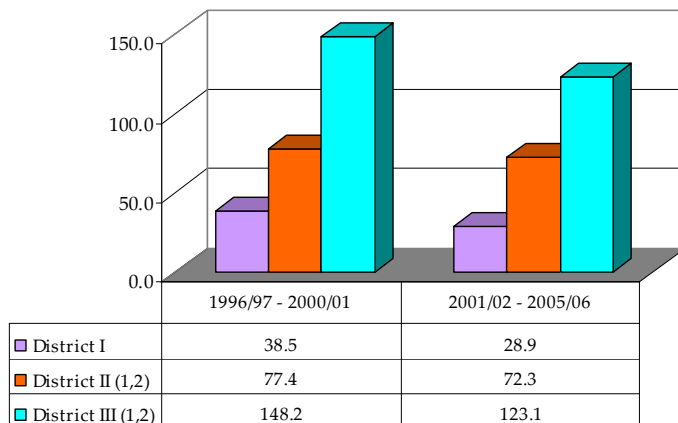


Figure 6.19: Teen Birth Rates by NOR-MAN District
Source: Manitoba Health, NRHA Profile Document, 2008/09

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

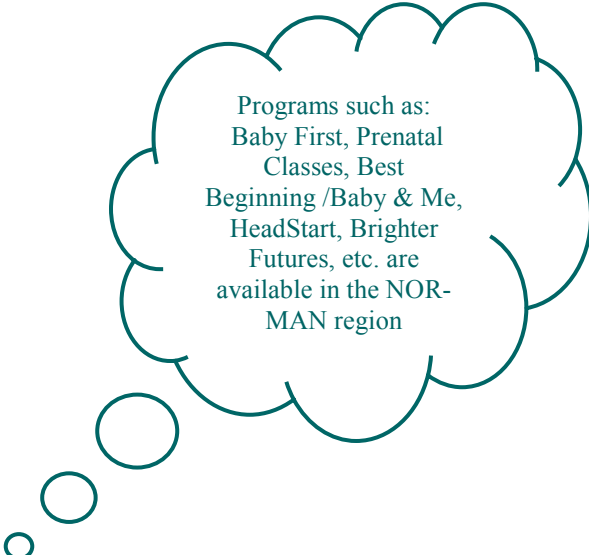
High Birth Weights (HBW)

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)



Programs such as: Baby First, Prenatal Classes, Best Beginning /Baby & Me, HeadStart, Brighter Futures, etc. are available in the NOR-MAN region

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:

High Birth Weights by NOR-MAN District
5-Year Average

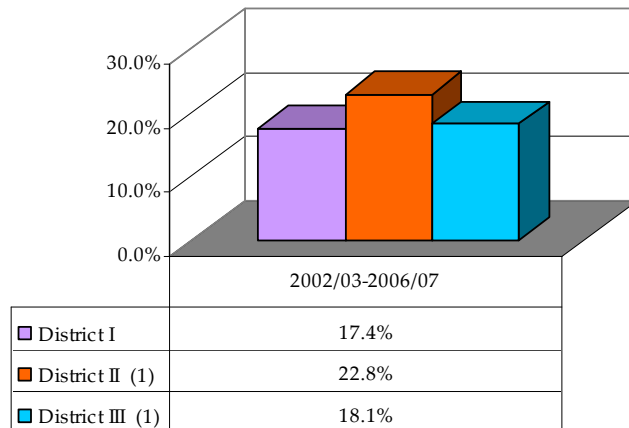


Figure 6.20: High Birth Weights by NOR-MAN District
Source: Manitoba Health, NRHA Profile Document, 2008/09

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%**

NRHA Primary Health Care, Manitoba Health and First Nations Inuit Health Branch (FNIHB) are all involved in immunizations in the NOR-MAN region

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**

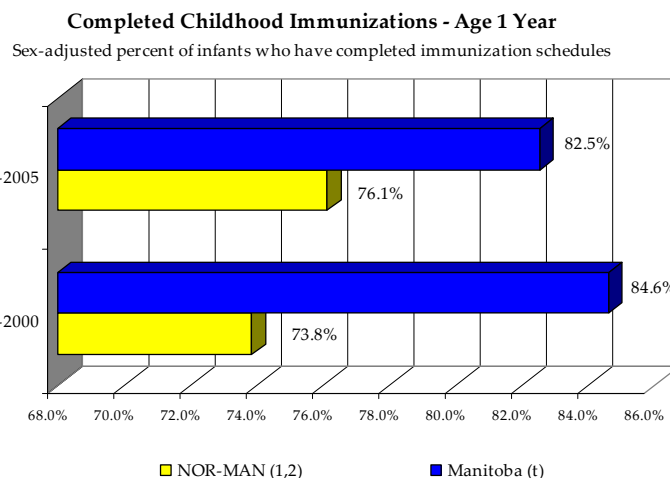


Figure 6.21: Completed Childhood Immunizations - Age 1 Year
Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

Generally, immunization rates are lower in areas that have the poorest overall health status

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:

Completed Childhood Immunizations - Age 1 Year by NOR-MAN District

Sex-adjusted percent of children who have completed immunization schedules

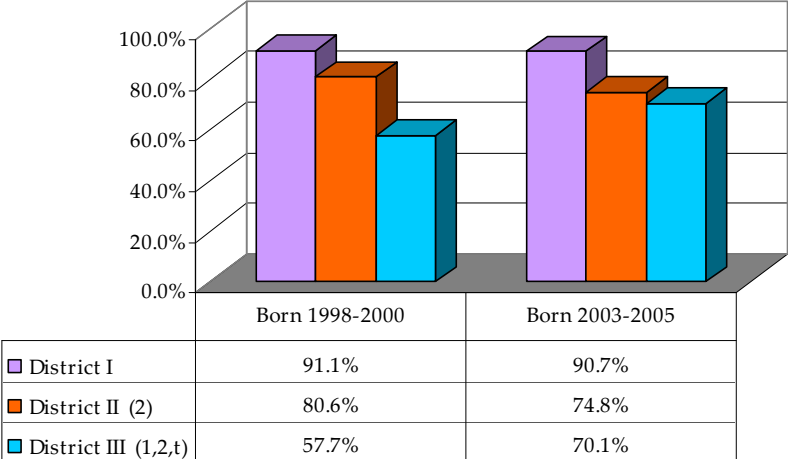


Figure 6.22: Completed Childhood Immunizations - Age 1 Year by NOR-MAN District
Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

- 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

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**.

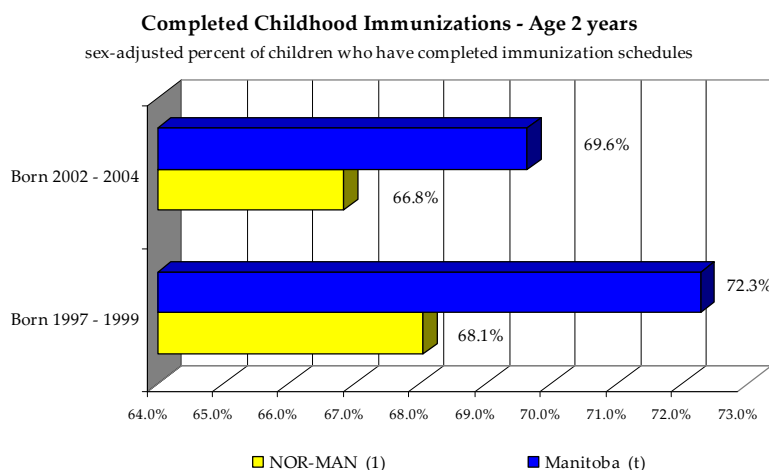


Figure 6.23: Completed Childhood Immunizations - Age 2 Years
Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

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

Completed Childhood Immunizations - Age 2 Years by NOR-MAN District

Sex-adjusted percent of children who have completed immunization schedules

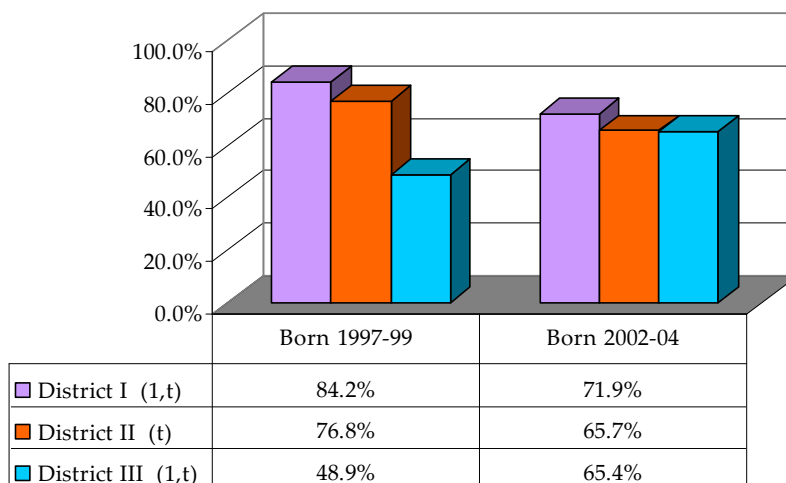


Figure 6.24: Completed Childhood Immunizations - Age 2 Years by NOR-MAN District
Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

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.**

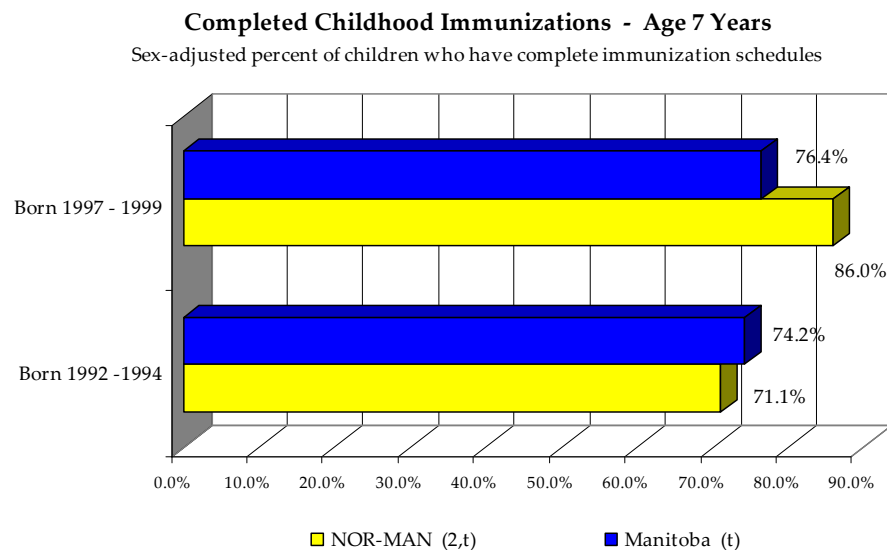


Figure 6.25: Completed Childhood Immunizations - Age 7 Years
Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

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 are 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

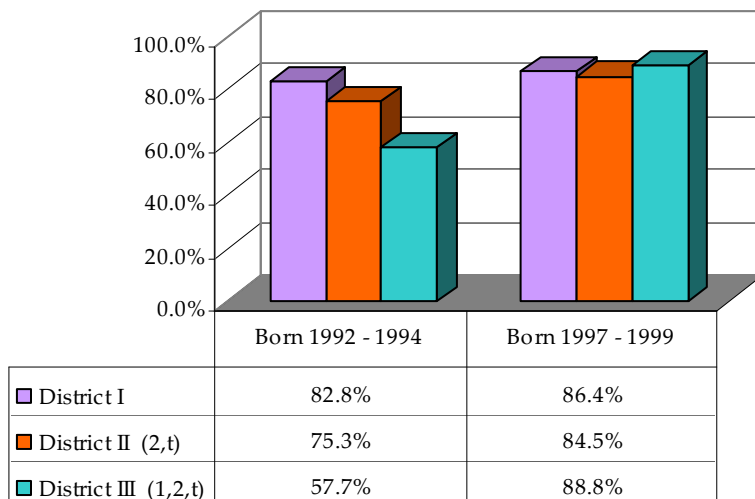


Figure 6.26: Completed Childhood Immunizations - Age 7 Years by NOR-MAN District
Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

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

Breastfeeding Initiation

Refers to when a mother begins to feed her infant milk from her breast

Rates are calculated by the ratio of live births who were exclusively or partially breast fed by the number of live births

(Statistics Canada)

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

Breastfeeding Initiation Rates by NOR-MAN District

Age-adjusted percent of mother, all ages

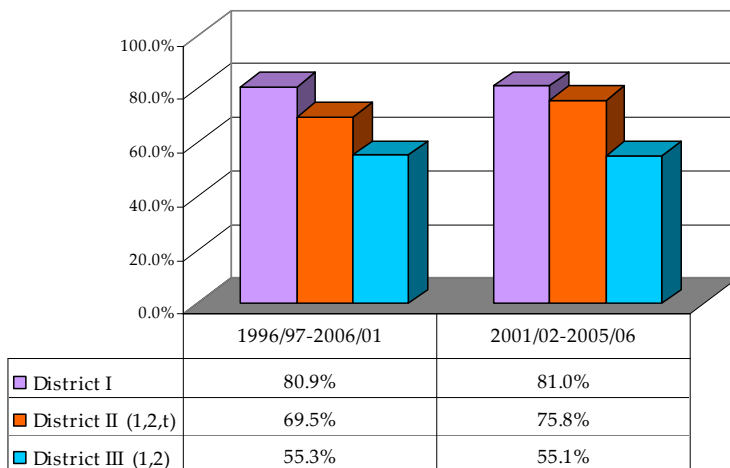


Figure 6.27: Breastfeeding Initiation Rates by NOR-MAN Districts
Source: Manitoba Centre for Health Policy, Child Health Atlas, 2008

- 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

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.

Readiness for School

Refers to the readiness of a child to begin grade one

Children are assessed in each of the following five areas of development:

- Physical health & well-being
- Social competence
- Emotional maturity
- Language & cognitive skills
- Communication skills & general knowledge

(Healthy Child Manitoba)

Percentage of Kindergarten Children "Not Ready" (bottom 10%) for School

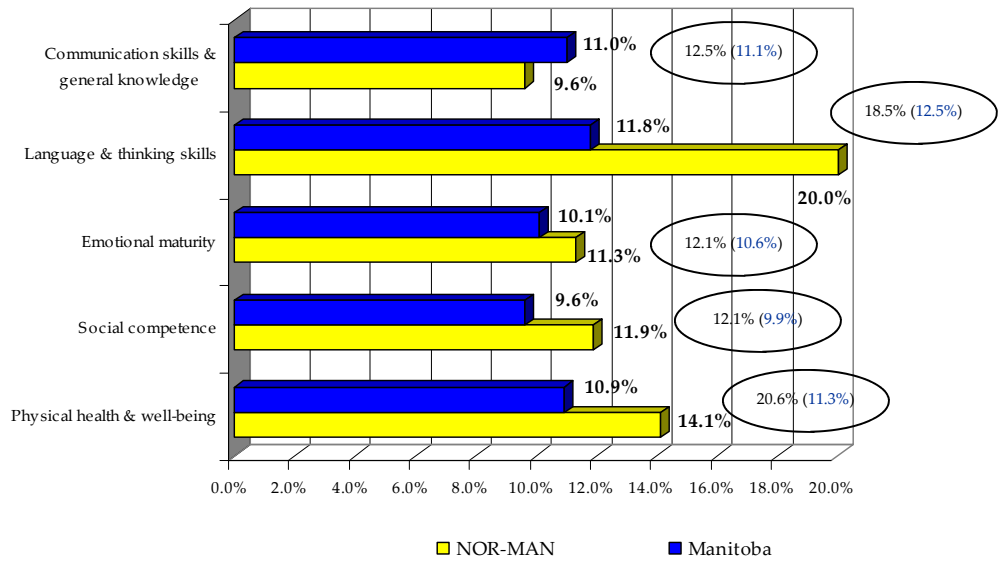


Figure 6.28: Percentage of Kindergarten Children "Not Ready" (bottom 10%) for School
Source: Healthy Child Manitoba

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 at and physical health & well-being.

Also, our results for every category but emotional maturity improved during 2005-2006.

Percentage of Kindergarten Children "Very Ready" (top 30%) for School

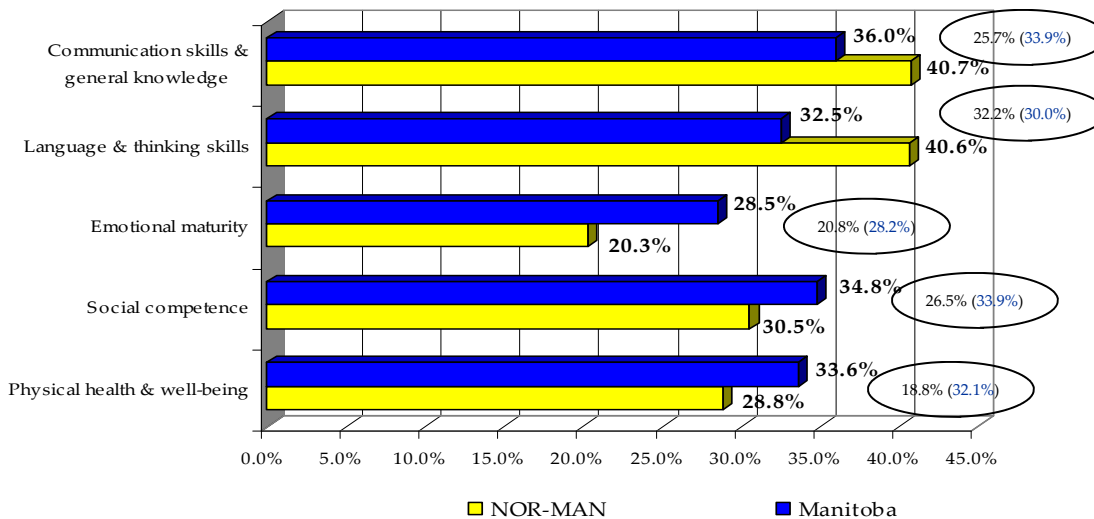


Figure 6.29: Percentage of Kindergarten Children "Very Ready" (top 30%) for School
Source: Healthy Child Manitoba

Important to remember that a rating over 10% indicates a need in that areas of development

(Healthy Child Manitoba)

Important to remember that a rating over 30% indicates strength in that areas of development

(Healthy Child Manitoba)

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)

CCHS data limitations is that surveying does not occur in First Nation Reserve Communities

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%**.

The gap in life-expectancy between smokers and non-smokers has widened over the past several decades.

Tobacco Smoking Rates by RHA

Age- and sex-adjusted percent of weighted sample age 12+ from combined CCHS cycles 1.1 (2001), 2.1 (2003), and 3.1 (2005)

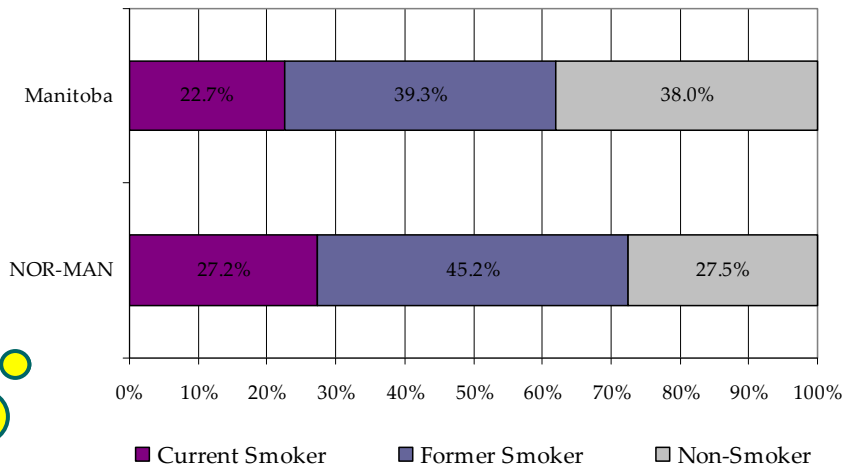


Figure 6.30: Tobacco Smoking Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

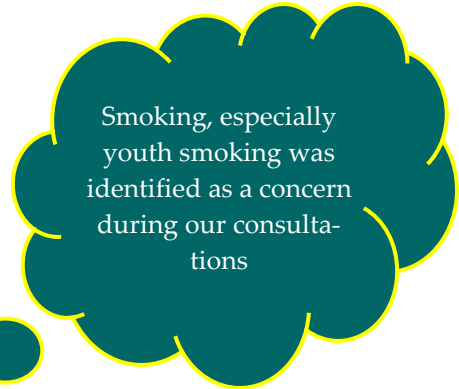
When reviewing the data for former smokers, NOR-MAN is home to a larger number of former smokers at **45.2%** than the province as a whole at **39.3%**.

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:

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%

- 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%**

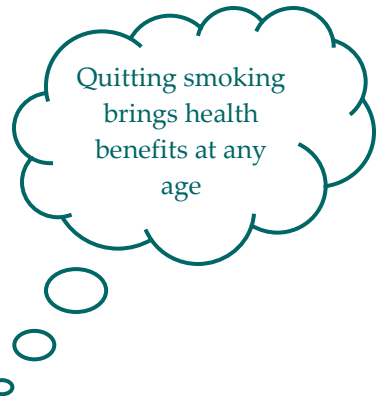


Smoking Types	NOR-MAN Males	NOR-MAN Females
Current Smoker	28.0%	26.5%
Former Smoker	49.4%	41.1%
Non-Smoker	22.6%	32.4%

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

Tobacco Smoking Rates by NOR-MAN District

Age- and sex-adjusted percent of weighted sample age 12+ from combined CCHS cycles 1.1 (2001), 2.1 (2003), and 3.1 (2005)

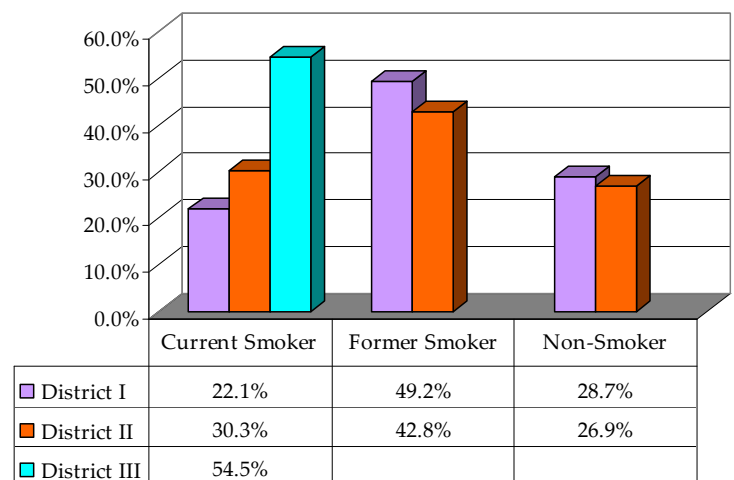


Figure 6.31: Tobacco Smoking Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

Youth in low or lower-middle income households were more likely to smoke (13%) than were those in households from higher incomes (9%)

- 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 age 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:

CCHS data limitations is that surveying does not occur in First Nation Reserve Communities

- **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 increase to **37%** by grade twelve.

Drugs and alcohol use was identified as a concern during our consultations

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 binge drinking rates for both NOR-MAN and the province as a whole. For both, having had five or more drinks on one

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%**.

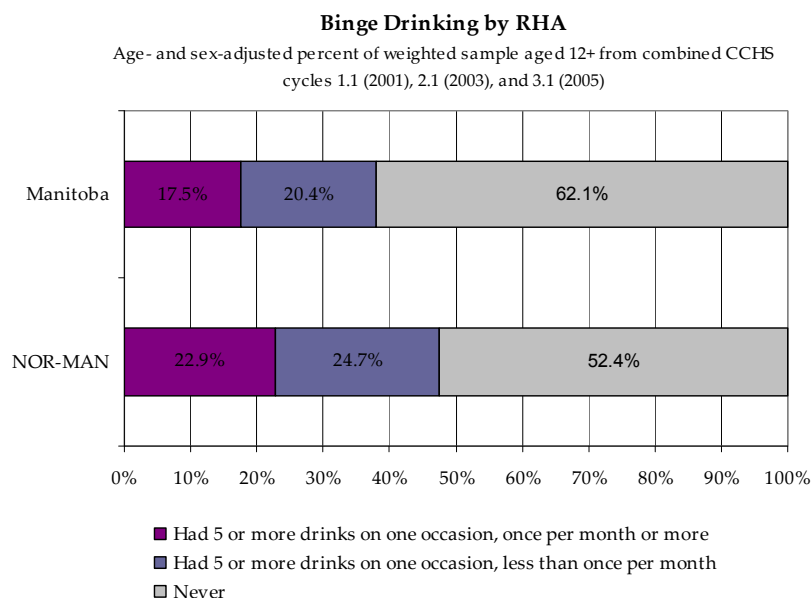


Figure 6.32: Binge Drinking Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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.

Binge drinking (1 to 5 days) results from the Youth Health Survey reported NOR-MAN student in grade 9 at **32%**, grade 10 at **41%**, grade 11 at **47%** and grade 12 at **49%**

According to the Youth Health Survey, **22%** of NOR-MAN students reported using an illegal drug in the last 30 days, this percentage rose from **29%** in grade nine (9) to **32%** in grade twelve (12)

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%**

Fruit and Vegetable Consumption

Refers to the proportion of the population aged 12 and over who report that they consumed on average 5 or more servings of fruit and vegetables per day

One serving = 1/2 cup of fresh, frozen or canned fruits and vegetables, 1 piece of fruit or 1/2 cup of fruit juice

(Manitoba Centre for Health Policy)

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%.**

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

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)

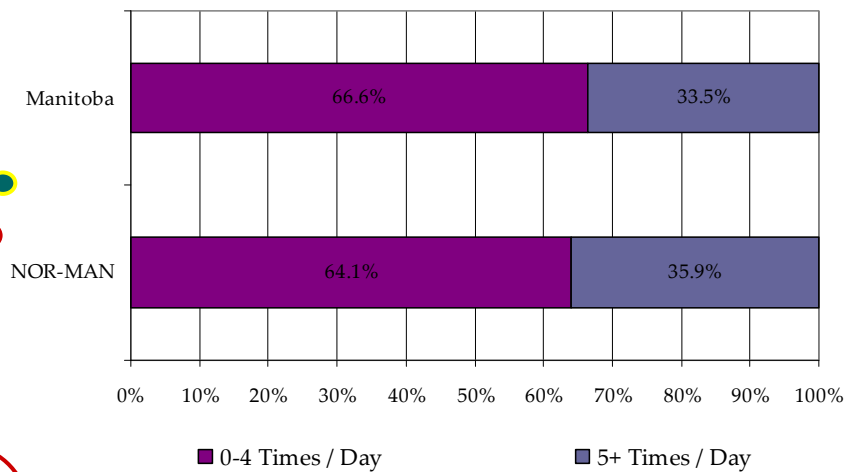


Figure 6.33: Average Daily Consumption of Fruits and Vegetables
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

According to the NRHA Youth Health Survey report, only 7% of NOR-MAN students reported eating five or more fruits and vegetables per day

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%**

Average Daily Consumption of Fruits and Vegetables	NOR-MAN Males	NOR-MAN Females
0 - 4 servings	70.3%	58.0%
5+ servings	29.7%	42.0%

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:

Body Mass Index (BMI)

Is a statistical measure commonly used to determine if an individual's weight is in a healthy range based on their height

BMI is calculated as weight in kilograms divided by the height in meters squared

BMI groupings are:
Underweight, Normal, Overweight, Obese

(Manitoba Centre for Health Policy)

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

- “acceptable weight” if between 18.5 - 24.9
- “overweight” if higher than 25.0 - 29.9
- “obese” if 30.0 or higher when using the International Standards.

When reviewing data from the Canadian Community Health Survey (Cycle 1.1, 2.1 and 3.1) for NOR-MAN residents 12 years and older as shown in Figure 6.34, our BMI highlights are:

- 37.1% reported being underweight / normal compared to a provincial rate of 44.2%
- 34.6% reported being overweight compared to a provincial rate of 35.0%
- 28.3% reported being obese compared to a provincial rate of 20.8%

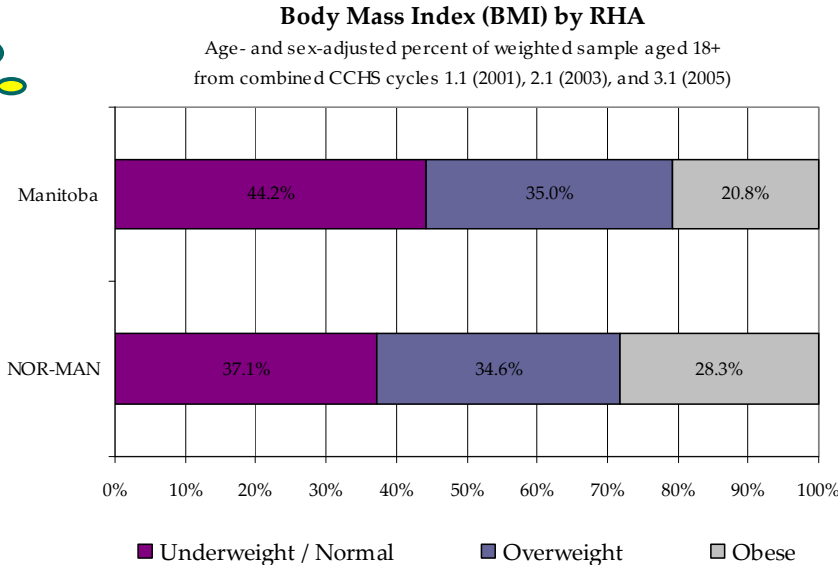
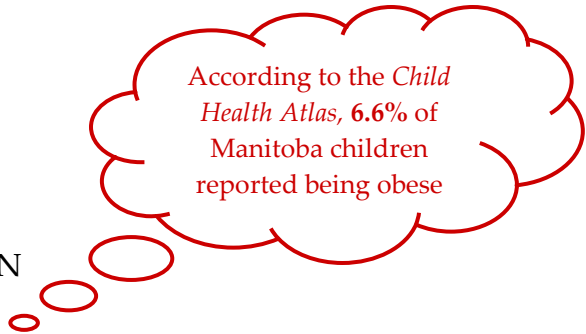


Figure 6.34 Body Mass Index Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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%**



Body Mass Index	NOR-MAN Males	NOR-MAN Females
Normal/underweight	31.1%	43.0%
Overweight	40.8%	28.4%
Obese	28.1%	28.6%

Table 6.9: Body Mass Index Rates by Sex
 Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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.

Total Physical Activity

Refers to the self-reported level of physical activity about frequency, duration, and intensity of their participation in leisure-time physical activity - active, moderately active, or inactive

(Statistics Canada)

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

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)

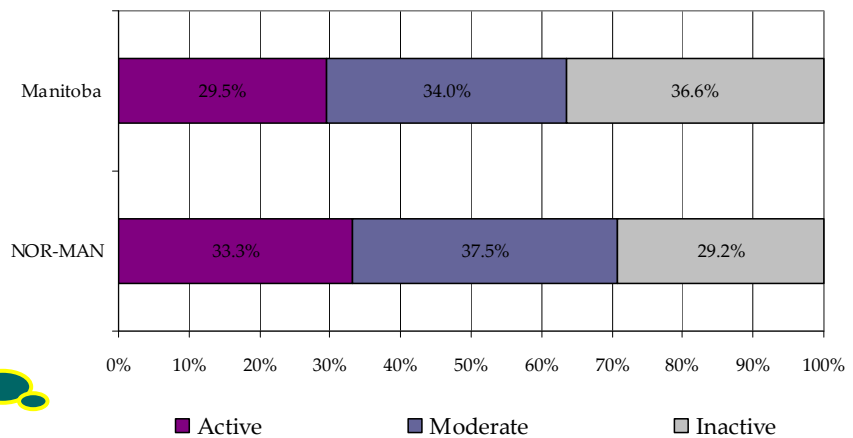


Figure 6.35: Total Activity Level (Work + Leisure + Travel) Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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%
- NOR-MAN females reported a statistically different (lower) rate at 36.8% who are inactive

Total Physical Activity	NOR-MAN Males	NOR-MAN Females
Active	41.3%	25.2%
Moderate	37.0%	38.0%
Inactive	21.7%	36.8%

Table 6.10: Total Physical Activity Levels by Sex
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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)

Cervical Screening rates do not include PAP tests completed by NRHA Primary Health Care staff

The NOR-MAN rate is getting worse faster compared to the Manitoba time trend

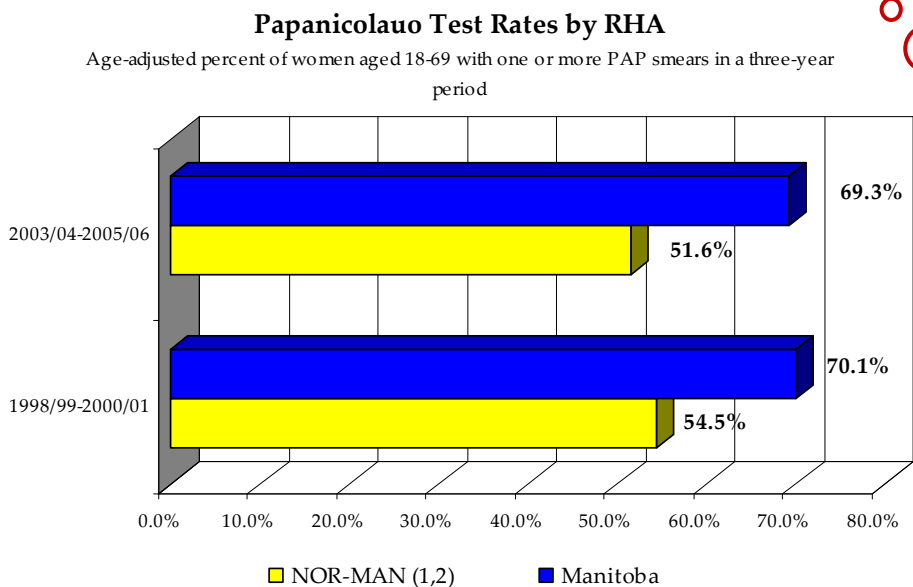


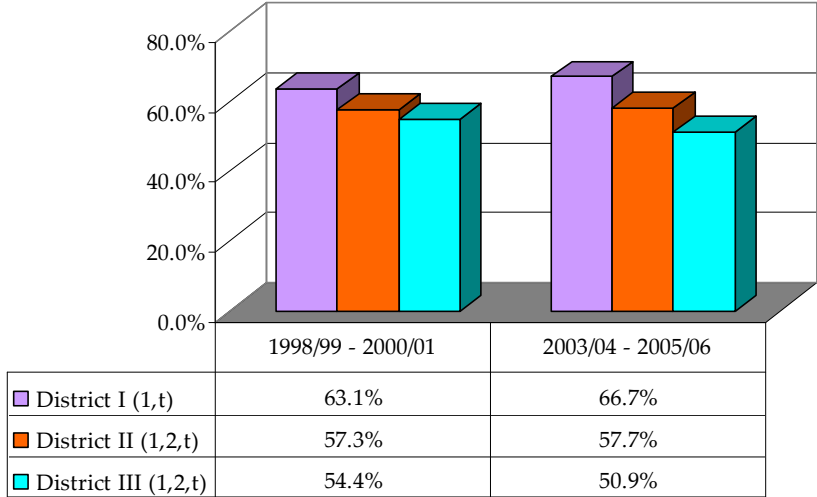
Figure 6.36: Papanicolaou Test Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

NRHA Primary Health Care Nurses performed a total of 474 PAP tests and NRHA Midwives performed a total of 45 PAP test during 2008/09

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

Papanicolaou Test Rates by NOR-MAN District
Age-adjusted percent of women aged 18-69 with one or more PAP smears in a three-year period



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.

Figure 6.37: Papanicolaou Test Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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%.

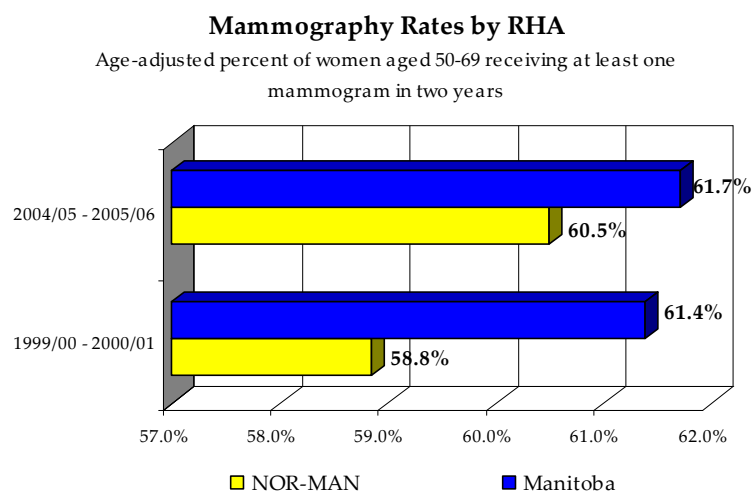


Figure 6.38: Mammography Screening Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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%

Mammography Screening

Is a procedure commonly used to determine if a woman has breast cancer

is the proportion of women 50 - 69 years old who received at least one mammogram screening in a two-year period

(Statistics Canada)

The NOR-MAN rate is improving faster compared to the Manitoba time trend

The Manitoba Mobile Breast Screening Program has had a significant impact on breast screening rates in the NOR-MAN region

Mammography Rates by NOR-MAN District

Age-adjusted percent of women aged 50-69 receiving at least one mammogram in two years

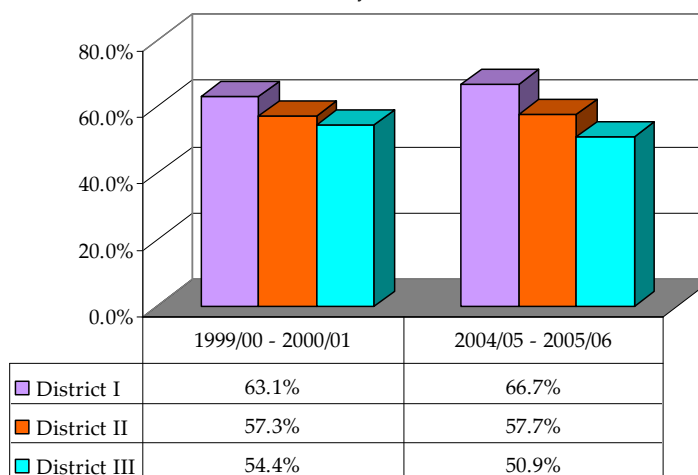


Figure 6.39: Mammography Screening Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

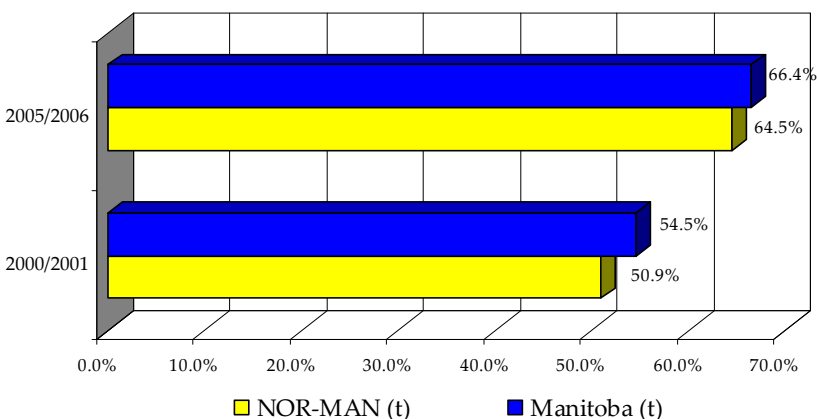


Figure 6.40: Adult Influenza Immunization Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

Age- & sex-adjusted percent of residents aged 65+ who received a flu shot

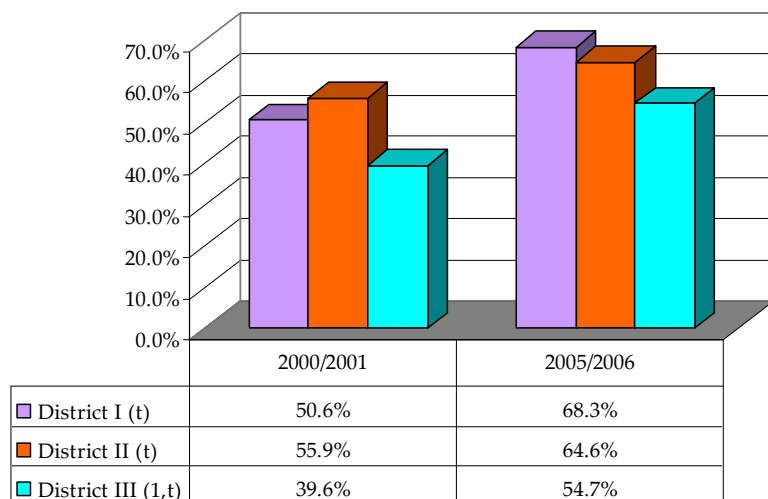
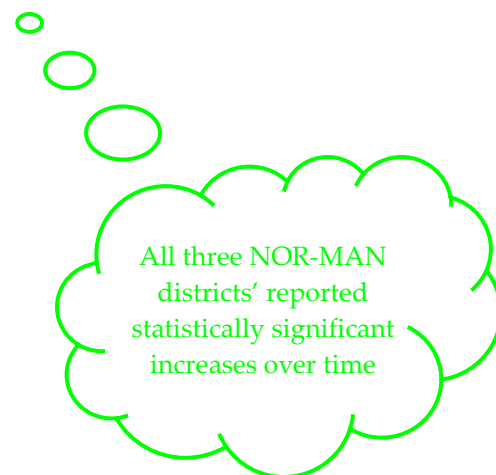


Figure 6.41: Adult Influenza Immunization Rates by NOR-MAN District

Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009



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.

Pneumococcal Immunization (Flu shots)

Is a once in a lifetime way to prevent pneumococcal 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 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.

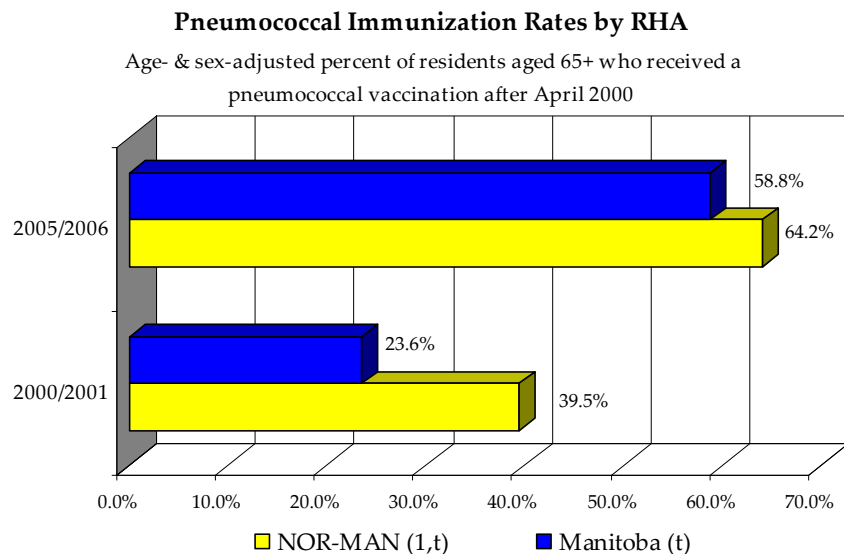


Figure 6.42: Adult Pneumococcal Immunization Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

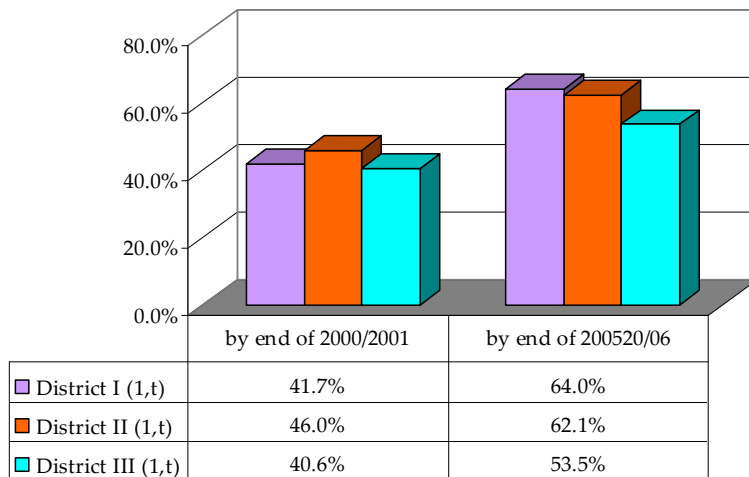
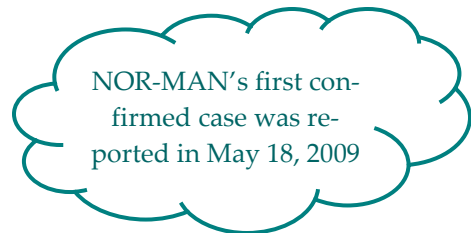


Figure 6.43: Adult Pneumococcal Immunization Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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.

Community	Total # Vaccinated	% of Population
R.M. of Kelsey	930	37%
Snow Lake	457	52%
Flin Flon	2,603	44%
Grand Rapids	52	8%
The Pas	3,455	48%
Channing	75	57%
Cormorant	309	78%
Easterville	88	15%
Moose Lake	59	8%
Pukatawagan	205	56%
Sherridon	63	67%
OCN	1,053	61%
Misipawistik CN	29	6%
Chemawawin CN	132	19%
Mosakahiken CN	44	9%
Mathias Colomb CN	752	59%
NRHA Totals	10,306	42%

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.**

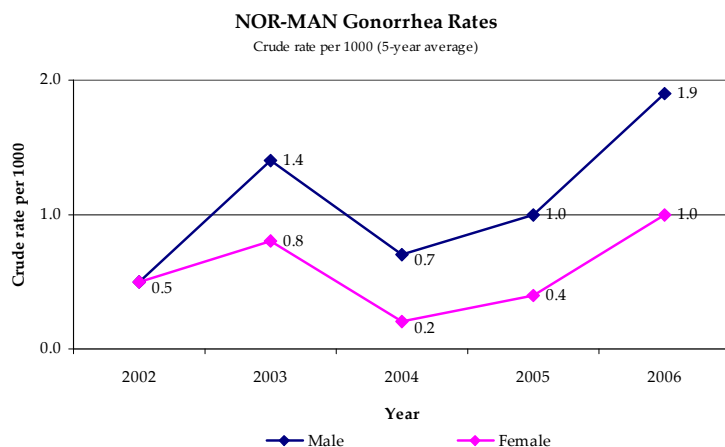


Figure 6.44: NOR-MAN Gonorrhea Rates
Source: Manitoba Health, NRHA Profile Document, 2008/09

Gonorrhea

Is a bacterial infection (commonly know as "the clap") that is transmitted through oral, genital or anal sex with an infected person - gonorrhea cases are those reported via positive lab test

(Health Canada)

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 2.9/1,000. 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.

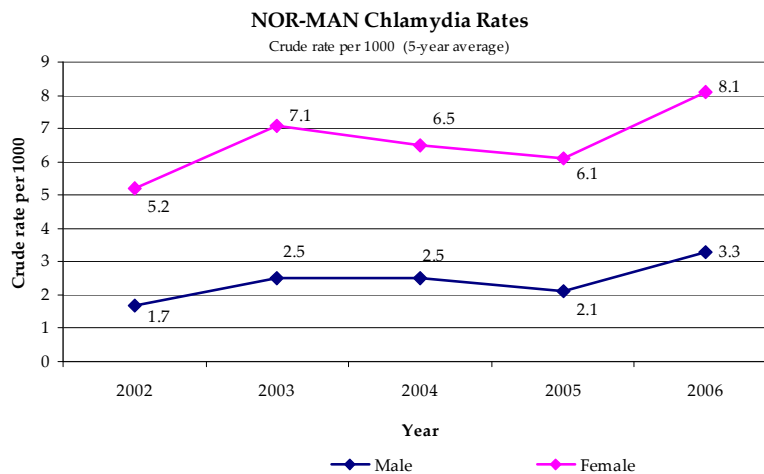


Figure 6.45: NOR-MAN Chlamydia Rates
Source: Manitoba Health, NRHA Profile Document, 2008/09

Figure 6.45 shows the five year trend for NOR-MAN males compared to females, whose rates are showing similar growth trends. NOR-MAN

According to the Women's Health Profile, First Nation Manitobans, especially young women experience higher rates of Chlamydia infections than do other Manitobans

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 year.

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.

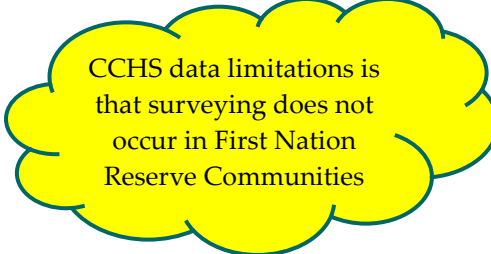
Overall, **40.6%** of NOR-MAN CCHS respondents reported low stress lives, **43.3%** reported medium stress lives and only **16.0%** reported high stress lives in comparison to provincial rates of **34.9%**, **44.1%** and **21.0%**.

HIV and AIDS

Is caused by the Human Immunodeficiency Virus (HIV) is the virus that causes Acquired Immunodeficiency Syndrome (AIDS)

AIDS is fatal - there is no cure

(Health Canada)



CCHS data limitations is that surveying does not occur in First Nation Reserve Communities

Life Stress

Is an emotional and/or physical response by the body to any situation or thought that causes a disparity in a person's usual biological, psychological, or social system—either positive or negative

(Manitoba Centre for Health Policy)

Environmental Factors

Second-Hand Smoke

Second Hand Smoke

Is the ambient smoke from a burning cigarette, pipe or cigar, or the smoke exhaled by a smoker

(Manitoba Centre for Health Policy)

According to the NRHA Youth Health Survey, 81% of students think that all public places should be smoke-free

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%**

Second Hand Smoke at Home

Refers to the proportion of the non-smoking population age 12 and older, exposed to environmental tobacco smoke at home on most days

(Manitoba Centre for Health Policy)

Exposure to Smoke at Home	NOR-MAN Males	NOR-MAN Females
Yes	24.9%	22.1%
No	75.1%	77.9%

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

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)

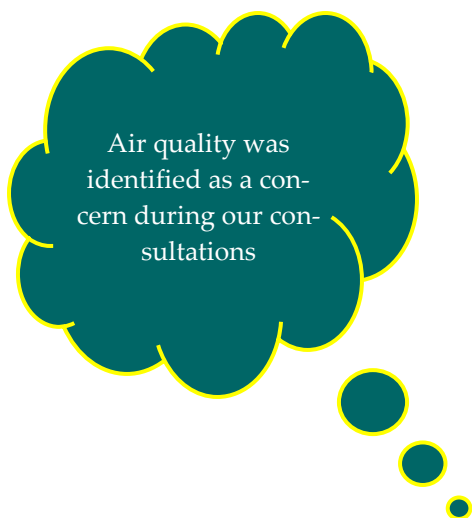
Examines the possible risks to human health from exposure to contaminants in the environment - will provide a comprehensive assessment of possible human exposure to metals in Flin Flon and Creighton

(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.

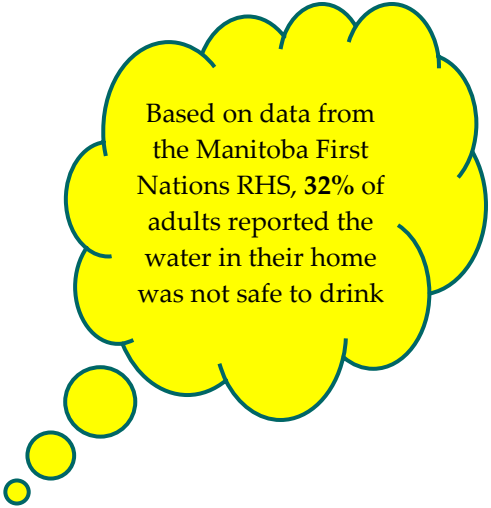
Drinking Water Quality and Sewage Treatment

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 indicators (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



Based on data from the Manitoba First Nations RHS, 32% of adults reported the water in their home was not safe to drink



Water quality and contamination was identified as a concern during our consultations

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

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



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



Loss of employment opportunities for youth was identified as a concern during our consultations



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

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

- 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

- 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
- Gonorrhoea 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) than 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

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

Obesity was identified as a concern during our consultations

Lack of recreational opportunities was identified as a concern during our consultations

Air quality was identified as a concern during our consultations



- Generally, drinking water quality is very good in all NOR-MAN communities

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



NRHA DISTRICTS

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)

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

Acute Care and
Personal Care Homes
facilities are located

in:

Flin Flon
Snow Lake
The Pas

NRHA Health Centres
are located in:

Cormorant
Cranberry Portage
Sherridon

Primary Health Care
Centres are located

in:

Flin Flon – 2 sites
The Pas – 1 site

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)

Access
 is the ease with which the client and/or community obtains services and supports in the most appropriate settings.
 (Canadian Health Services Research Foundation)

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.

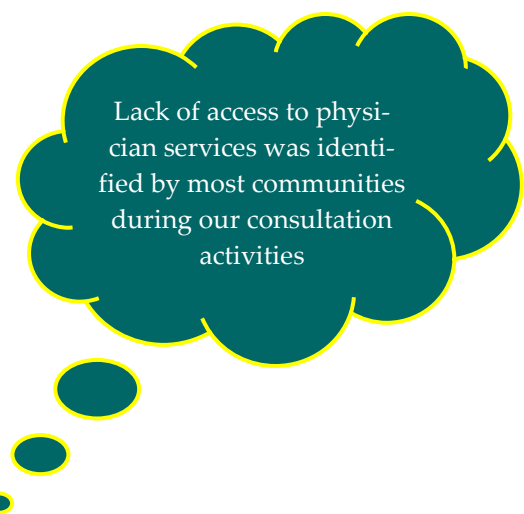


Figure 7.1 shows that **77.8%** of NOR-MAN residents visited a physician in 2005/06 compared to our rate of **79.8%** in 2000/01. Our rate is statistically different (lower) than the provincial visits rate of **83.2%** in the second time period.

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

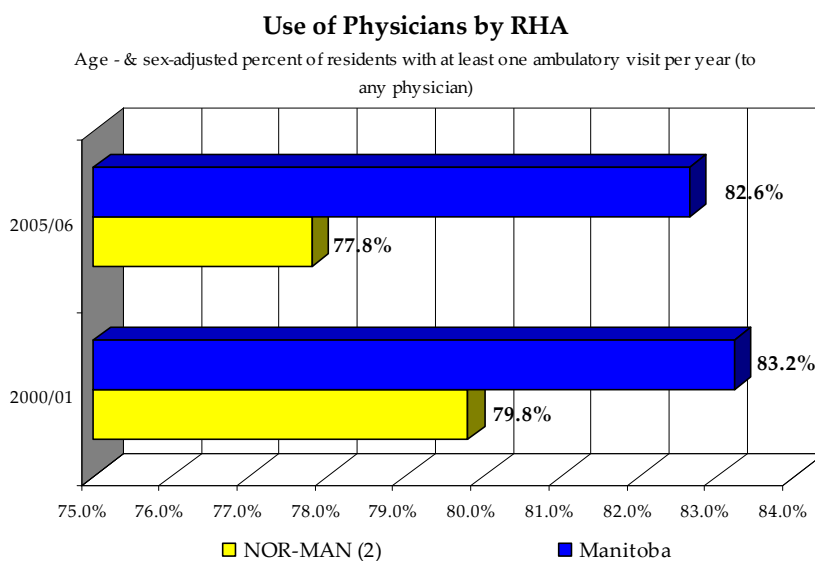


Figure 7.1: Use of Physicians
 Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

Use of Physicians by District

Age - & sex-adjusted percent of residents with at least one ambulatory visit per year (to any physician)

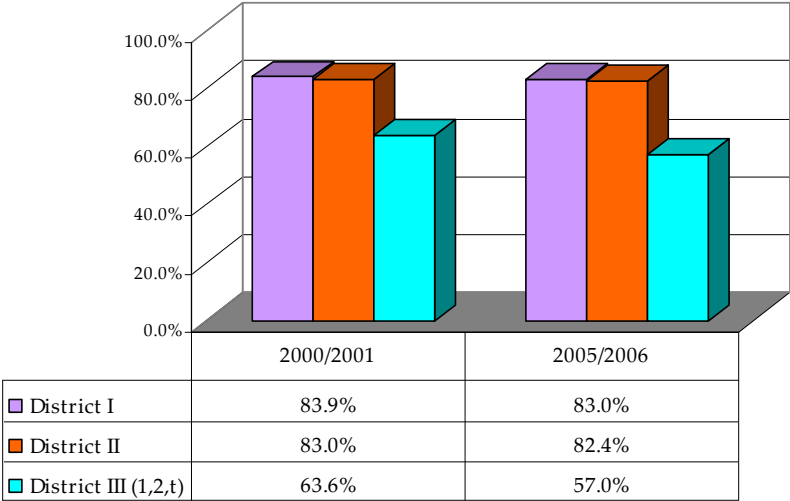


Figure 7.2: Use of Physicians by NOR-MAN District
 Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Ambulatory Visits

Ambulatory Visits are all contacts with physicians - office visits, home visits, personal care home visits, visits to outpatient departments and some emergency room visits.

Ambulatory visits do not include visits to hospital patients.

(Manitoba Centre for Health Policy)

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.

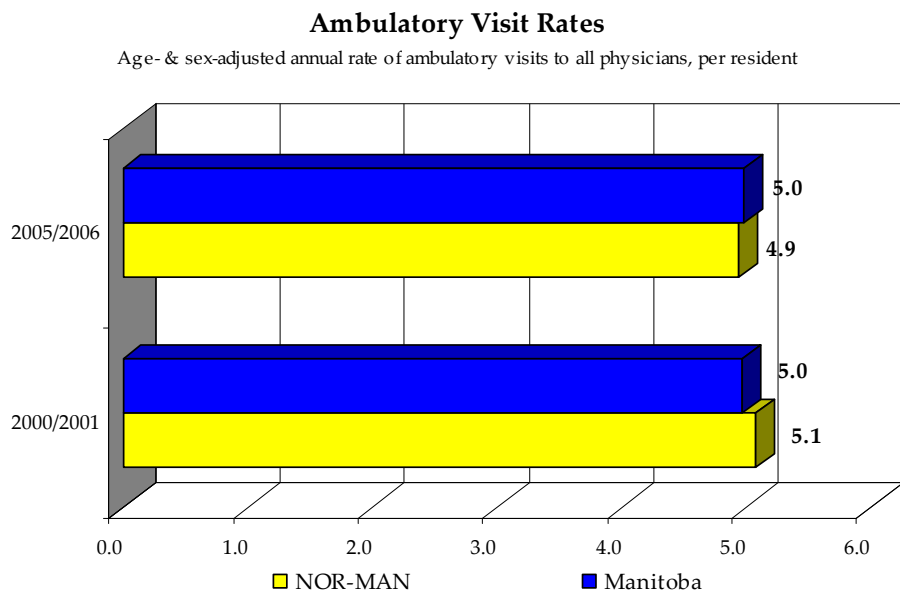


Figure 7.3: Ambulatory Visit Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

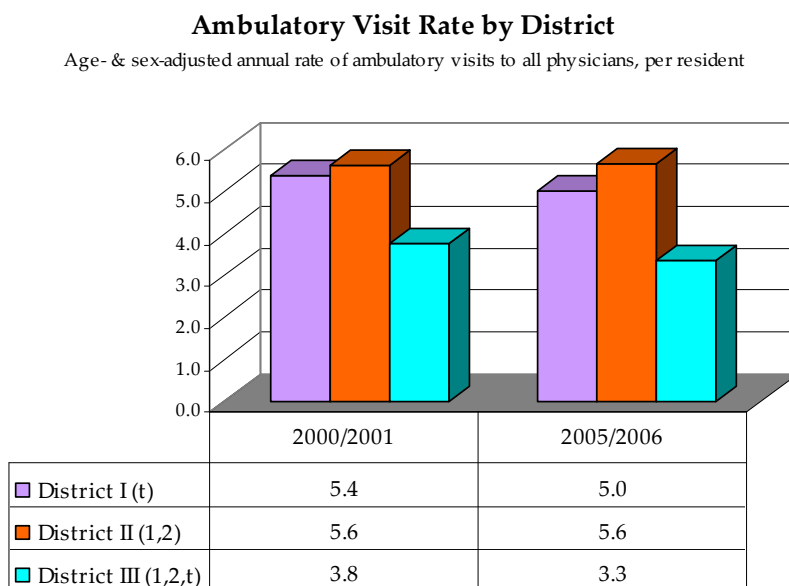


Figure 7.4: Ambulatory Visits by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

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

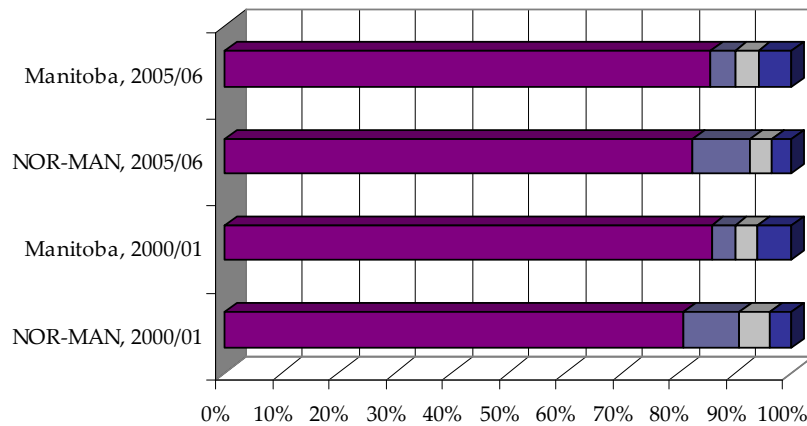
(Manitoba Centre for Health Policy)

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%.

NOR-MAN physician use in the region has increased slightly between the two time periods.

Where RHA Residents Went for Visits to GP/FPs



	NOR-MAN, 2000/01	Manitoba, 2000/01	NOR-MAN, 2005/06	Manitoba, 2005/06
■ % To Winnipeg	3.9%	6.1%	3.5%	5.9%
■ % To Other RHA	5.3%	3.9%	3.8%	4.1%
■ % Elsewhere in RHA	9.8%	4.2%	10.2%	4.4%
■ % In District	80.9%	85.8%	82.6%	85.6%

Figure 7.5: Location of Visits to GP/FPs
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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:

Location of Visits to GP/FPs by District, 2000/01

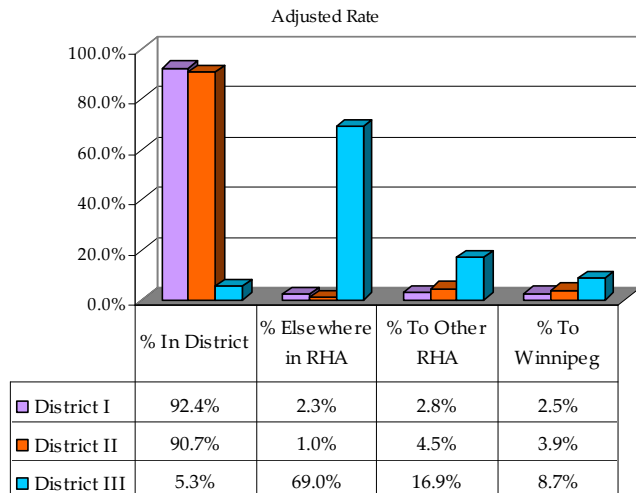


Figure 7.6: Location of Visits to GP/FPs by NOR-MAN District, 2000/01
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

- 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.

Location of Visits to GP/FPs by District, 2005/06

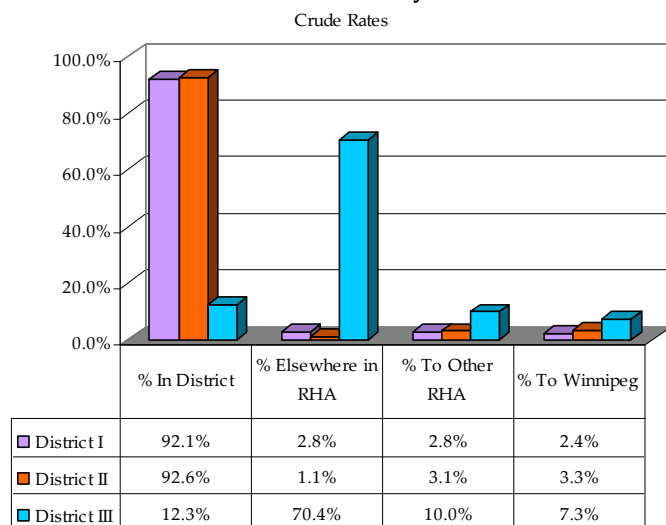


Figure 7.7: Location of Visits to GP/FPs by NOR-MAN District, 2005/06
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Physician Visit Rates by Top Ten Causes

Is the average annual number of ambulatory visits to all physicians by category of illness, ranking the causes by relative frequency of visits

Visit rate are reported in two one-year time periods

(Manitoba Centre for Health Policy)

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 Physican Visits, North, 2005/06

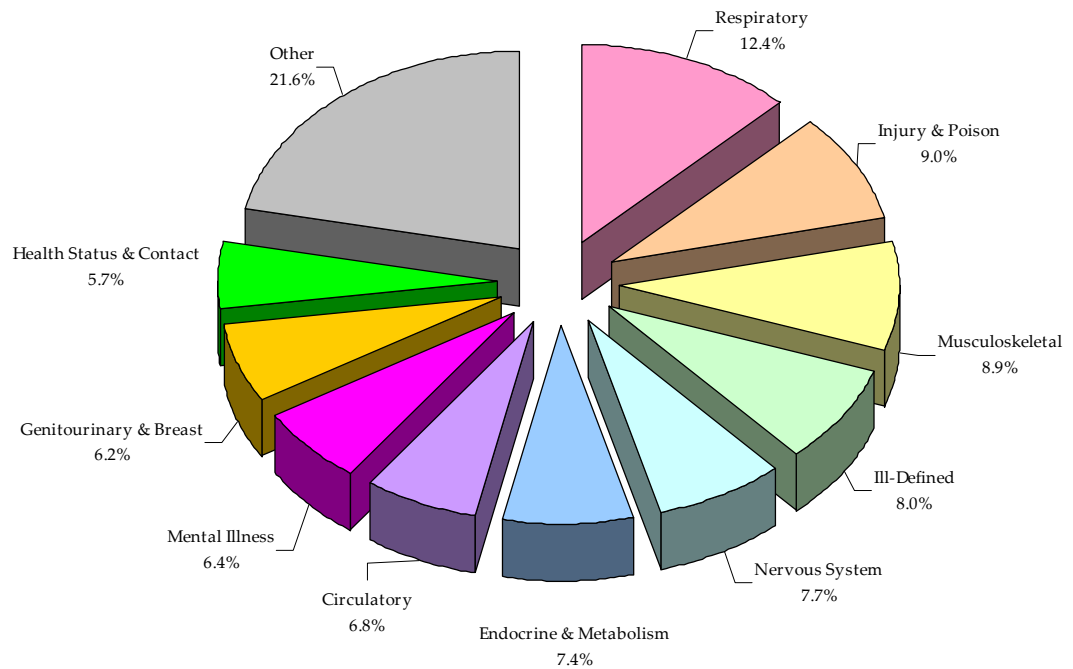


Figure 7.8: Cause of Physician Visits
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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.

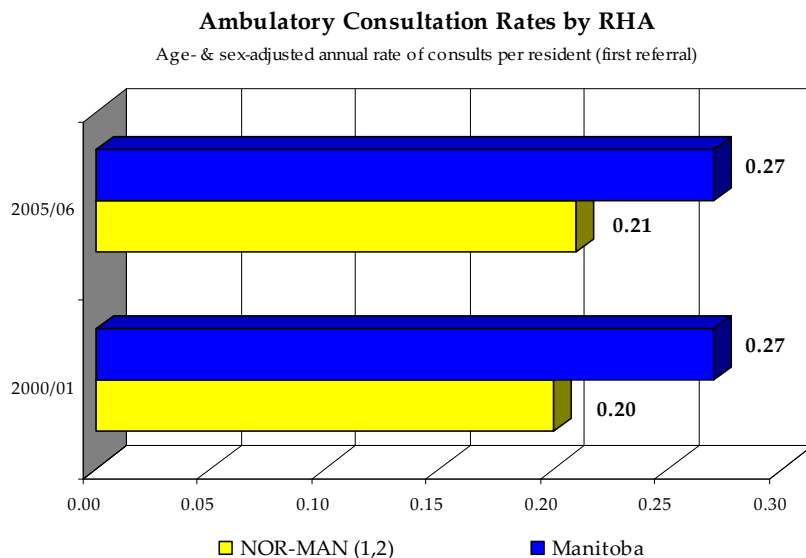


Figure 7.9: Ambulatory Consultations Rates
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Ambulatory Consultations

Occur when one physician refers a patient to another physician – usually a specialist

(Manitoba Centre for Health Policy)

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

Ambulatory Consultation Rates by District
Age- & sex-adjusted annual rate of consults per resident (first referral)

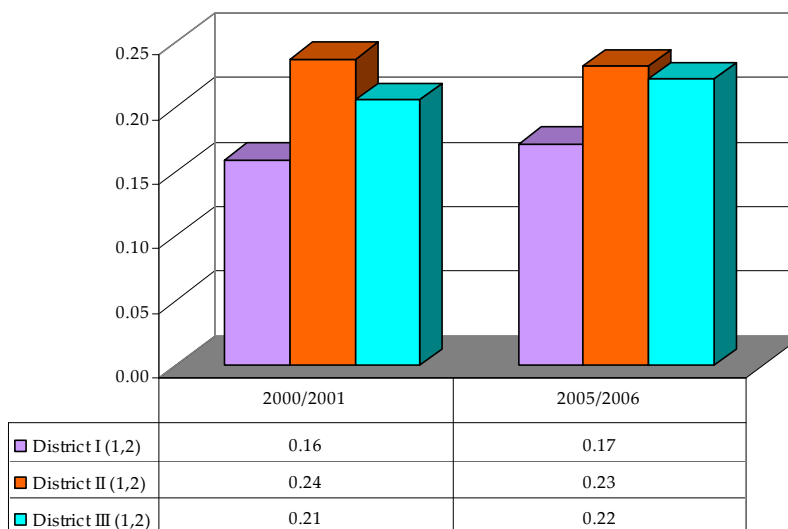


Figure 7.10: Ambulatory Consultation Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Ambulatory Visits to Specialist

Is the average number of ambulatory visits (including consultations) made to specialist physicians per resident per year - specialist physicians include all internal medicine specialists, pediatricians, psychiatrists, obstetricians & gynecologists, and surgeons

Rates are calculated annually

(Manitoba Centre for Health Policy)

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)**.

Lack of access to Physician Services was identified as a concern during our consultations

Ambulatory Visits to Specialists
Age- & sex-adjusted annual rate of visits to specialist physicians, per resident

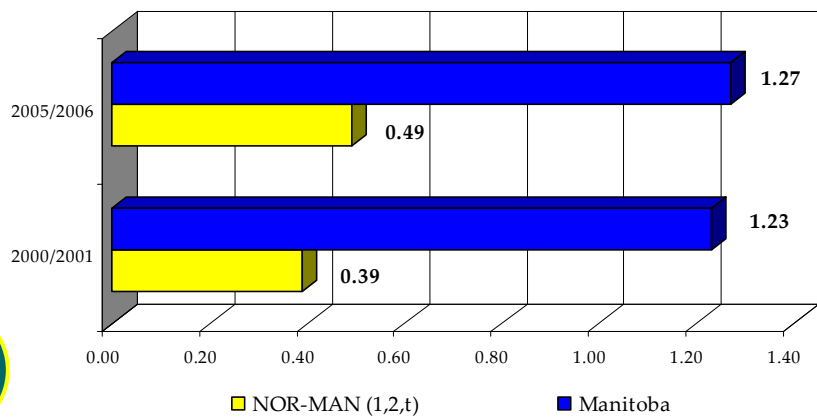


Figure 7.11: Ambulatory Visit Rates to Specialists
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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**

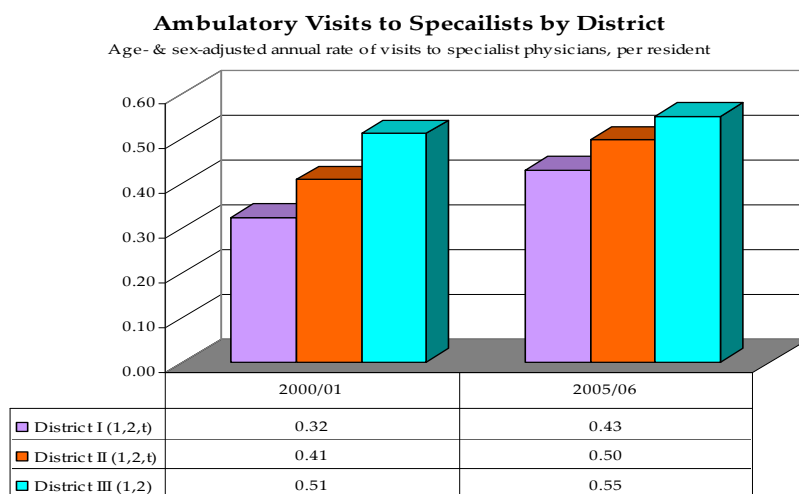
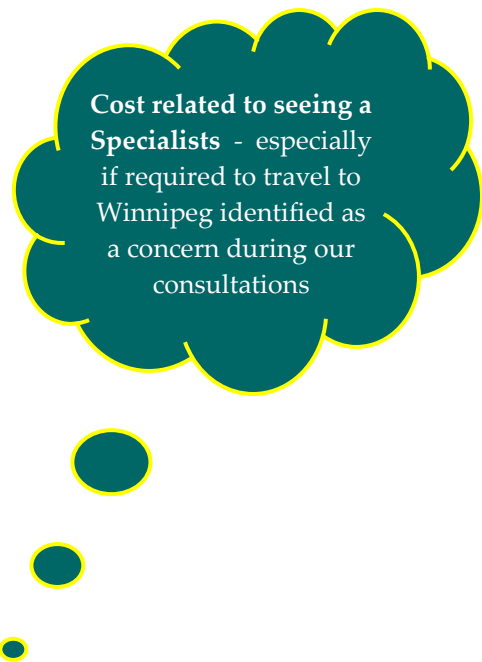


Figure 7.12: Ambulatory Visit Rates to Specialists by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

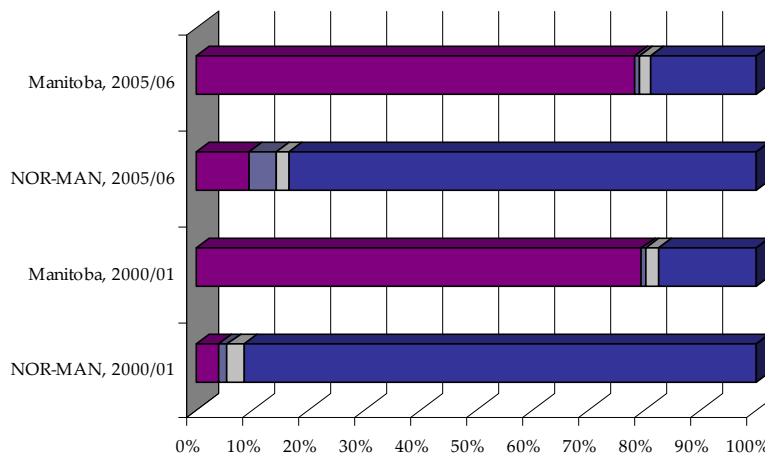
Location of Visits to Specialists

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%

Where RHA Residents Went for Visits to Specialists



	NOR-MAN, 2000/01	Manitoba, 2000/01	NOR-MAN, 2005/06	Manitoba, 2005/06
■ % To Winnipeg	91.4%	17.3%	83.4%	18.9%
□ % To Other RHA	3.0%	2.5%	2.4%	2.0%
■ % Elsewhere in RHA	1.5%	0.6%	4.9%	0.8%
■ % In District	4.0%	79.6%	9.3%	78.2%

Figure 7.13: Location of Visits to Specialist
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

NOR-MAN specialists visit rate occurring in our region also increased in the second time period.

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

Physician Visits for those with Mental Illness

Is the average of annual ambulatory visits to all physicians for which a mental illness was coded as the cause of the visit

(Manitoba Health)

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 persons overall health. Individuals with a regular family physician (or specialist) may have improved health outcome as a result of one physician managing their health care needs over an extend 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
 Is the percentage of residents receiving at least 50% of their ambulatory visits over a two year period from the same physician
 (Manitoba Centre for Health Policy)

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

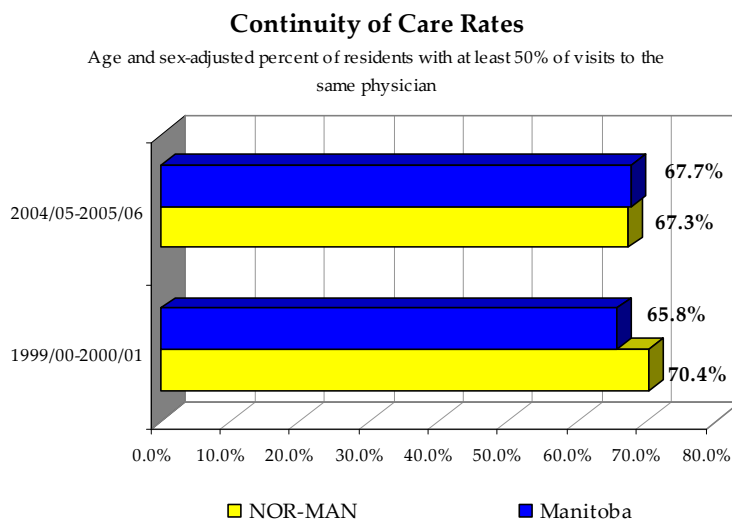


Figure 7.14: Continuity of Care Rates
 Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Continuity of Care Rates by District
Age and sex-adjusted percent of residents with at least 50% of visits to the same physician

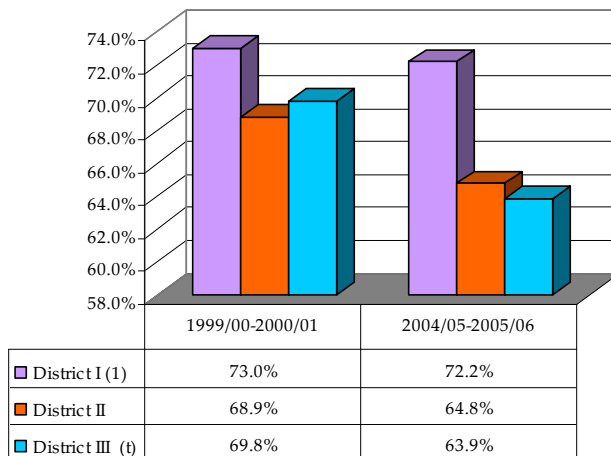


Figure 7.15: Continuity of Care Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

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.

	Obstetrical Beds	Adult Medical Beds	Pediatric Beds	Surgical Beds	Special Care Unit Beds	Palliative Care Bed	Psychiatric Beds
Flin Flon General Hospital	6	18	7	8	2	1	0
St. Anthony's General Hospital	8	12	2	5	3	2	8
Snow Lake Health Centre	0	2	0	0	0	0	0

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.

Hospital Use

Is the proportion of residents who were admitted to an acute care hospital at least once in a fiscal year

All inpatient hospitalization of area residents are included, regardless of the hospital location; outpatients services were excluded

(Manitoba Centre for Health Policy)

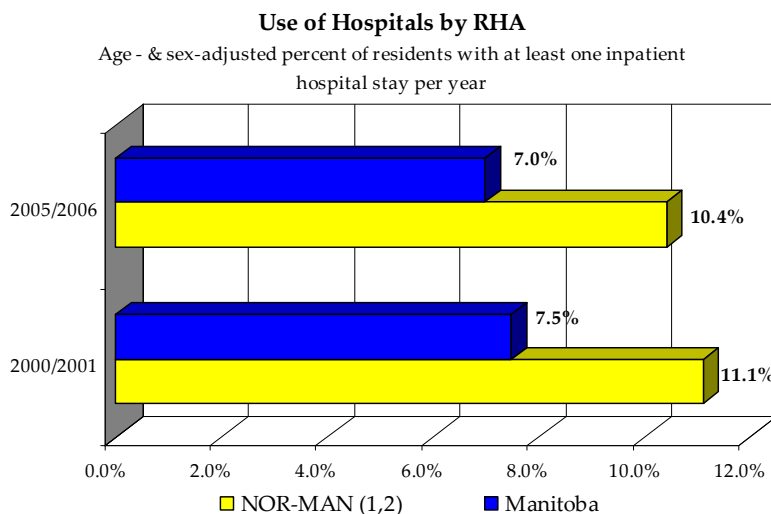


Figure 7.16: Use of Hospitals
 Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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%**

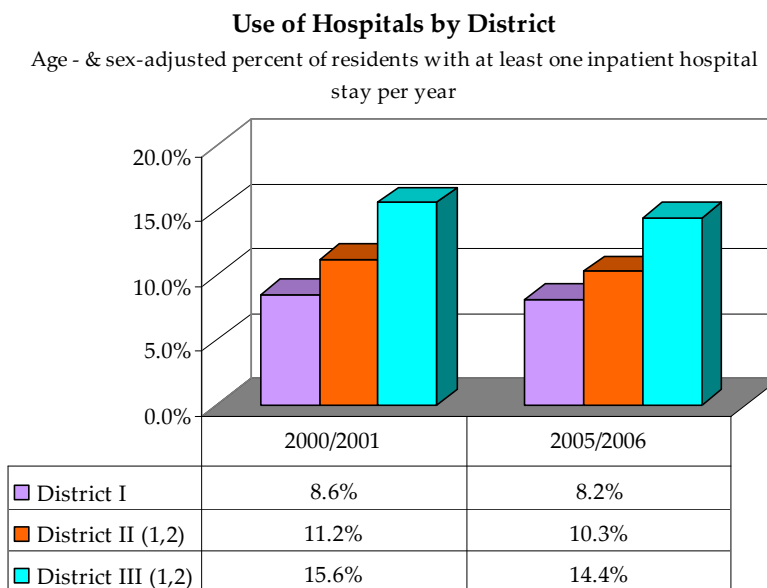


Figure 7.17: Use of Hospitals by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Hospital Separation - Where NRHA Resident went for Hospitalizations

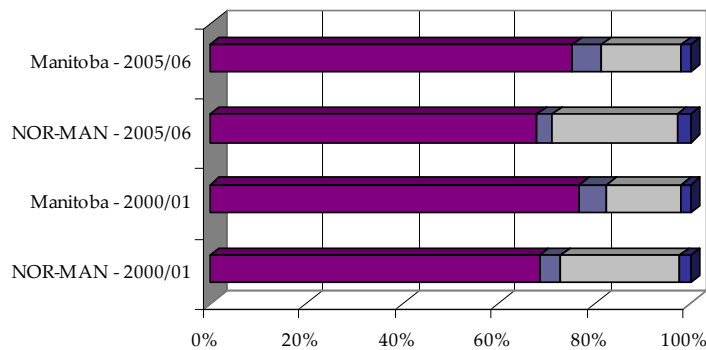
Where our residents are hospitalized is important to understand. During the first time period (2000/01), the majority of NOR-MAN residents who required hospitalization were admitted to NRHA facilities at **68.6%** compared to the Manitoba rate of **76.9%** as shown in Figure 7.18. Of note, in the second 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



	NOR-MAN - 2000/01	Manitoba - 2000/01	NOR-MAN - 2005/06	Manitoba - 2005/06
■ Out of Province Hospital	2.3%	1.8%	2.8%	1.9%
□ Winnipeg Hospital	24.7%	15.7%	26.0%	16.6%
■ Other RHA Hospital	4.4%	5.6%	3.3%	6.0%
■ RHA Hospital	68.6%	76.9%	68.0%	75.5%

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.

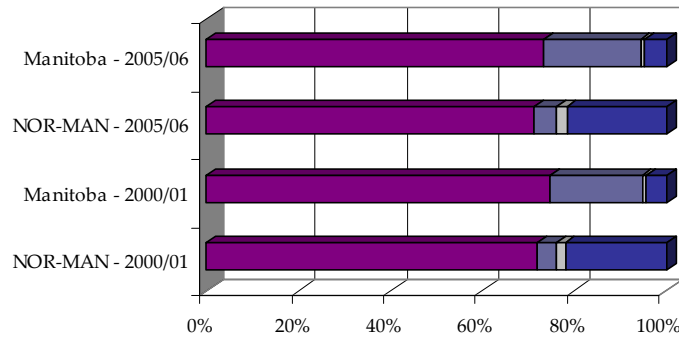
During the first time period (2000/01), the majority of NOR-MAN residents who required hospitalization were admitted to NRHA facilities

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 **26,766** days compared to **16,712** days in 2005/06.

at **68.6%** compared to the Manitoba rate of **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 **22.0%** to **21.6%**.

Where RHA Hospital Patients Came From: Separations



	NOR-MAN - 2000/01	Manitoba - 2000/01	NOR-MAN - 2005/06	Manitoba - 2005/06
■ Non-Manitobans	22.0%	4.4%	21.6%	4.7%
■ Residents of Winnipeg	1.8%	0.9%	2.2%	0.9%
■ Residents of Other RHAs	4.3%	19.9%	4.9%	21.0%
■ RHA Residents	71.9%	74.8%	71.2%	73.4%

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.

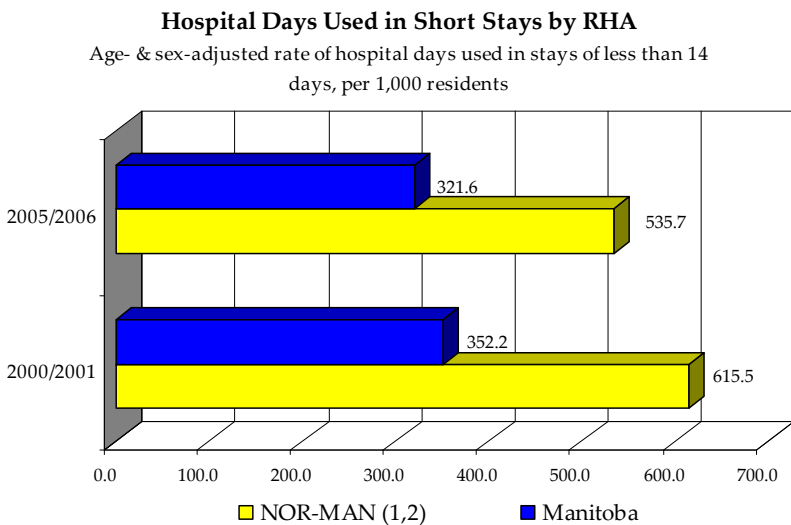


Figure 7.20: Hospital Days Used in Short Stays
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

The NOR-MAN rate in both time periods at **615.5/1,000** in 2000/01 and **537.7/1,000** in 2005/06 is statistically different (higher) than the provincial rates of **352.2/1,000** and **321.6/1,000**.

Both NOR-MAN and the province as a whole experienced a decline in their hospital short stays.

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

Hospital Days Used in Short Stays by District

Age- & sex-adjusted rate of hospital days used in stays of less than 14 days, per 1,000 residents

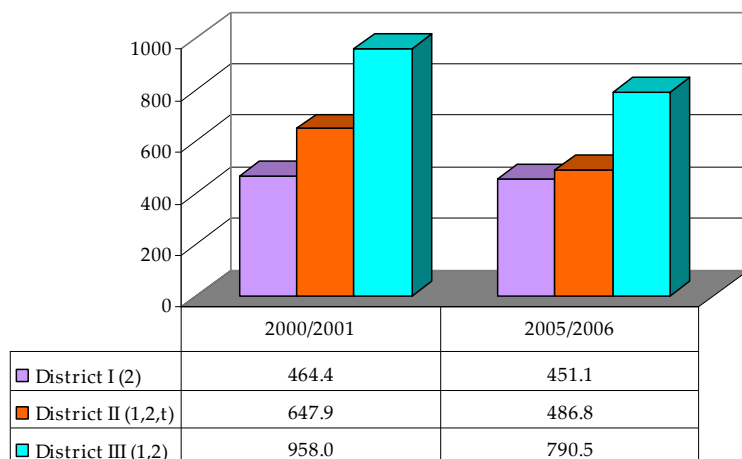


Figure 7.21: Hospital Days Used in Short Stays by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

Long Stay Hospital Days

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

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)

statistically different (higher) than the Manitoba rate at **659.5/1,000**. We observed a statistically significant decrease over time and are now lower than the Manitoba average.

Long Term Care patients previously at the Flin Flon General Hospital's 4th Floor were moved to Northern Lights Manor in February 2001

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

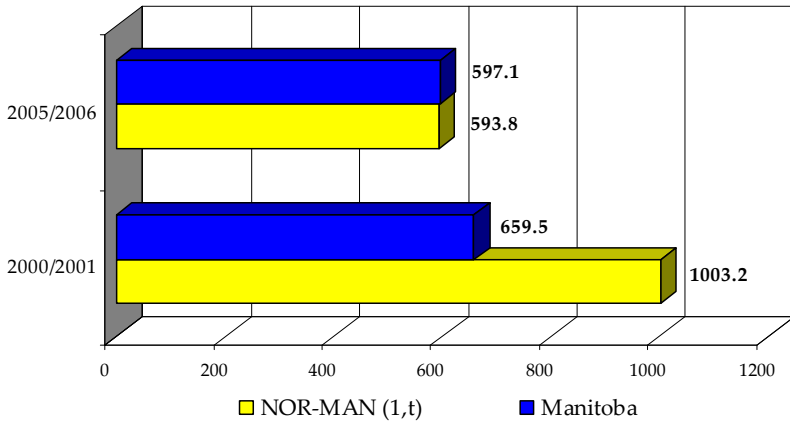


Figure 7.22: Hospital Days Used in Long Stays
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

When reviewing our district level long stay hospitalizations as shown in Figure 7.23, the following differences are of note:

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

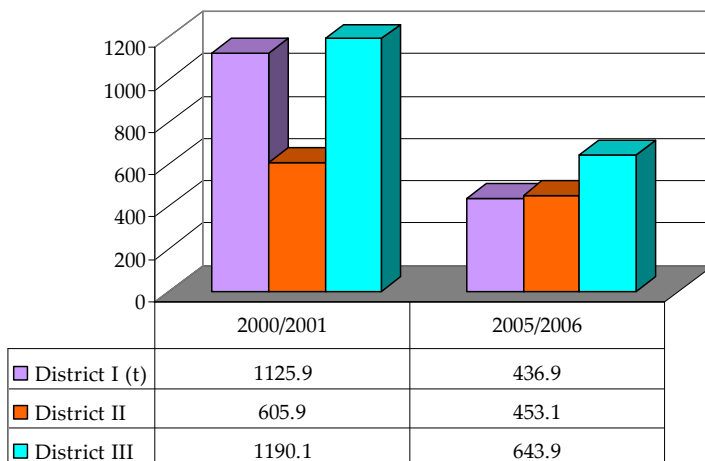


Figure 7.23: Hospital Days Used in Long Stays by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

- 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

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%**

Causes of Hospitalization

Is the distribution of the “Most Responsible” diagnoses attributed during inpatient hospitalizations, grouped by the International Classification of Disease (ICD) system

Hospitalization rate are reported in two one-year time periods

(Manitoba Centre for Health Policy)

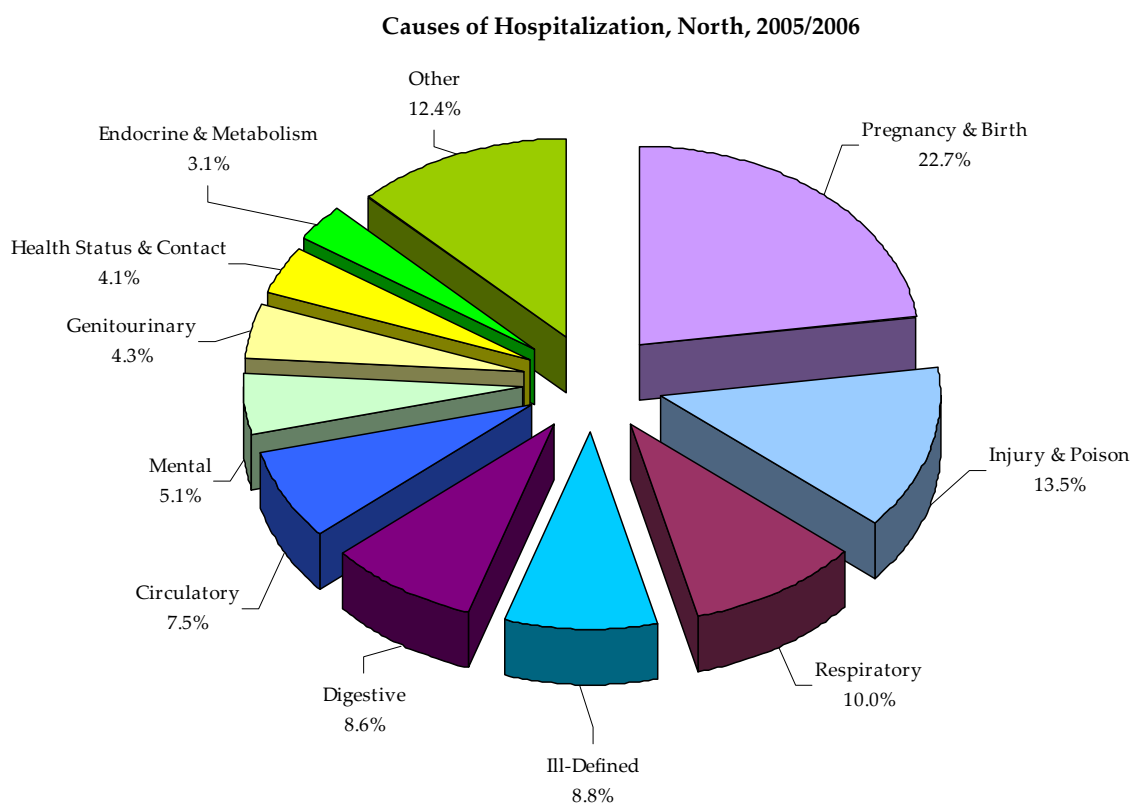


Figure 7.24: Causes of Hospitalization, North
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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

Ambulatory Care Sensitive Conditions (ACS)

Are a set of 17 different medical diseases/diagnoses for which timely and effective outpatient care can help to reduce the risks of hospitalizations - Is rate at which area residents were hospitalized for ACS conditions per 1,000 residents

Hospitalization rate are reported in two one-year time periods

(Manitoba Centre for Health Policy)

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:

Ambulatory Care Sensitive Conditions by District		
	2000/2001	2005/2006
District I	12.1/1,000	13.1/1,000
District II (1,2)	20.5/1,000	16.6/1,000
District III (1,2)	36.6/1,000	31.0/1,000

- 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

Table 7.2: Ambulatory Care Sensitive Conditions by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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.

Hospital Separation for Mental Illness Disorders

Is the number of hospitalizations in acute care hospitals per 1,000 residents per year, for which a mental illness disorder was coded as the most responsible cause of hospitalization

Hospitalization rate are reported in one five-year time period

(Manitoba Health - Hospital Discharge Abstract System)

Hospital Separation for Mental Illness Disorders for those with Cumulative Disorders, 1997/98 - 2001/02

Age-adjusted rate of separations per 1,000 residents aged 10 and older

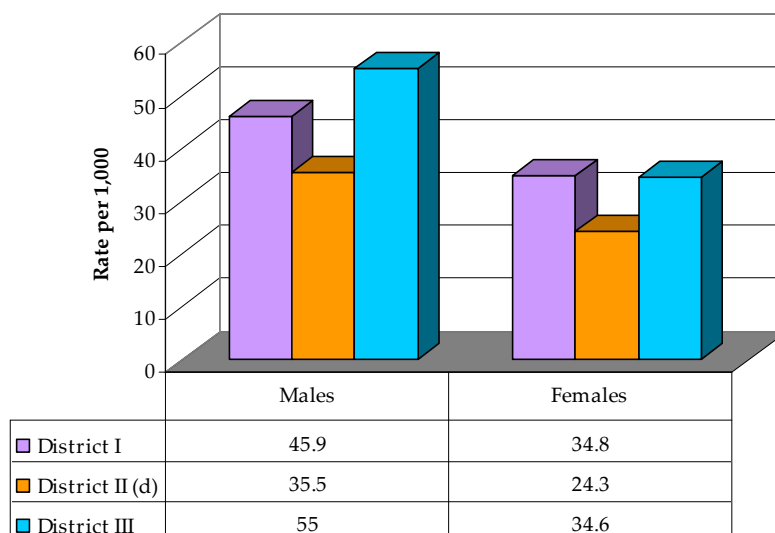
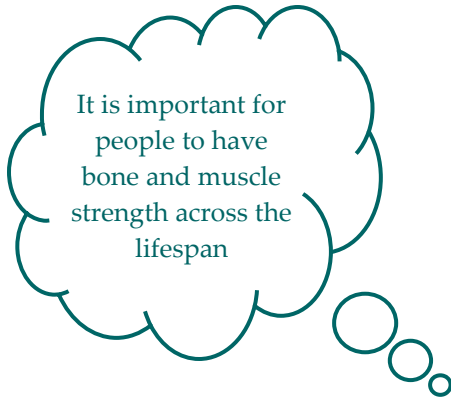


Figure 7.25: Hospital Separations for Mental Illness Disorders - Cumulative Disorders
Source: Manitoba Centre for Health Policy, Patterns of Regional Mental Illness Report, 2004



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

Is the replacement of parts of the knee with artificial materials that are cemented into place - is the number of total knee replacement performed on area residents age 40 and older, per 1,000 area residents aged 40 and older

Visit rate are reported in two one-year time periods

(Manitoba Centre for Health Policy)

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 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

Knee Replacement Surgery by District		
	1996/97 - 2000/01	2001/02 - 2005/06
District I	1.9/1,000	2.9/1,000
District II	1.4/1,000	2.3/1,000
District III	2.1/1,000	3.9/1,000

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.

Hip Replacement Surgery

Is the replacement of the ball and sockets with artificial materials - is the number of total hip replacement performed on area residents age 40 and older, per 1,000 area residents aged 40 and older

Visit rate are reported in two one-year time periods

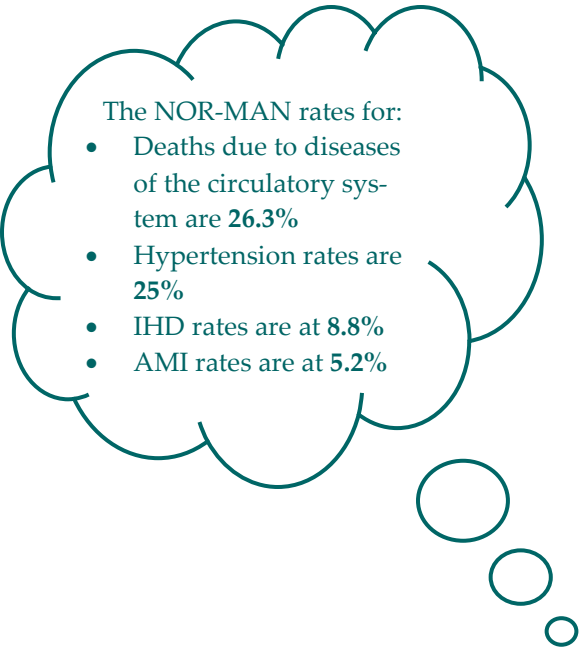
(Manitoba Centre for Health Policy)

Hip Replacement Surgery by District		
	1996/97 - 2000/01	2001/02 - 2005/06
District I	1.5/1,000	1.7/1,000
District II	1.4/1,000	1.8/1,000
District III	1.7/1,000	2.1/1,000

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 -



Percutaneous Coronary Interventions (PCI)

Is the number of percutaneous transluminal coronary angioplasty procedures (with or without stent insertion) performed on area residents age 40 and older, per 1,000 residents age 40 and older

Hospitalization rate are reported in two five-year time periods

(Manitoba Centre for Health Policy)



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-bursting 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.

Percutaneous Coronary Interventions by District		
	1996/97 - 2000/01	2001/02 - 2005/2006
District I	1.8/1,000	1.6/1,000
District II (t)	0.9/1,000	2.4/1,000
District III	1.1/1,000	1.8/1,000

Table 7.5: Percutaneous Coronary Interventions by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

As shown in Table 7.5, NOR-MAN district rates differ:

- 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.

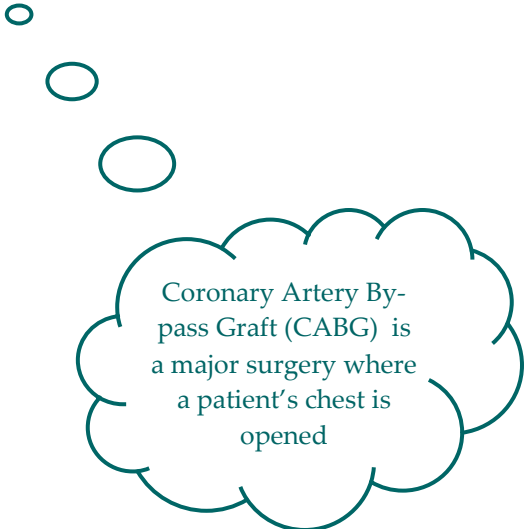
NOR-MAN residents experienced higher CABG rates at 1.8/1,000 in 1996/97 - 2000/01 compared to a Manitoba rate of **1.7/1,000**. In 2001/02 - 2005/06,

Coronary Artery Bypass Surgery

Is the number of bypass surgeries performed on area residents age 40 and older, per 1,000 area residents age 40 and older

Hospitalization rate are reported in two five-year time periods

(Manitoba Centre for Health Policy)



Coronary Artery Bypass Graft (CABG) is a major surgery where a patient's chest is opened

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:

Coronary Artery Bypass Surgery Rates by District		
	1996/97 - 2000/01	2001/02 - 2005/2006
District I	1.4/1,000	1.1/1,000
District II (2)	2.0/1,000	2.5/1,000
District III	2.6/1,000	2.9/1,000

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 Catheterizations

Is the number of cardiac catheterizations performed on area residents age 40 and older, per 1,000 residents in same age category

Rate are calculated in two three-year time periods

(Manitoba Centre for Health Policy)

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**.

Cardiac Catheterization Rates by District		
	1998/99 - 2000/01	2003/04 - 2005/2006
District I	6.4/1,000	6.1/1,000
District II (2,t)	5.6/1,000	10.2/1,000
District III	7.7/1,000	7.1/1,000

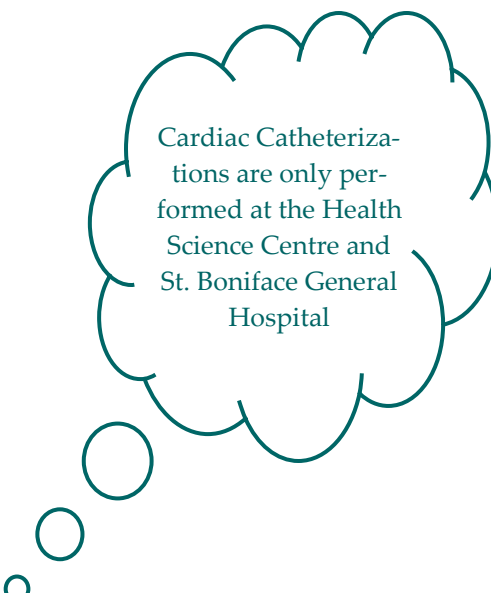
Table 7.7: Cardiac Catheterization Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicators Atlas, 2009

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



Cardiac Catheterizations are only performed at the Health Science Centre and St. Boniface General Hospital

Cataract Surgery

Is the number of cataract surgeries performed on area residents age 50 and older, per 1000 residents in same age category

Rate are calculated in two one-year time periods

(Manitoba Centre for Health Policy)

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		
	2000/01	2005/2006
District I (1,t)	14.0/1,000	22.9/1,000
District II	29.0/1,000	29.5/1,000
District III	33.8/1,000	28.4/1,000

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-

Re-admission Rates (AMI)

Is the risk-adjusted rate of unplanned readmissions for selected reasons with 28 days following discharge for a "heart attack"

Hospitalization rate are based on three years of pooled data

(Canadian Institute for Health Information)

Unfortunately due to the size of the NOR-MAN region, no NOR-MAN specific data is available

Antidepressant Prescription Follow-up

Is the proportion of patients with a new prescription for antidepressants and a physician diagnosis of depression who had at least three physician visits within four months of the prescription being filled.

Crude rates are calculated in two three-year time periods

(Manitoba Centre for Health Policy)

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

MAN is that our rate has increased but has not reached a statistically significant level

Antidepressant Prescription Follow-up by RHA

Crude annual percent of new depression patients who received at least 3 physician visits in 4 months

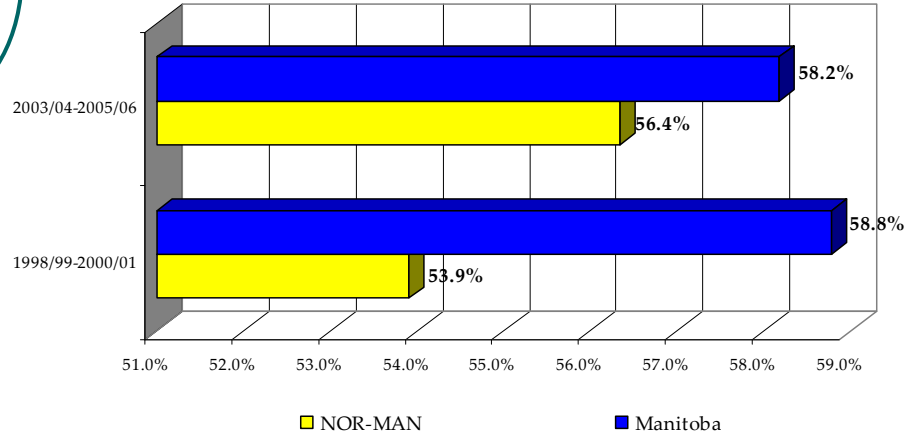


Figure 7.26: Antidepressant Prescription Follow-up
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

When reviewing NOR-MAN district level data as shown in Figure 7.27, the following differences are of note:

Antidepressant Prescription Follow-Up by District

Crude annual percent of new depression patients who received at least 3 physician visits in 4 months

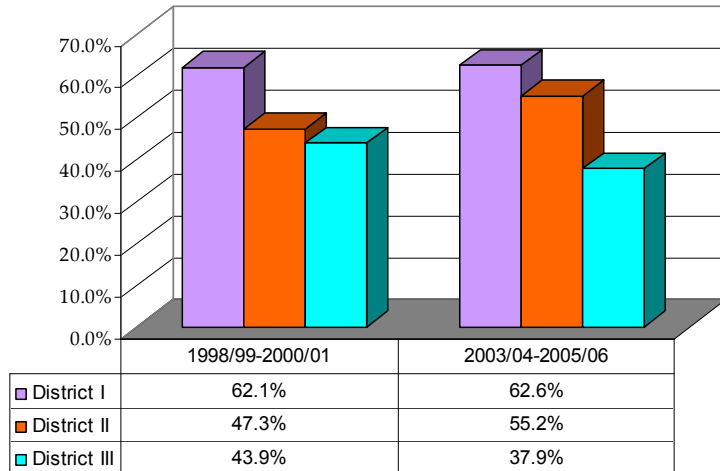


Figure 7.27 Antidepressant Prescription Follow-up by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

- 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

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 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

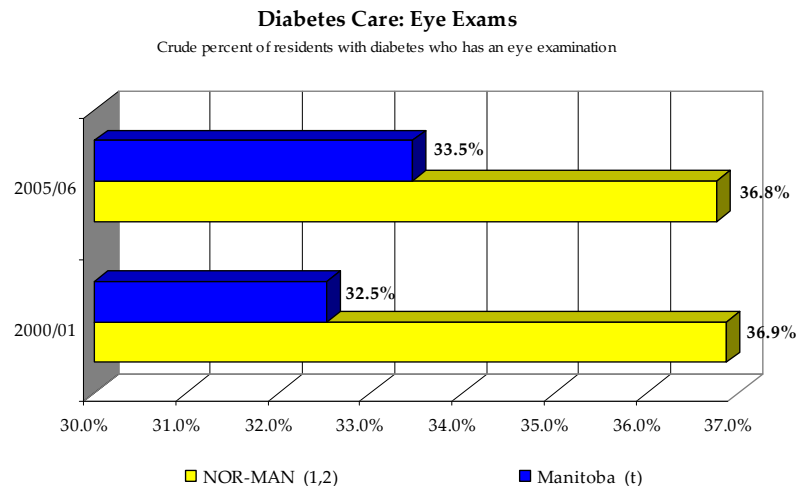


Figure 7.28 Diabetes Care: Eye Exam
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

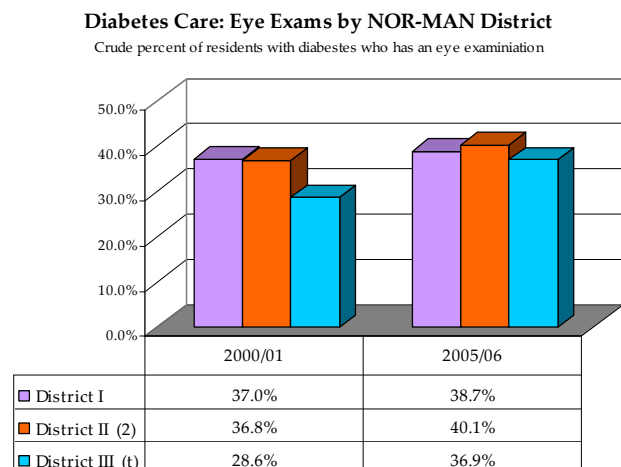


Figure 7.29 Diabetes Care: Eye Exam by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

- 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

5-Year Cancer Survival Rates

Is the specific probability to survive following the diagnosis of a cancer - ratio of the actual survival of cancer cases to matched age, sex, and year-specific probability to survive in general population

(Manitoba Health)

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.**

Male Cancer Survival Rates - 2000/2004			
	Colorectal	Lung	Prostate
NOR-MAN	61%	21%	77%
Manitoba	59%	15%	94%

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**.

Caesarean Section

Is the age-adjusted percentage of all birth delivered by Caesarean Section by RHA residence, regardless of location of provision

Rates are reported in two five-year time periods

(Manitoba Centre for Health Policy)

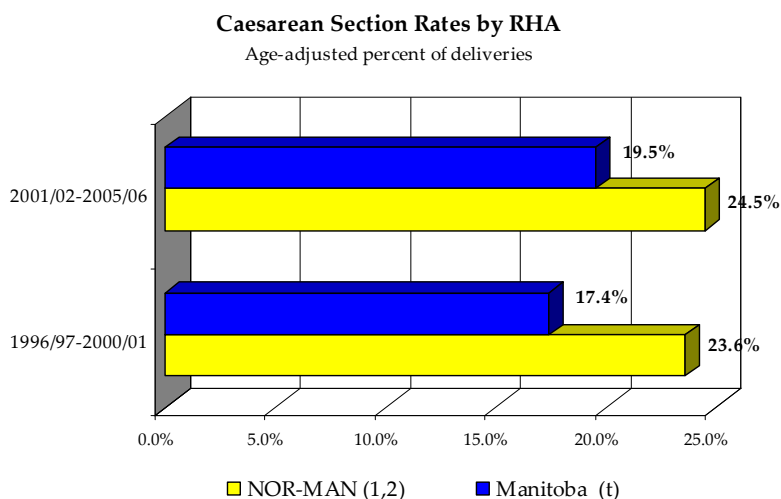


Figure 7.30: Caesarean Section Rates
Source: Manitoba Centre for Health Policy, Child Health Atlas Update, 2008

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 **continues 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

Caesarean Section Rates by District

Age-adjusted percent of deliveries

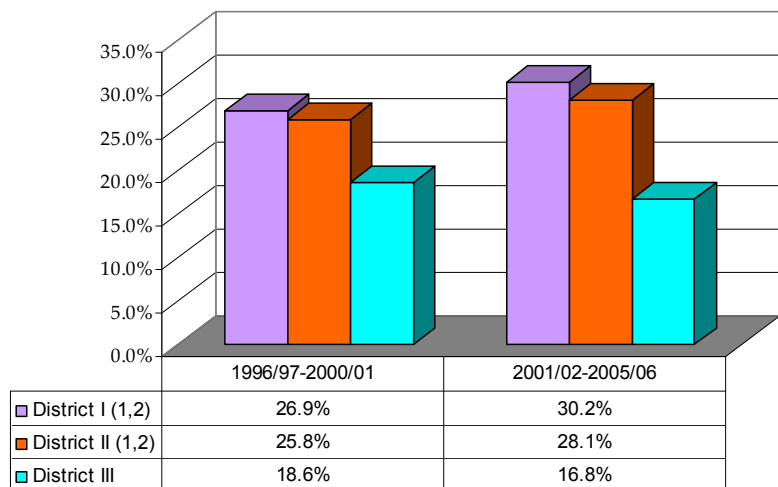


Figure 7.31 Caesarean Section Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, Child Health Atlas Update, 2008

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

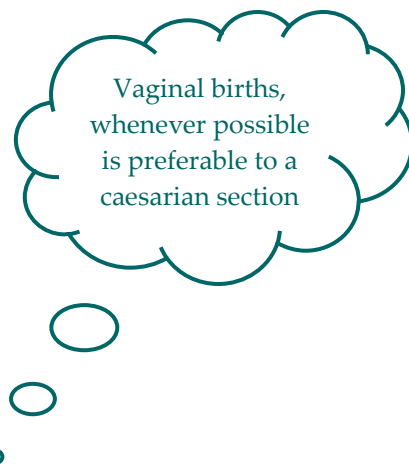
(Manitoba Centre for Health Policy)

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

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%.



Vaginal Births After C-Section			
	District I	District II	District III
1996/97 - 2000/01	suppressed	13.8% (1)	20.7%
2001/02 - 2005/06	23.7%	22.4%	36.3%

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

Is the age adjusted number of hysterectomies performed per 1,000 women aged 25 and older, by RHA of residence, regardless of location of provision

Rate are reported in two five-year time periods

(Manitoba Centre for Health Policy)

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.

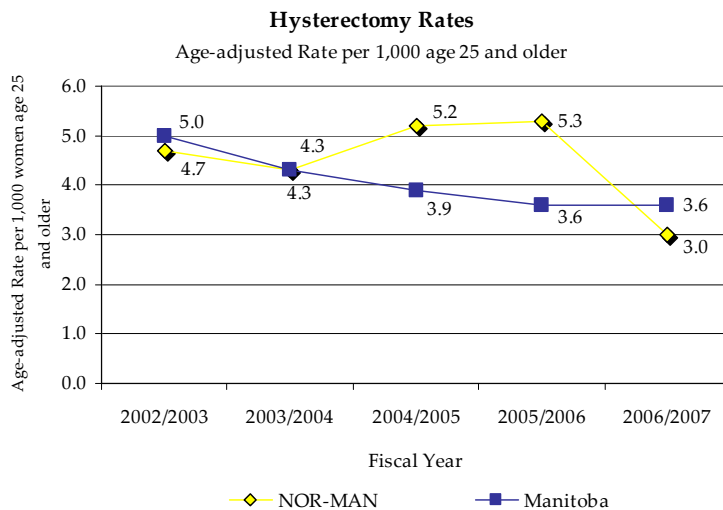


Figure 7.32: Hysterectomy Rates
Source: Manitoba Health, NRHA Profile Document, 2008/09

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.

According to CIHI, it is estimated that more than 1 in 4 Canadian women older than 45 has had a hysterectomy

Tonsillectomy/Adenoidectomy

Is the surgical removal of tonsils and/or adenoid glands

Rate are reported in two five-year time periods

(Manitoba Centre for Health Policy)

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

Tonsillectomy and Adenoidectomy Rates by RHA

Age- and sex-adjusted rates per 1,000 children aged 0-14

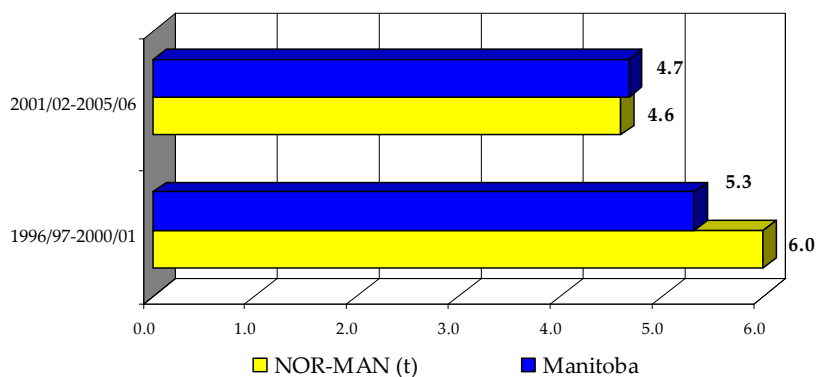


Figure 7.33: Tonsillectomy and Adenoidectomy Rates
Source: Manitoba Centre for Health Policy, Child Health Atlas Update, 2008

Tonsillectomy and Adenoidectomy Rates by District

Age- and sex-adjusted rates per 1,000 children aged 0-14

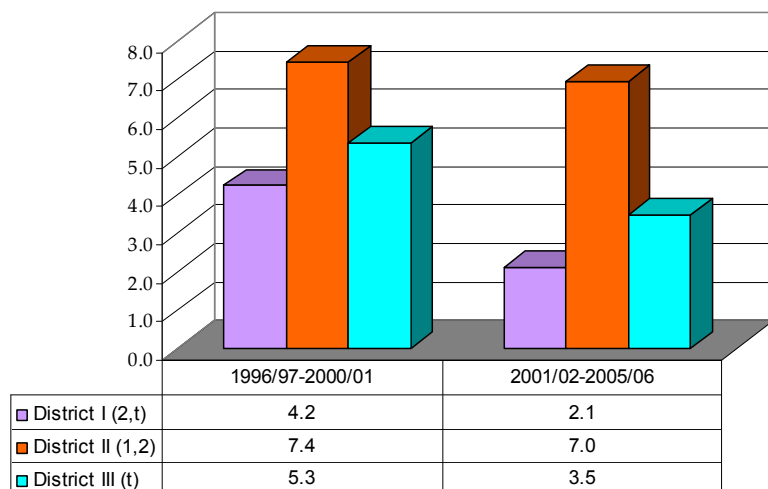


Figure 7.34: Tonsillectomy and Adenoidectomy Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, Child Health Atlas Update, 2008



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

New Home Care Cases

Is the percentage of the population (all ages) with a new home care case open in a year.

Rate are shown as the annual average for a two-year period

(Manitoba Centre for Health Policy)

New Home Care Cases by District

Age- & sex-adjusted annual percent of residents with a new home care case

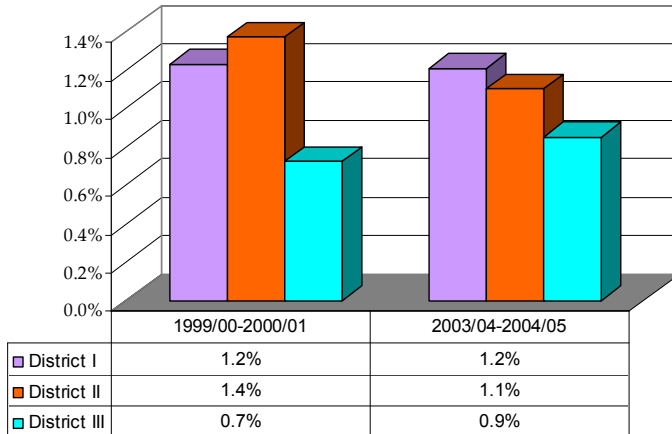


Figure 7.35: New Home Care Cases by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

Open Home Care Cases

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)

Open Home Care Cases by RHA

Age- & sex-adjusted annual percent of residents with an open home care case

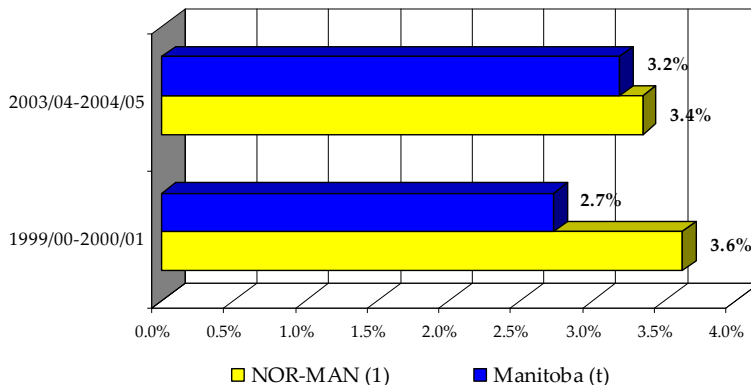


Figure 7.36: Open Home Care Cases
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

Open Home Care Cases by District

Age- & sex-adjusted annual percent of residents with an open home care case

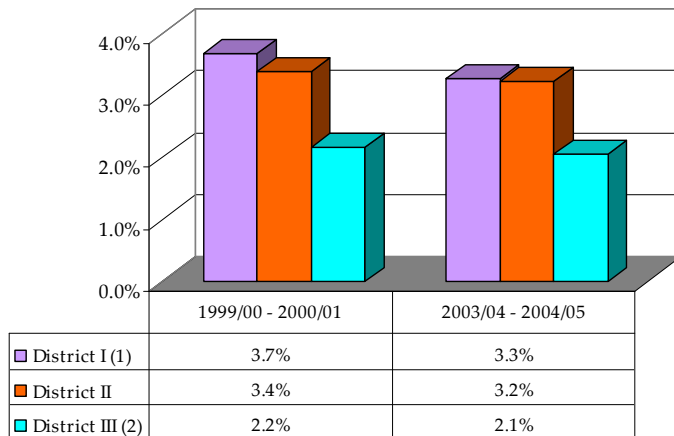


Figure 7.37: Open Home Care Cases by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

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

Is the percentage of the population (all ages) with a home care case which closed during the year.

Rate are shown as the annual average for a two-year period

(Manitoba Centre for Health Policy)

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.

Home Care Case Closing Rates by District

Age- & sex-adjusted annual percent of residents with a closed home care case

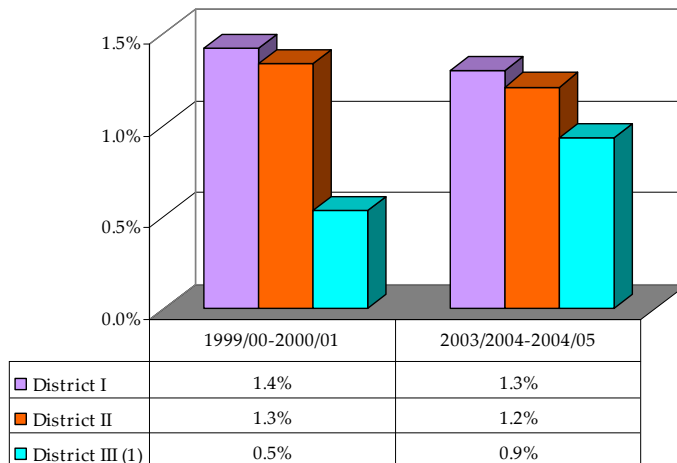


Figure 7.38: Home Care Case Closing Rates by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

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.

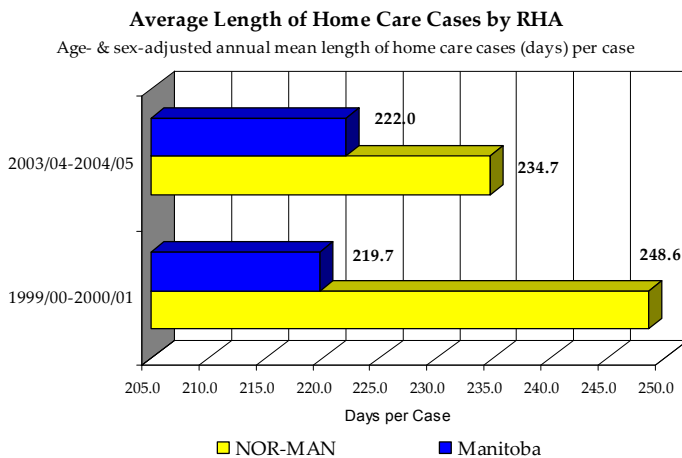


Figure 7.39: Average Length of Home Care Cases
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

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

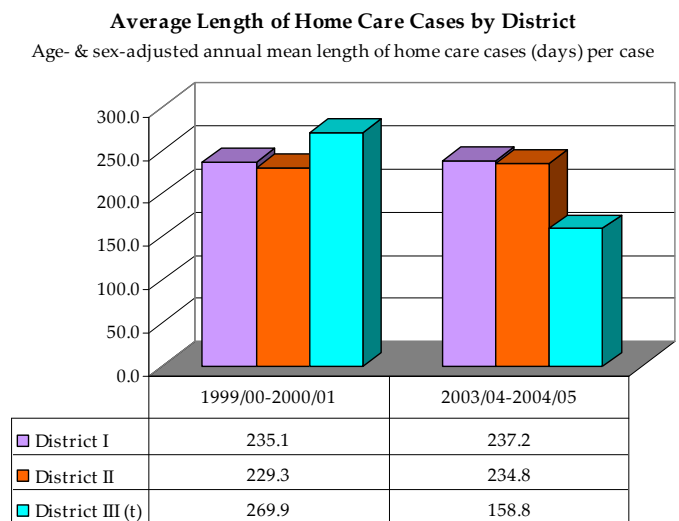


Figure 7.40: Average Length of Home Care Cases by NOR-MAN District
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

Average Length of Stay

Is the average length (in days) of all home care cases open in a two-year period. A home care client may have more than one case in a period and each would be counted as a separate case with a separate length

Rate are shown as the annual average for a two-year period

(Manitoba Centre for Health Policy)

Personal Care Homes (PCH)

Personal care homes (PCH), sometimes referred to as nursing homes, are residential facilities for person 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.

Personal Care Home Bed Supply

Is the number of PCH beds per 1,000 residents age 75 years and older

Rate are shown for two two-year periods

(Manitoba Centre for Health Policy)

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**

Personal Care Home Admissions

Is the percentage of area residents age 75 years and older admitted to a PCH in a year

Rate are shown for two two-year periods

(Manitoba Centre for Health Policy)

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

older admitted to our facilities in the 1999/00 - 2000/01 time period.

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.

Levels of Care on Admission
 Is the distribution of levels of care assigned to PCH residents at the time of their admission.
 (Manitoba Centre for Health Policy)

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%**

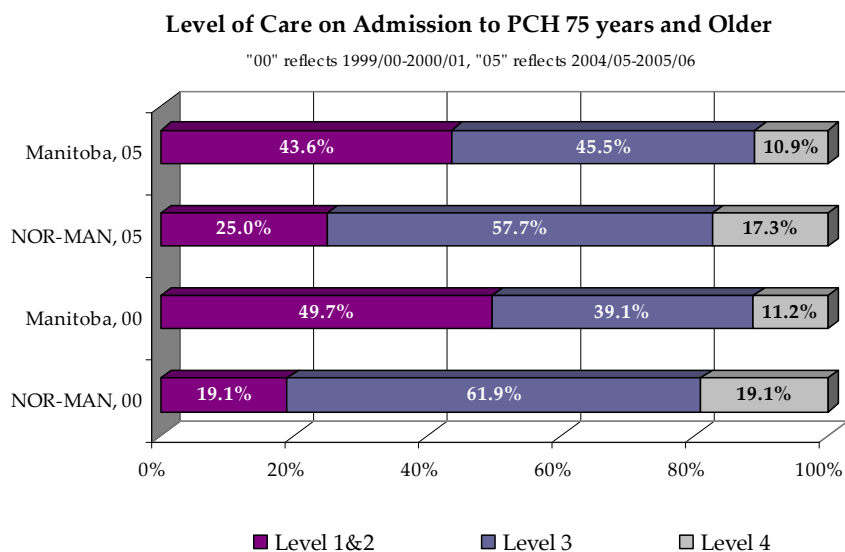


Figure 7.41: Levels of Care on Admission to PCH Aged 75 and Older
 Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

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 Level

The median length of stay (in years) of PCH residents, according to their level of care on admission is the amount of time which half of all residents stayed

(Manitoba Centre for Health Policy)

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.

Median Length of Stay (years) by Level of Care on Admission

"00" reflects 1999/00 -2000/01; "05) reflects 2004/05 - 2005/06

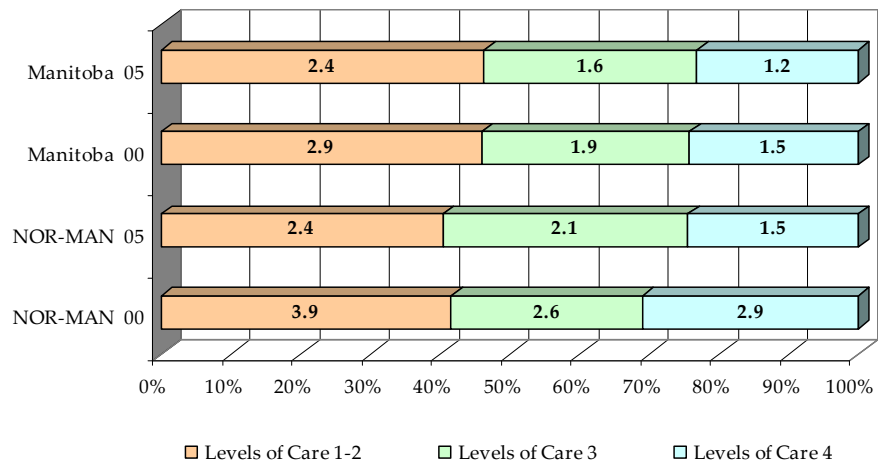


Figure 7.42: Median Length of Stay (years) by Level of Admission
Source: Manitoba Centre for Health Policy, The Manitoba RHA Indicator Atlas, 2009

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

Median Wait Times for PCH Admissions

The amount of time it took for half of all residents to be admitted, after being assessed as requiring a PCH placement (by weeks)

(Manitoba Centre for Health Policy)



The screening process does not include families from First Nation reserves because of provincial / federal jurisdictions

Alcohol use by Mother during Pregnancy Prevalence Rate

Is the percentage of regional post partum population screened for enrolment in the Families First Program with alcohol use by the mother during pregnancy .

(Healthy Child Manitoba)

According to Family First data, our rates of drug use during pregnancy is statistically higher at 9.3% than the provincial rate 4.2%

Smoking use by Mother during Pregnancy Prevalence Rate

Is the percentage of regional post partum population screened for enrolment in the Families First Program with smoking use by the mother during pregnancy .

(Healthy Child Manitoba)

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.

Maternal Depression and Anxiety Disorders by Mother with Newborns Prevalence Rate

Is the percentage of regional post partum population screened for enrolment in the Families First Program with maternal depression and anxiety disorders combined .

(Healthy Child Manitoba)

Income Support or Financial Difficulties of Mother with Newborns Prevalence Rate

Is the percentage of regional post partum population screened for enrolment in the Families First Program with income support or financial difficulties .

(Healthy Child Manitoba)

**Less than Grade 12 Education
by Mother with Newborns
Prevalence Rate**

Is the percentage of regional post partum population screened for enrolment in the Families First Program with a mother with less than a grade 12 education

(Healthy Child Manitoba)

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
Prevalence Rate**

Is the percentage of regional post partum population screened for enrolment in the Families First Program where parents experienced relationship distress

(Healthy Child Manitoba)

**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
Prevalence Rate**

Is the percentage of regional post partum population screened for enrolment for enrolment in the Families First Program where the mother experienced three or more risk factors

(Healthy Child Manitoba)

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%**

(2006). 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)



Screening For and Use of Families First Programs

Is the percentage of regional post partum population screened for enrolment for enrolment in the Families First Program, and the percentage screened positive that actually enrolled

(Healthy Child Manitoba)

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

Program Area	Wait Time
Physiotherapy Priority (The Pas) Non-Urgent	24 days 44 days
Physiotherapy Priority (Flin Flon) Non-Urgent	14 days 25 days
Audiology	71 people
Speech Language Pathology	2 to 4 months
DER The Pas Flin Flon Snow Lake Outlying Communities	2 week or less 2 weeks or less 6 weeks or less 6 - 8 weeks or less
Mental Health Children/ Youth Adult	3 to 4 weeks 1 week
Rosaire House	91 on wait list (annual average) 8 week wait time
Home Care HCA/HSW Nursing Services	4 people 5 people
CT Scan – The Pas	2 weeks (MB = 6 weeks)
Ultrasound – The Pas	6 weeks (MB = 7 weeks)
Ultrasound – Flin Flon	2 weeks
X-Ray – The Pas	Same Day
X-Ray – Flin Flon	Same Day
Long Term Care (July 2009)	17 people - Flin Flon 3 people - The Pas

Table 7.12: NRHA Wait Times

Source: NOR-MAN Regional Health Authority, Responsiveness Scorecard, October 2009

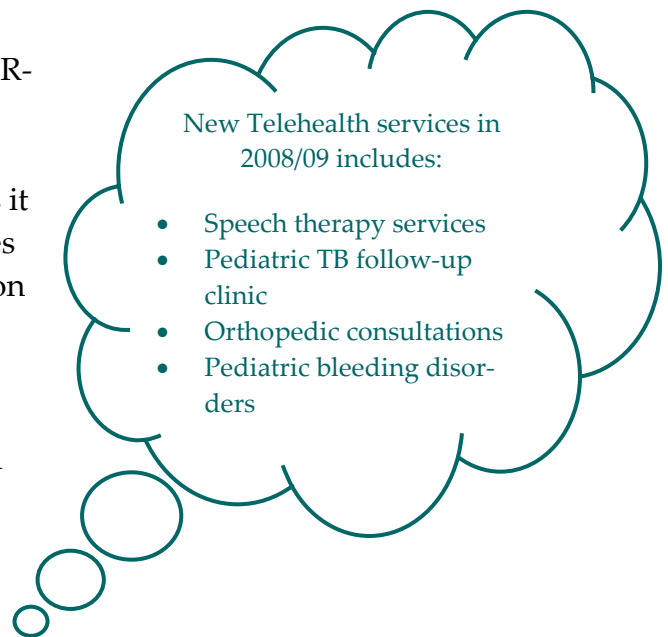
concerned about excessive wait times for cancer treatments and cardiac surgery. Today, Manitobans enjoy a health care system that both patients and experts rank among the highest in Canada in delivering quality.

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)

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.

MBTelehealth Overall Network Utilization Summary - NOR-MAN

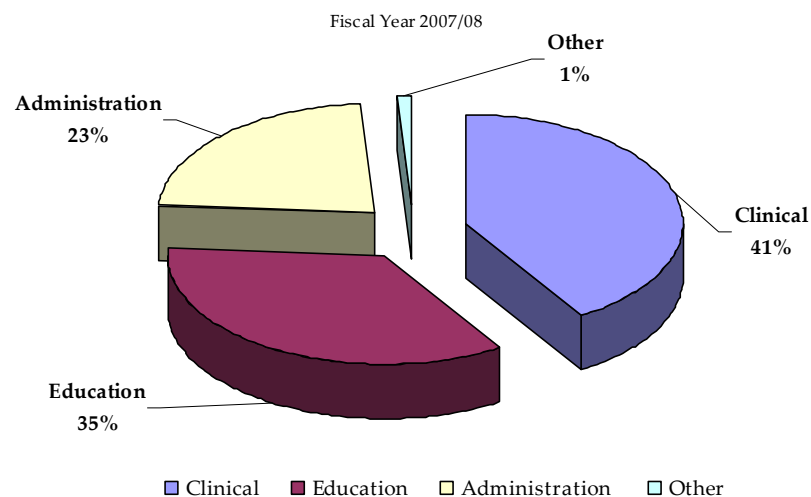


Figure 7.43: MBTelehealth Overall Network Utilization Summary - NOR-MAN
Source: Manitoba Telehealth, NRHA Report, 2009

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.

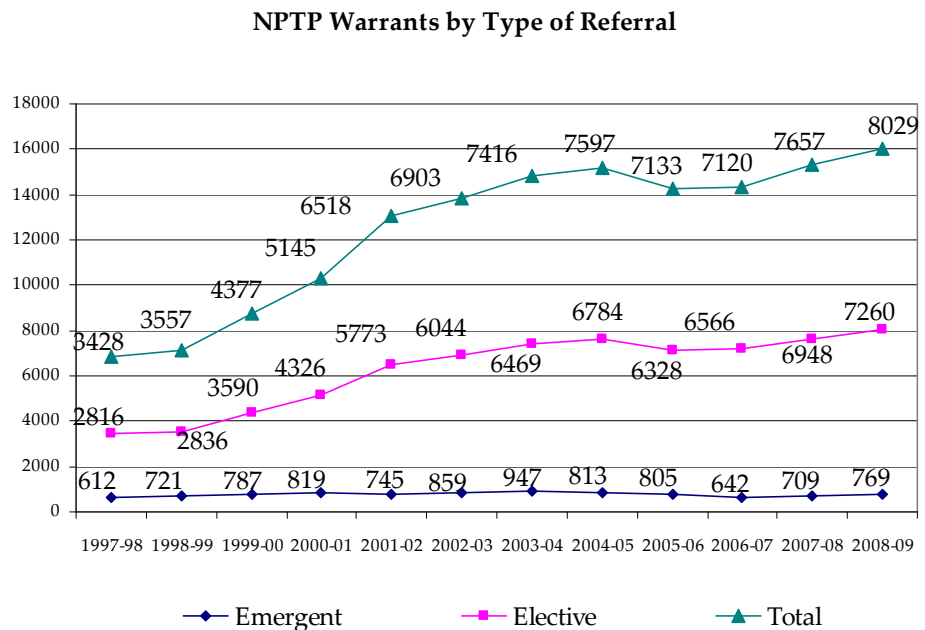


Figure 7.44 NPTP Warrants by Type of Referral
Source: NOR-MAN Regional Health Authority, Responsiveness Scorecard, October 2009

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.

The Pas & Surrounding Area			
2007-08 Total Referrals: 4532		2008-09 Total Referrals: 4633	
Internal Medicine	641 (14%)	Orthopedic	647 (14%)
Orthopedic	572 (13%)	Ophthalmology	462 (10%)
Ophthalmology	438 (10%)	Cardiology	422 (9%)
Oncology	338 (7%)	Internal Medicine	380 (8%)
Surgery	332 (7%)	Oncology	379 (8%)
Cardiology	319 (7%)	Surgery	326 (7%)
Neurology	268 (6%)	Endocrinology	253 (5%)
Gynecology	240 (5%)	Gynecology	213 (5%)
Endocrinology	198 (4%)	Neurology	209 (5%)
Respiratory	170 (4%)	Obstetrics	195 (4%)

Our reasons for travel by physician specialty has changed since our last CHA report from diagnostics at **15%**, orthopedics at **8%** and oncology at **7%** for The Pas

Table 7.13: NPTP Travel by Physician Specialty, The Pas
Source: NOR-MAN Regional Health Authority, Responsiveness Scorecard, October 2009

Our reasons for travel by physician specialty has changed since our last CHA report from orthopedics at **13%**, internal medicine at **10%** and oncology at **8%** for Flin Flon

Flin Flon & Surrounding Area			
2007-08 Total Referrals: 4240		2008-09 Total Referrals: 3048	
Internal Medicine	682 (16%)	Internal Medicine	740 (24%)
Orthopedics	630 (15%)	Orthopedic	568 (18%)
Oncology	337 (8%)	Oncology	354 (12%)
Renal	291 (7%)	Ophthalmology	271 (9%)
Cardiology	258 (6%)	Surgery	259 (8%)
Ophthalmology	237 (6%)	Renal	236 (8%)
Diagnostics	237 (6%)	Cardiology	194 (6%)
Surgery	212 (5%)	Gynecology	180 (6%)
Neurology	190 (4%)	Dialysis	156 (5%)
Gynecology	140 (3%)	Neurology	146 (5%)

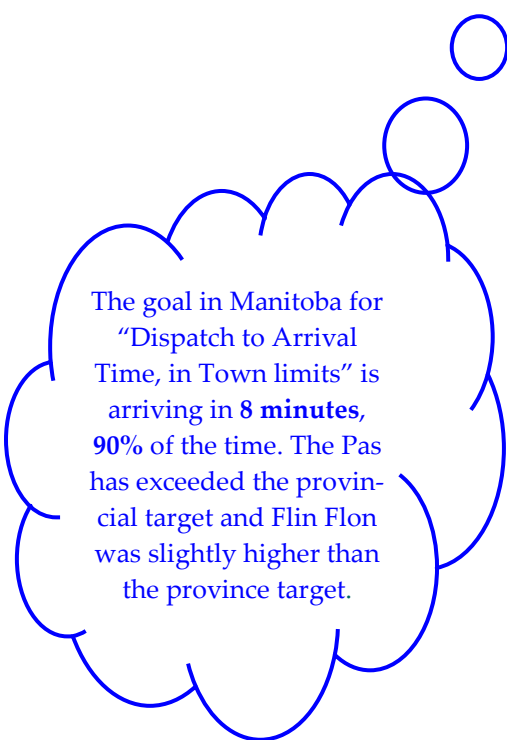
Table 7.14: NPTP Travel by Physician Specialty, Flin Flon
Source: NOR-MAN Regional Health Authority, Responsiveness Scorecard, October 2009

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,



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.

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 **1767** 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

Summary

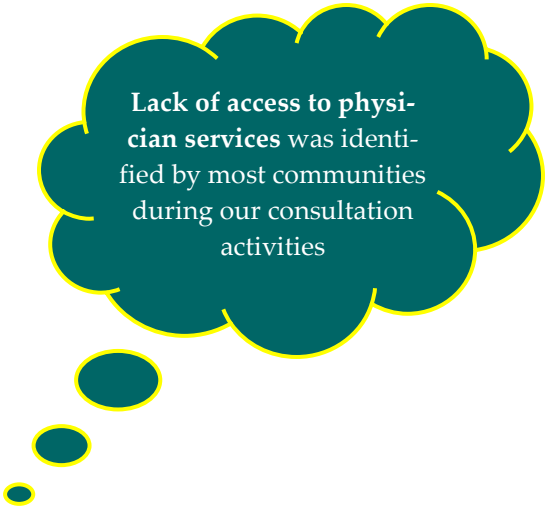
This chapter explored two questions:

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



Lack of access to physician services was identified by most communities during our consultation activities



Cost related to seeing a Specialist - especially if required to travel to Winnipeg identified as a concern during our consultations

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**

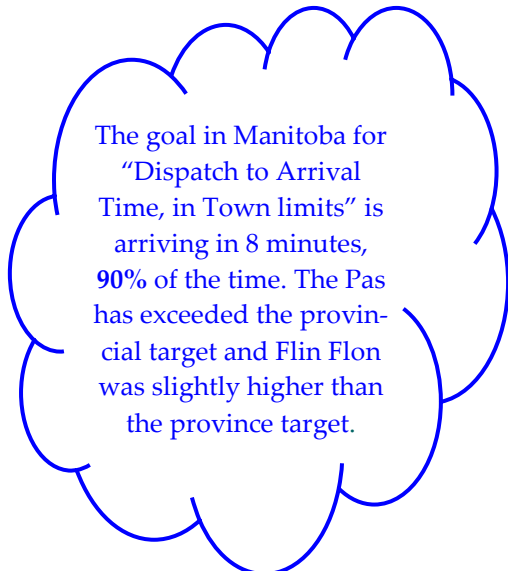
- NOR-MAN residents with mental illness disorders continue to be admitted to hospital more often
- NOR-MAN residents are receiving less knee replacement surgery than Manitobans as a whole - our rate is increasing
- NOR-MAN residents are receiving less hip replacement surgery than Manitobans as a whole - 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%.

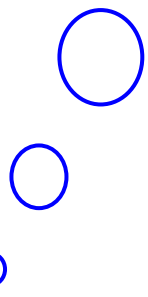
- The good news is that NOR-MAN males have a higher 5 year cancer survival rate for both colorectal and lung cancer. Prostate cancer survival rates are of concern.
- The good news is that NOR-MAN females have a higher 5 year cancer survival rate for colorectal cancer. Lung cancer survival rates are a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



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.



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%**

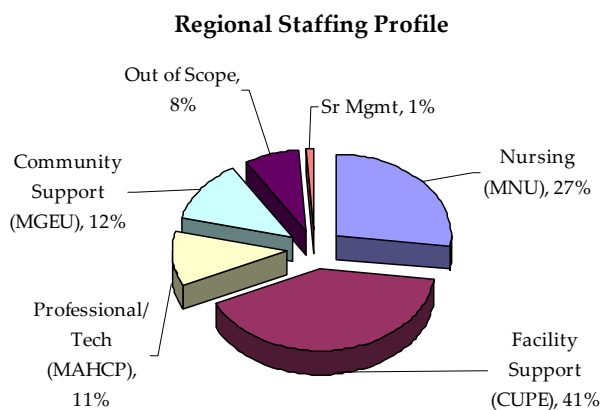


Figure 8.1: Regional Staffing Profile
Source: NRHA Worklife Scorecard, February 2010

- 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.

Recommendations from Communication Focus Groups:

- Regular All Staff Meetings
- Email Notice of New Hires
- Access to Email Off-Site
- Groupwise Directory Update
- NRHA IntraNet.

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

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.

	Acute Care Costs by RHA				
	2002/03	2003/04	2004/05	2005/06	2006/07
Manitoba	60%	60%	59%	53%	52%
Burntwood	54%	55%	55%	50%	50%
NOR-MAN	51%	54%	54%	55%	56%
Churchill	80%	83%	80%	81%	78%
Parkland	43%	44%	43%	43%	43%
N. Eastman	32%	34%	33%	32%	33%
Interlake	39%	40%	41%	38%	40%
Winnipeg	69%	68%	67%	57%	55%
Brandon	60%	60%	63%	62%	62%
Assiniboine	38%	37%	36%	37%	37%
Central	44%	42%	43%	42%	41%
S. Eastman	41%	40%	36%	36%	40%

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 at, 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%**,

	Community Costs by RHA				
	2002/03	2003/04	2004/05	2005/06	2006/07
Manitoba	15%	16%	16%	15%	15%
Burntwood	29%	30%	32%	33%	32%
NOR-MAN	19%	18%	18%	17%	17%
Churchill	8%	6%	8%	8%	10%
Parkland	20%	19%	19%	19%	19%
N. Eastman	22%	23%	25%	25%	24%
Interlake	25%	24%	25%	23%	25%
Winnipeg	14%	14%	15%	13%	13%
Brandon	13%	13%	13%	14%	14%
Assiniboine	14%	14%	15%	14%	14%
Central	15%	15%	15%	15%	15%
S. Eastman	23%	24%	22%	23%	27%

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

	Personal Care Home Costs by RHA				
	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007
Manitoba	18%	17%	17%	15%	14%
Burntwood	0%	0%	0%	0%	0%
NOR-MAN	14%	14%	14%	13%	13%
Churchill	0%	0%	0%	0%	0%
Parkland	30%	30%	31%	31%	31%
N. Eastman	34%	31%	31%	31%	31%
Interlake	26%	25%	23%	29%	23%
Winnipeg	13%	13%	13%	10%	10%
Brandon	16%	15%	14%	14%	14%
Assiniboine	36%	36%	36%	34%	35%
Central	29%	29%	29%	28%	28%
S. Eastman	30%	29%	25%	26%	28%

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%**.

Table 8.3: Personal Care Home Costs by RHA
Source: Manitoba Health, NRHA Profile Document, 2008/09

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 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)

Required Organizational Practices

Is defined as an essential practice that organizations must have in place to enhance patient/client safety and minimize risk

(Accreditation Canada)

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.

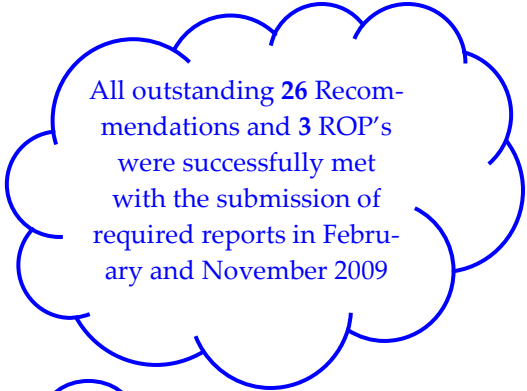
Priority processes - Priority processes are systems or processes that Accreditation Canada has identified as having a significant impact on patient/client safety and quality of care or service. Surveyors assess priority processes using tracers during the survey visit.

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 participate 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.



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 sections each received 100% compliance rate.

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

Patient Safety

Is defined as the prevention and mitigation of unsafe acts within the health care system

(Accreditation Canada)

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

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

5

Could have resulted un 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)

- Quality Audits
- Satisfaction Surveys
- Failure Mode Effects & Analysis
- Root Cause Analysis.

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).

Occurrence Rporting by Type

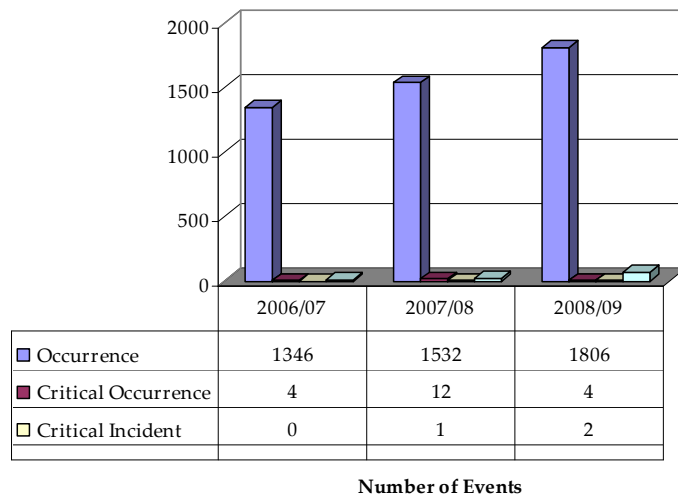


Figure 8.2: Occurrence Reporting by Type
Source: NRHA System Competency Scorecard, December 2009

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.

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.

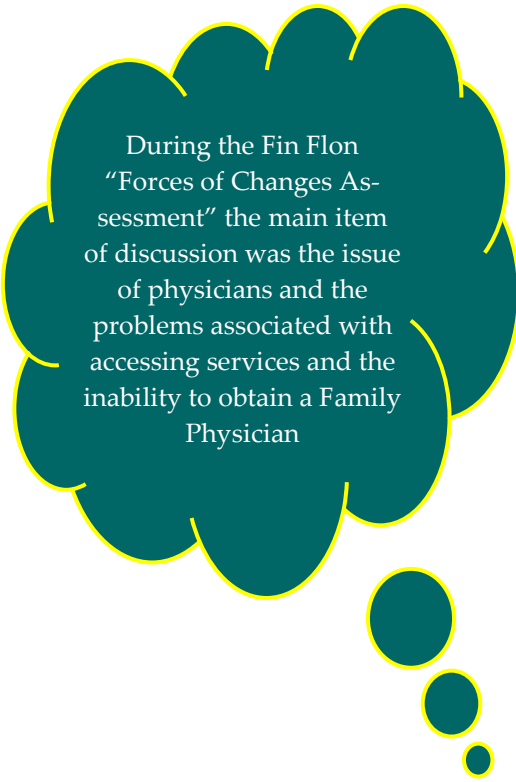
Access to Services

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



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

Flin 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

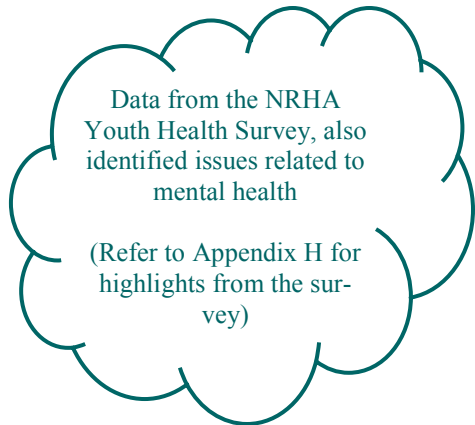
The issue of travel, was discussed on a couple of different levels throughout our consultation activities. Concerns were expressed about the distances some residents have to travel to access service in the NOR-MAN region. When living in a community other than Flin Flon, The Pas and Snow Lake, the communities 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?**

Question 1	Strongly Disagree/ Mostly Disagree	Agree/Mostly Agree/ Strongly Agree
NRHA Staff	15.4%	84.7%
Physicians	3.8%	96.2%
Partners	15.9%	84.1%

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?**

Question 2	Strongly Disagree/ Mostly Disagree	Agree/Mostly Agree/ Strongly Agree
NRHA Staff	28.6%	71.4%
Physicians	20.9%	79.1%
Partners	22.7%	77.2%

Table 8.5: Question 2
Source: NRHA Health System Performance Survey2009/10

- Question 3 - **How satisfied do you feel residents are with the accessibility of NRHA services and programs?**

Question 3	Dissatisfied/Very Dissatisfied	Neutral	Satisfied/ Very Satisfied
NRHA Staff	30.5%	36.0%	33.6%
Physicians	11.5%	46.2%	42.3%
Partners	34.1%	38.6%	27.3%

Table 8.6: Question 3
Source: NRHA Health System Performance Survey2009/10

Question 4	Dissatisfied/Very Dissatisfied	Neutral	Satisfied/Very Satisfied
NRHA Staff	12.5%	29.1%	58.2%
Physicians	7.6%	42.3%	50.0%
Partners	16.6%	23.8%	59.5%

Table 8.7: Question 4
Source: NRHA Health System Performance Survey2009/10

- Question 4 - How satisfied do you feel residents are with the friendliness of NRHA staff?

Question 5	Dissatisfied/Very Dissatisfied	Neutral	Satisfied/Very Satisfied
NRHA Staff	15.1%	41.0%	43.9%
Physicians	7.6%	26.9%	65.4%
Partners	31.8%	29.5%	38.6%

Table 8.8: Question 5
Source: NRHA Health System Performance Survey2009/10

- Question 5 - How satisfied do you feel residents are with the quality of NRHA services and programs?

Question 6	Dissatisfied/Very Dissatisfied	Neutral	Satisfied/Very Satisfied
NRHA Staff	19.6%	39.3%	41.1%
Physicians	7.6%	53.8%	38.4%
Partners	29.5%	34.1%	36.4%

Table 8.9: Question 6
Source: NRHA Health System Performance Survey2009/10

- Question 6 - How satisfied do you feel residents are with the delivery methods of NRHA services and programs?

Question 7	Dissatisfied/Very Dissatisfied	Neutral	Satisfied/Very Satisfied
NRHA Staff	31.3%	36.2%	32.6%
Physicians	15.3%	38.5%	46.2%
Partners	37.2%	44.2%	18.6%

Table 8.10: Question 7
Source: NRHA Health System Performance Survey2009/10

- Question 7 - How satisfied do you feel residents are with the timeliness of NRHA services and programs?

Question 8	Dissatisfied/Very Dissatisfied	Neutral	Satisfied/Very Satisfied
NRHA Staff	17.2%	42.9%	39.9%
Physicians	4.0%	40.0%	56.0%
Partners	32.6%	34.9%	32.5%

Table 8.11: Question 8
Source: NRHA Health System Performance Survey2009/10

- Question 8 - Overall, how satisfied do you feel residents are with the NRHA?

- Question 9 - **How important do you believe accessibility of NRHA services and programs is to residents?**

Question 9	Unimportant/ Very Unimportant	Neutral	Important/ Very Important
NRHA Staff	4.7%	7.6%	87.6%
Physicians	0.0%	12.0%	88.0%
Partners	0.0%	2.3%	97.7%

Table 8.12: Question 9
Source: NRHA Health System Performance Survey2009/10

- Question 10 - **How important do you believe friendliness of NRHA staff is to residents?**

Question 10	Unimportant/ Very Unimportant	Neutral	Important/ Very Important
NRHA Staff	0.6%	5.9%	93.5%
Physicians	0.0%	11.5%	88.4%
Partners	0.0%	4.5%	95.4%

Table 8.13: Question 10
Source: NRHA Health System Performance Survey2009/10

- Question 11 - **How important do you believe the quality of NRHA services and programs is to residents?**

Question 11	Unimportant/ Very Unimportant	Neutral	Important/ Very Important
NRHA Staff	1.2%	3.7%	95.1%
Physicians	0.0%	0.0%	100.0%
Partners	0.0%	2.3%	97.7%

Table 8.14: Question 11
Source: NRHA Health System Performance Survey2009/10

- Question 12 - **How important do you believe the delivery method of NRHA services and programs is to residents?**

Question 12	Unimportant/ Very Unimportant	Neutral	Important/ Very Important
NRHA Staff	1.2%	10.1%	88.6%
Physicians	0.0%	11.5%	88.5%
Partners	2.3%	4.5%	93.2%

Table 8.15: Question 12
Source: NRHA Health System Performance Survey2009/10

- Question 13 - **How important do you believe timeliness of NRHA services and programs is to residents?**

Question 13	Unimportant/ Very Unimportant	Neutral	Important/ Very Important
NRHA Staff	0.9%	4.6%	94.4%
Physicians	0.0%	0.0%	100.0%
Partners	2.3%	6.8%	90.9%

Table 8.16: Question 13
Source: NRHA Health System Performance Survey2009/10

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 year

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



65% of clients are from the NOR-MAN region

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%** of responded negatively about awareness of the NRHA complaint/ Compliment form
- **40.7%** responded negatively about their contact time with the Resource Coordinator

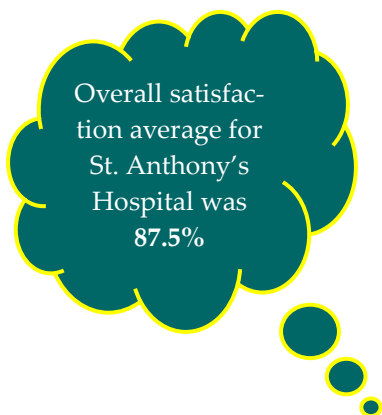
Hospice and Palliative Care Family Satisfaction Survey -

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

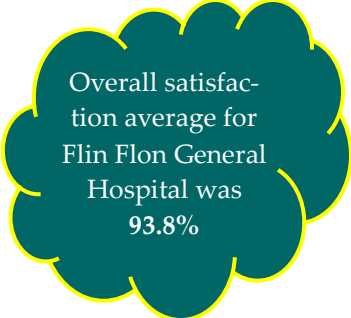
- **Acute Care** - results from the last survey administered between April 2008 to March 2009 are:

- Overall food service satisfaction for St. Anthony's Hospital was **88%** - this rate is **above** the Aarmark standard



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

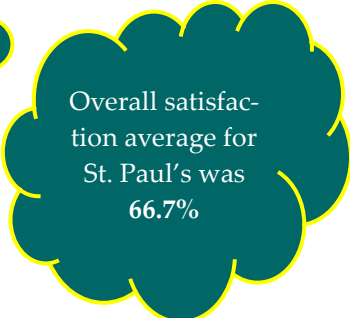


Overall satisfaction average for Flin Flon General Hospital was **93.8%**

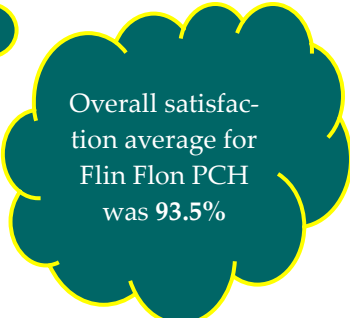
Support Services Client Satisfaction Experience

- **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



Overall satisfaction average for St. Paul's was **66.7%**




Overall satisfaction average for Flin Flon PCH was **93.5%**

Primary Health Care Client Satisfaction

Expereince - results from the last survey administered between October 2008 to November 2009 are:

- **92%** responded that the overall quality of care



Overall satisfaction average for NLM was **94.9%**

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 spend with the Health Care Provider

Community Mental Health Consumer

Satisfaction Experience - results from the last survey administered in December 2009 are:

- 100% of responded 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:

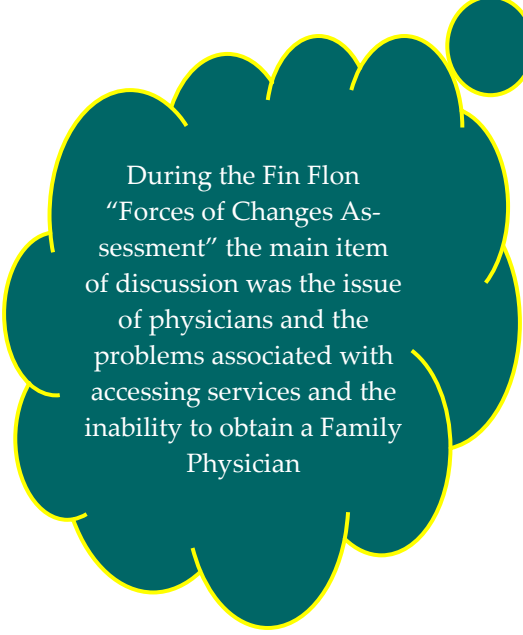
- Regular All Staff Meetings
- Email Notice of New Hires
- Access to Email Off-Site
- Groupwise Directory Update
- NRHA IntraNet.

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

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

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

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

- 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.

Sustainable Governance, Effective Organization, Child and Youth Populations, and Maternal Child Population standards section received 100% compliance rate.

- 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,

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



RHA's are legislated under the Regional Health Authorities Act of Manitoba to develop and submit a Regional Health Plan, which includes a 5-year strategic component and an annual health plan component

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 weakness) 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

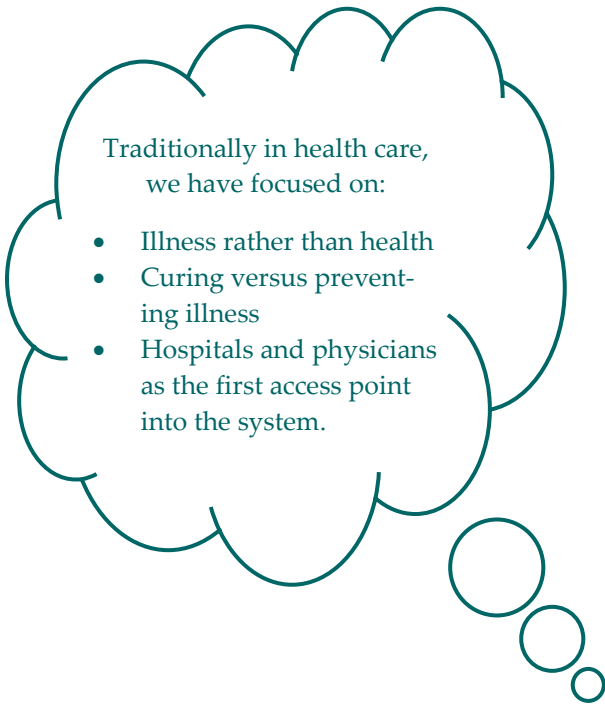
immunization rates were steadily improving

- 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



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.



We have 989 employees:

- 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:

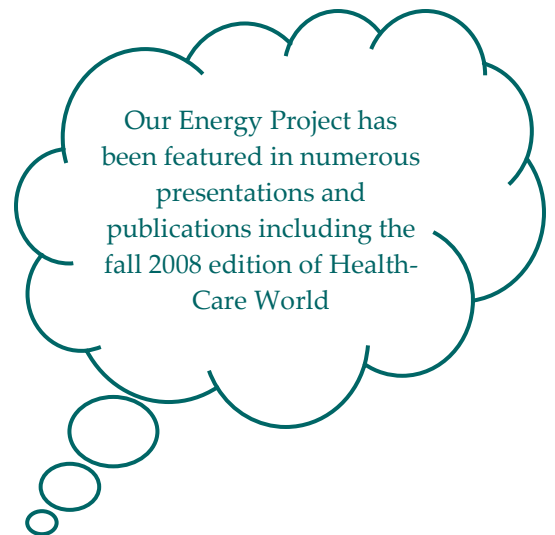
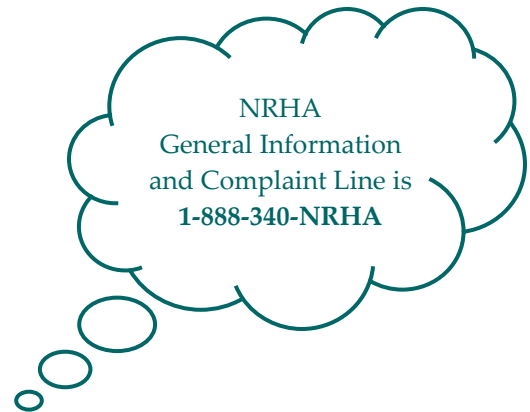
Healthy Communities

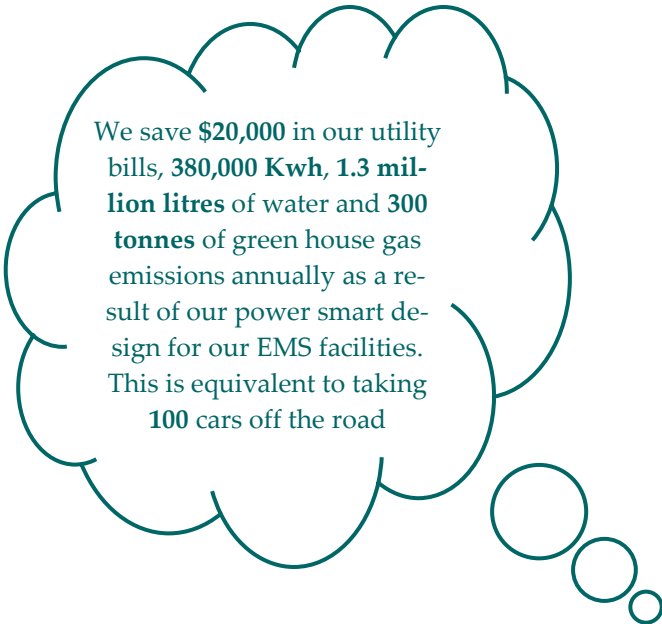
Communications

- 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.

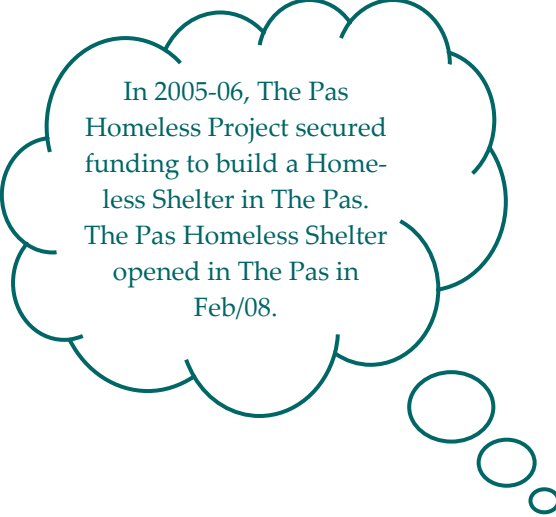
Environment

- 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 green house 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



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.

tonnes of greenhouse gas emissions annually.

- 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

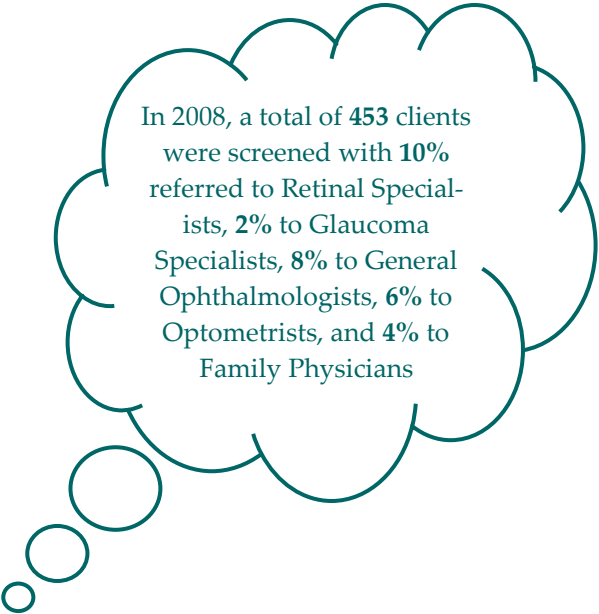
Community Plan Advisory Committee, The Pas Homeless Shelter, Parent Child Coalition, Chronic Disease Prevention Initiative (CDPI), Play it Safer, Children's Therapy Initiative (CTI) and the Baby Friendly Initiative.

- 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."



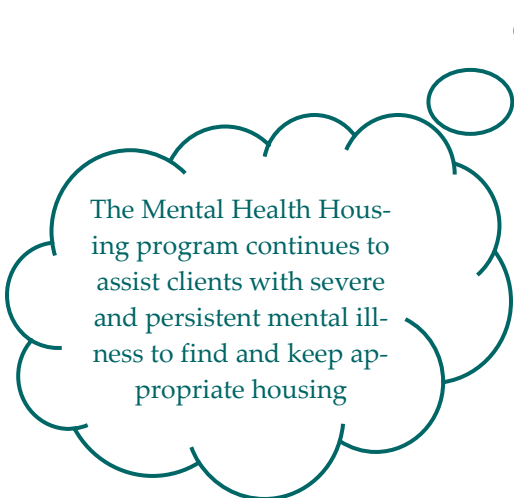
In 2008, a total of 453 clients were screened with 10% referred to Retinal Specialists, 2% to Glaucoma Specialists, 8% to General Ophthalmologists, 6% to Optometrists, and 4% to Family Physicians




We received \$23,600 in funding for the Healthy Northern Foods Initiative, CDPI Partnership for school nutrition and community gardening projects



The Wellness Centre opened in the fall of 2009. Office and program space for Primary Health Care staff as well as an outpatient physiotherapy program was included in the design of the centre



The Mental Health Housing program continues to assist clients with severe and persistent mental illness to find and keep appropriate housing



Funding was received to implement "Protect Your Pairs," an adolescent breast and testicular health fair targeted at high school students in our region

- 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

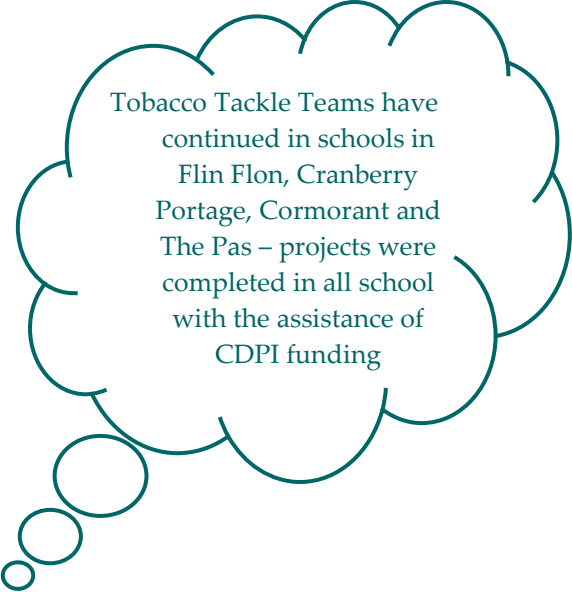
- In 2006-07, through the Children's Therapy Initiative (CTI), an Occupational Therapist (OT) was hired full-time for the region which allowed a shifting of resources so that children previously not eligible could receive OT services.
- In 2006-07, we received provincial funding for the Healthy Smiles, 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.

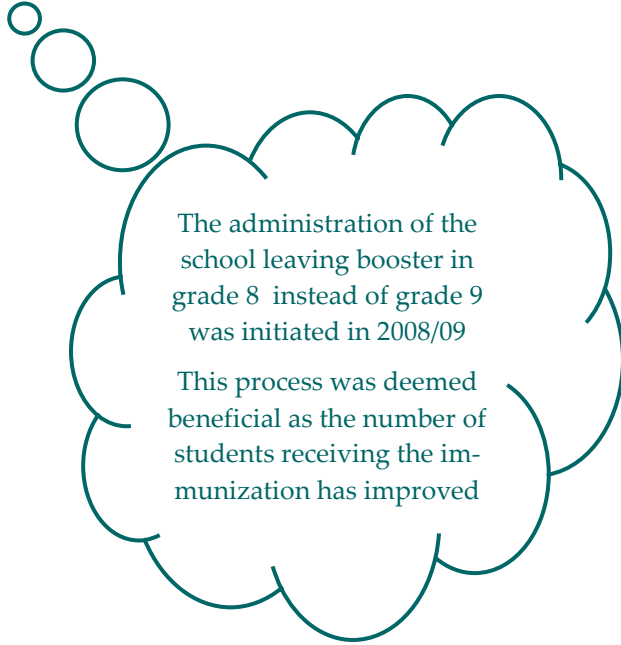
- Risk Factor Surveillance surveying (Youth Health Survey) for grades 6-12 has occurred in all schools in the region in 2009. Next steps are to review the results with the local schools and school boards with the intent of partnering in projects to meet identified issues/concerns.
- The Families First 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

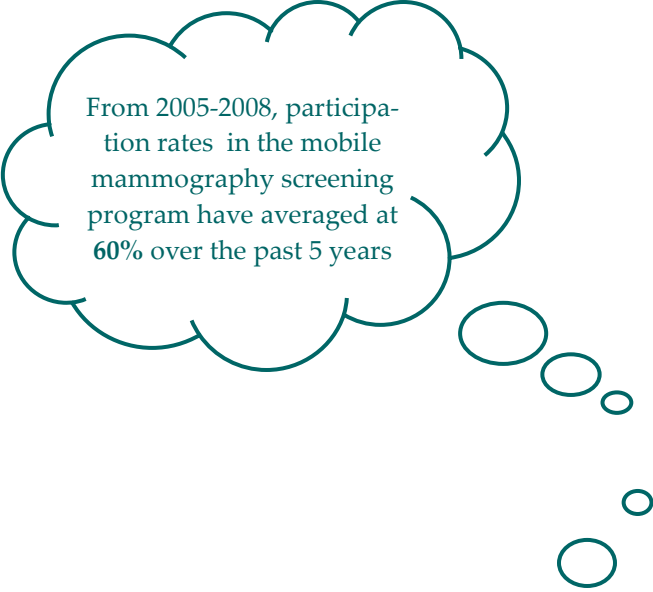
- The Manitoba Mobile Breast Screening Program (MBSP) has had a significant impact on breast screening rates. Since the program began, our breast screening rates have been above the provincial rate in all reporting periods.
- Over the past several years, there has been an increase in promotion of the 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



From 2005-2008, participation rates in the mobile mammography screening program have averaged at 60% over the past 5 years



In 2008, the Pink Project distributed 1750 pink carnations, BSE shower cards and information on the NOR-MAN Breast cancer Network to women throughout the region



Elder Abuse Committee launched an Elder Abuse Video in June 2009

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:




Meals on Wheels program is offered through Home Care with a strong volunteer base



The Support to Seniors in Group Living (SSGL) program was implemented in the Legion Housing in Flin Flon in June 2007 and in Northern View Lodge in The Pas in June 2008



Since the last CHA, Telehealth Services are now available in Grand Rapids, Easterville and Pukatawagan



Interpretative Services in NRHA facilities continue to be provided by our Aboriginal Liaisons or staff volunteers

We participated in Accreditation Canada's Work Life Pulse in October 2007 with a **61%** response rate. NRHA staff satisfaction rates are on par with national compliance rate

(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%**.

The Four (4) Pillars of Primary Health Care:

1. Team Approach
2. Access
3. Healthy Living
4. Community Involvement

Wait times to access CT is **3 weeks** which is less than the Manitoba average of **5 weeks**

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**

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

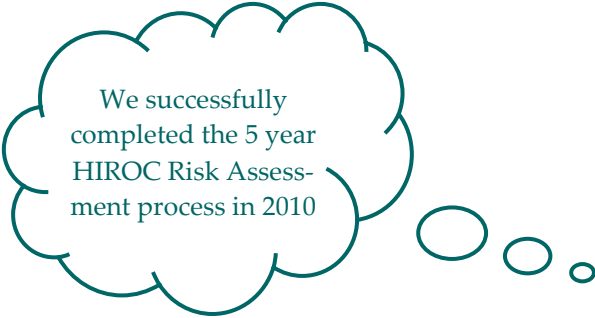
Total Capital Investment since 1999:

- Flin Flon: \$10,818,318
- The Pas: \$10,053,664
- Snow Lake: \$1,247,969
- Grand Rapids: \$94,678
- Cormorant: \$28,575
- Sherridon: \$21,695

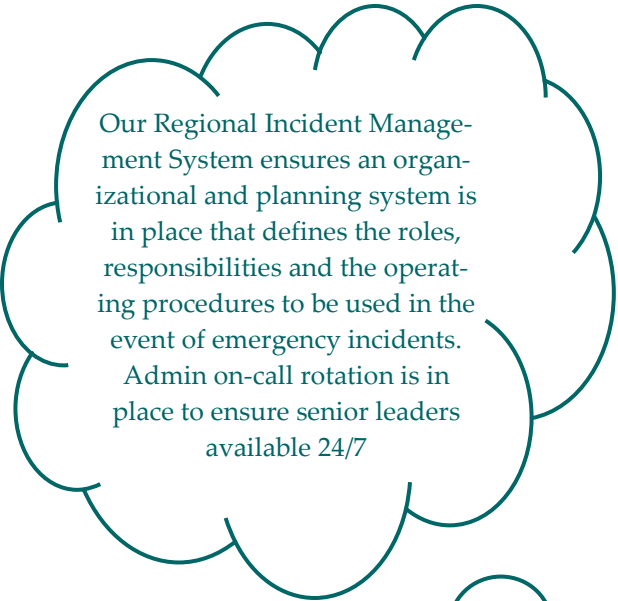
Accreditation Canada Compliance Rates

NRHA (National average)

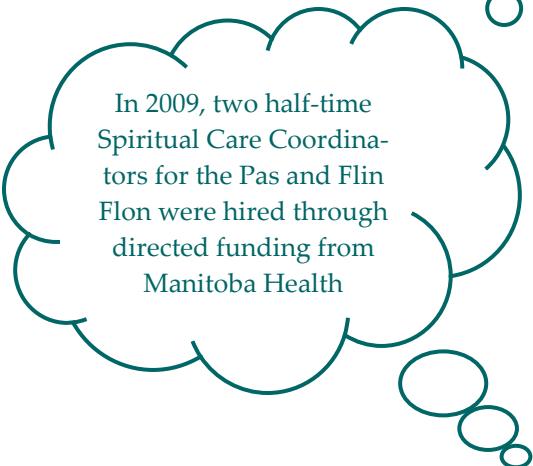
Population Focus 91% (90%)
Accessibility 97% (93%)
Safety 89% (85%)
Work Life 96% (91%)
Client-centred 96% (91%)
Effectiveness 89% (91%)
Continuity 88% (91%)
Efficiency 95% (91%)



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

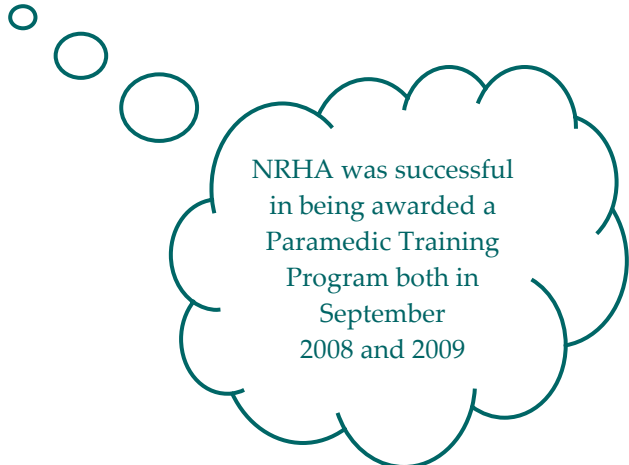
- We continue to seek out creative ways to deal with staff and physician shortages including continuing with student sponsorships and return of services agreements; High School Bursary Program; and incentives to students completing senior practicum experience with RHA, to name a few.
- We continue to 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**



In partnership with the Office of Rural and Northern Health (ORNH), we participated in the Home for the Summer program in the summers of 2007, 2008 and 2009



NRHA was successful in being awarded a Paramedic Training Program both in September 2008 and 2009



We publish four Quality Scorecards annually on the topics of:

1. Work Life
2. Responsiveness
3. System Competency
4. Client/ Community Focus

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**

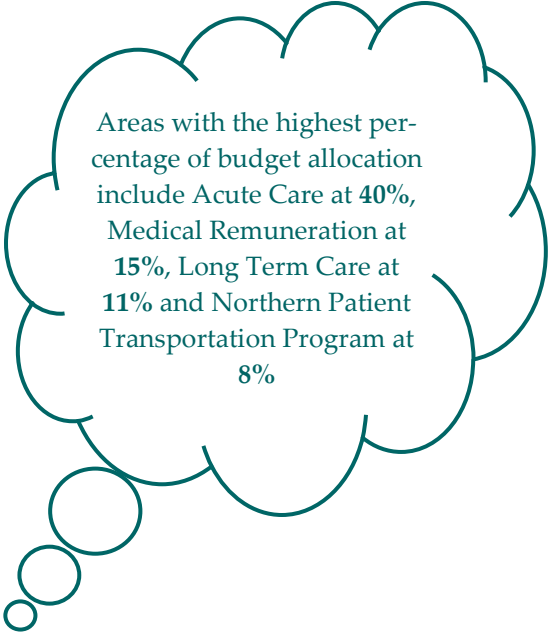
Our operating expenses continue to increase each year at a rate that is higher than our allocated funding level from Manitoba Health. The largest majority of the increase is related to negotiated wage increases, cost of living increases, utility increases, and transportation costs increases.

- **Physician Remuneration**

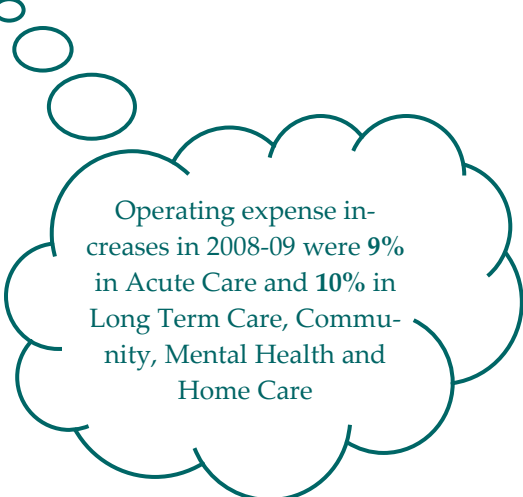
Physician remuneration costs increased by 9% in the 2009-10 fiscal year. Increases were largely related to negotiated payment increases to physicians as well physician shortages and the need to depend on locum services (in particular for Anesthesia and Obstetric Services in The Pas and Obstetrical and Surgical Services in Flin Flon).

- **Northern Patient Transportation Program**

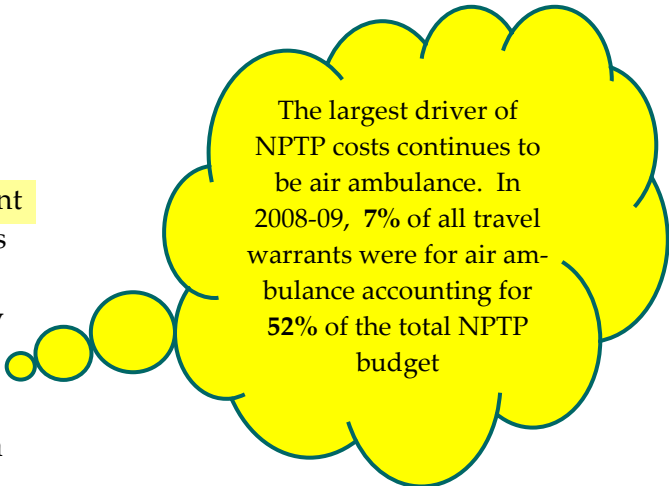
We continue to see a deficit in the Northern Patient Transportation Program (NPTP) program. This is a provincial program, which is grossly under funded, and one which we have little to no ability to control costs. In 2000-01, when NPTP became the responsibility of NRHA to fund, the funding level was at \$2.26 million (with a



Areas with the highest percentage of budget allocation include Acute Care at 40%, Medical Remuneration at 15%, Long Term Care at 11% and Northern Patient Transportation Program at 8%



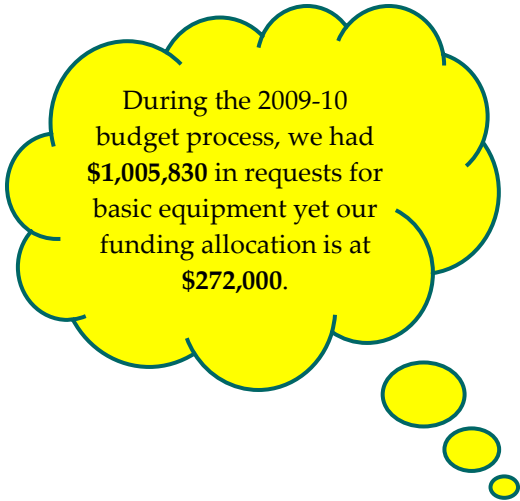
Operating expense increases in 2008-09 were 9% in Acute Care and 10% in Long Term Care, Community, Mental Health and Home Care



The largest driver of NPTP costs continues to be air ambulance. In 2008-09, 7% of all travel warrants were for air ambulance accounting for 52% of the total NPTP budget

deficit of **\$1.24 million**). 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.



During the 2009-10 budget process, we had **\$1,005,830** in requests for basic equipment yet our funding allocation is at **\$272,000**.

- **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.



We have three IT staff who manage over **600** user accounts, **300** workstations, **120** printers/copiers, **30** servers, and all telecommunications and security systems.

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.

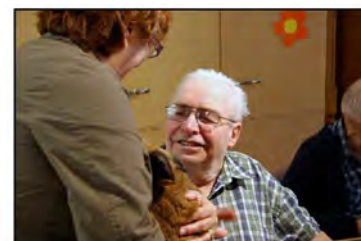
Whether at an individual, family, community or RHA level, we all have a role to play in improving our health status. We are recommending the following actions be taken to answer the question - **“What are our next steps?”**

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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NOR-MAN Regional Health Authority Community Health Assessment Teams Terms of Reference

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

- 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

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:

- 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.



NOR-MAN RHA Community Health Assessment Health System Performance Staff Survey

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.

	Strongly Agree	Mostly Agree	Agree	Mostly Disagree	Strongly Disagree
I believe that the NRHA is responsive to residents health care needs.	5	4	3	2	1
I believe that when residents need a health care service they know where to go.	5	4	3	2	1
	Very Satisfied	Satisfied	Neutra 1	Dissatisfied	Very Dissatisfied
How satisfied do you feel residents are with the <u>accessibility</u> of NRHA services and programs?	5	4	3	2	1
How satisfied do you feel residents are with the <u>friendliness</u> of NRHA staff?	5	4	3	2	1
How satisfied do you feel residents are with the <u>quality</u> of NRHA services and programs?	5	4	3	2	1
How satisfied do you feel residents are with the <u>delivery methods</u> of NRHA services and programs?	5	4	3	2	1
How satisfied do you feel residents are with the <u>timeliness</u> 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
	Very Important	Important	Neutra 1	Unimportant	Very Unimportant
How important do you believe <u>accessibility</u> of NRHA services and programs is to residents?	5	4	3	2	1
How important do you believe <u>friendliness</u> of NRHA staff is to residents?	5	4	3	2	1
How important do you believe the <u>quality</u> of NRHA services and programs is to residents?	5	4	3	2	1
How important do you believe the <u>delivery method</u> of NRHA services and programs is to residents?	5	4	3	2	1
How important do you believe <u>timeliness</u> 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

Number of years of service?	Less than 1 year	<input type="checkbox"/>	11- 20 years	<input type="checkbox"/>
	1 – 3 years	<input type="checkbox"/>	21 – 25 years	<input type="checkbox"/>
	4 – 10 years	<input type="checkbox"/>	26+ years	<input type="checkbox"/>
What is your employment status?	Full-time	<input type="checkbox"/>	Casual	<input type="checkbox"/>
	Part-time	<input type="checkbox"/>	Contract	<input type="checkbox"/>
Which department/area do currently work in?	Acute Care	<input type="checkbox"/>	Home Care	<input type="checkbox"/>
	Administration	<input type="checkbox"/>	Long Term Care	<input type="checkbox"/>
	Community	<input type="checkbox"/>	Support Services	<input type="checkbox"/>
	Other	<input type="checkbox"/>		
Which community are you based in?	Flin Flon	<input type="checkbox"/>	The Pas	<input type="checkbox"/>
	Snow Lake	<input type="checkbox"/>	Other	<input type="checkbox"/>
Which age category are you in?			Under 24 years	<input type="checkbox"/>
			25 – 34 years	<input type="checkbox"/>
			35 – 44 years	<input type="checkbox"/>
			45 – 54 years	<input type="checkbox"/>
			55 – 64 years	<input type="checkbox"/>
			65 + years	<input type="checkbox"/>
Sex	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>

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



NOR-MAN RHA Community Health Assessment Health System Performance Physician Survey

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.

	Strongly Agree	Mostly Agree	Agree	Mostly Disagree	Strongly Disagree
I believe that the NRHA is responsive to residents health care needs.	5	4	3	2	1
I believe that when residents need a health care service they know where to go.	5	4	3	2	1
	Very Satisfied	Satisfied	Neutra 1	Dissatisfied	Very Dissatisfied
How satisfied do you feel residents are with the <u>accessibility</u> of NRHA services and programs?	5	4	3	2	1
How satisfied do you feel residents are with the <u>friendliness</u> of NRHA staff?	5	4	3	2	1
How satisfied do you feel residents are with the <u>quality</u> of NRHA services and programs?	5	4	3	2	1
How satisfied do you feel residents are with the <u>delivery methods</u> of NRHA services and programs?	5	4	3	2	1
How satisfied do you feel residents are with the <u>timeliness</u> 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
	Very Important	Important	Neutra 1	Unimportant	Very Unimportant
How important do you believe <u>accessibility</u> of NRHA services and programs is to residents?	5	4	3	2	1
How important do you believe <u>friendliness</u> of NRHA staff is to residents?	5	4	3	2	1
How important do you believe the <u>quality</u> of NRHA services and programs is to residents?	5	4	3	2	1
How important do you believe the <u>delivery method</u> of NRHA services and programs is to residents?	5	4	3	2	1
How important do you believe <u>timeliness</u> 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?

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	<input type="checkbox"/>	11- 20 years	<input type="checkbox"/>
	1 – 3 years	<input type="checkbox"/>	21 – 25 years	<input type="checkbox"/>
	4 – 10 years	<input type="checkbox"/>	26+ years	<input type="checkbox"/>
Physician type?	Contract	<input type="checkbox"/>	Itinerant	<input type="checkbox"/>
	Fee-for-Service	<input type="checkbox"/>	Other	<input type="checkbox"/>
Physician Specialty? (please check all that apply)	Anesthesiology	<input type="checkbox"/>	Internal Medicine	<input type="checkbox"/>
	Emergency Room	<input type="checkbox"/>	Long Term Care	<input type="checkbox"/>
	Family Medicine	<input type="checkbox"/>	Support Services	<input type="checkbox"/>
	General Surgery	<input type="checkbox"/>	Psychiatry	<input type="checkbox"/>
	Gynecology	<input type="checkbox"/>	Radiology	<input type="checkbox"/>
Home community?	Flin Flon	<input type="checkbox"/>	The Pas	<input type="checkbox"/>
	Snow Lake	<input type="checkbox"/>	Other	<input type="checkbox"/>
Which age category are you in?			Under 24 years	<input type="checkbox"/>
			25 – 34 years	<input type="checkbox"/>
			35 – 44 years	<input type="checkbox"/>
			45 – 54 years	<input type="checkbox"/>
			55 – 64 years	<input type="checkbox"/>
Gender	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>

Thank you for completing this staff survey.

Please return completed survey by Monday February 15, 2010.

Completed surveys are to be returned in the attached self-addressed, stamped envelope.

If you have any questions, please do not hesitate to contact Catherine Hynes, Regional Manager Decision Support at 687-1338.



NOR-MAN RHA Community Health Assessment Health System Performance Partner Survey

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.

	Strongly Agree	Mostly Agree	Agree	Mostly Disagree	Strongly Disagree
I believe that the NRHA is responsive to residents health care needs.	5	4	3	2	1
I believe that when residents need a health care service they know where to go.	5	4	3	2	1
	Very Satisfied	Satisfied	Neutra 1	Dissatisfied	Very Dissatisfied
How satisfied do you feel residents are with the <u>accessibility</u> of NRHA services and programs?	5	4	3	2	1
How satisfied do you feel residents are with the <u>friendliness</u> of NRHA staff?	5	4	3	2	1
How satisfied do you feel residents are with the <u>quality</u> of NRHA services and programs?	5	4	3	2	1
How satisfied do you feel residents are with the <u>delivery methods</u> of NRHA services and programs?	5	4	3	2	1
How satisfied do you feel residents are with the <u>timeliness</u> 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
	Very Important	Important	Neutra 1	Unimportant	Very Unimportant
How important do you believe <u>accessibility</u> of NRHA services and programs is to residents?	5	4	3	2	1
How important do you believe <u>friendliness</u> of NRHA staff is to residents?	5	4	3	2	1
How important do you believe the <u>quality</u> of NRHA services and programs is to residents?	5	4	3	2	1
How important do you believe the <u>delivery method</u> of NRHA services and programs is to residents?	5	4	3	2	1
How important do you believe <u>timeliness</u> 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?

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

Which sector best describes your organization?	Health / Wellness	<input type="checkbox"/>	Service / No profits	<input type="checkbox"/>
	Education	<input type="checkbox"/>	Business / Industry	<input type="checkbox"/>
	Government Services	<input type="checkbox"/>	Community / Economic	<input type="checkbox"/>
	Justice / Protection	<input type="checkbox"/>	Development	<input type="checkbox"/>
	Recreation	<input type="checkbox"/>	Volunteer / Service Club	<input type="checkbox"/>
	Ministerial / Church Groups	<input type="checkbox"/>	Other	<input type="checkbox"/>
How many people are employed by the organization?	None	<input type="checkbox"/>	26 - 50 people	<input type="checkbox"/>
	Less than 5 people	<input type="checkbox"/>	51 - 100 people	<input type="checkbox"/>
	6 - 10 people	<input type="checkbox"/>	101 or more people	<input type="checkbox"/>
	11 - 25 people	<input type="checkbox"/>		
Which is your home community?	Cormorant	<input type="checkbox"/>	Cranberry Portage	<input type="checkbox"/>
	Easterville	<input type="checkbox"/>	Chemawawin CN	<input type="checkbox"/>
	Grand Rapids	<input type="checkbox"/>	Misipawistik CN	<input type="checkbox"/>
	Flin Flon	<input type="checkbox"/>	Snow Lake	<input type="checkbox"/>
	Moose Lake	<input type="checkbox"/>	Mosakahiken CN	<input type="checkbox"/>
	Pukatawagan	<input type="checkbox"/>	Mathias Colomb CN	<input type="checkbox"/>
	Sherridon	<input type="checkbox"/>	R.M. of Kelsey	<input type="checkbox"/>
	The Pas	<input type="checkbox"/>	Opaskwayak CN	<input type="checkbox"/>
	Wanless	<input type="checkbox"/>	Other	<input type="checkbox"/>
	Creighton	<input type="checkbox"/>	Denare Beach	<input type="checkbox"/>
	Which best describes your role in the organization?	Administration	<input type="checkbox"/>	Direct Service Provider
Management		<input type="checkbox"/>	Volunteer	<input type="checkbox"/>
What are your years of service in the organization?	Less than 1 year	<input type="checkbox"/>	11 - 20 years	<input type="checkbox"/>
	1 - 3 years	<input type="checkbox"/>	21- 25 years	<input type="checkbox"/>
	4 - 10 years	<input type="checkbox"/>	26 or more years	<input type="checkbox"/>

Thank you for completing this staff survey.

NOR-MAN Regional Health Authority

Organizational Overview

2009 - 2010

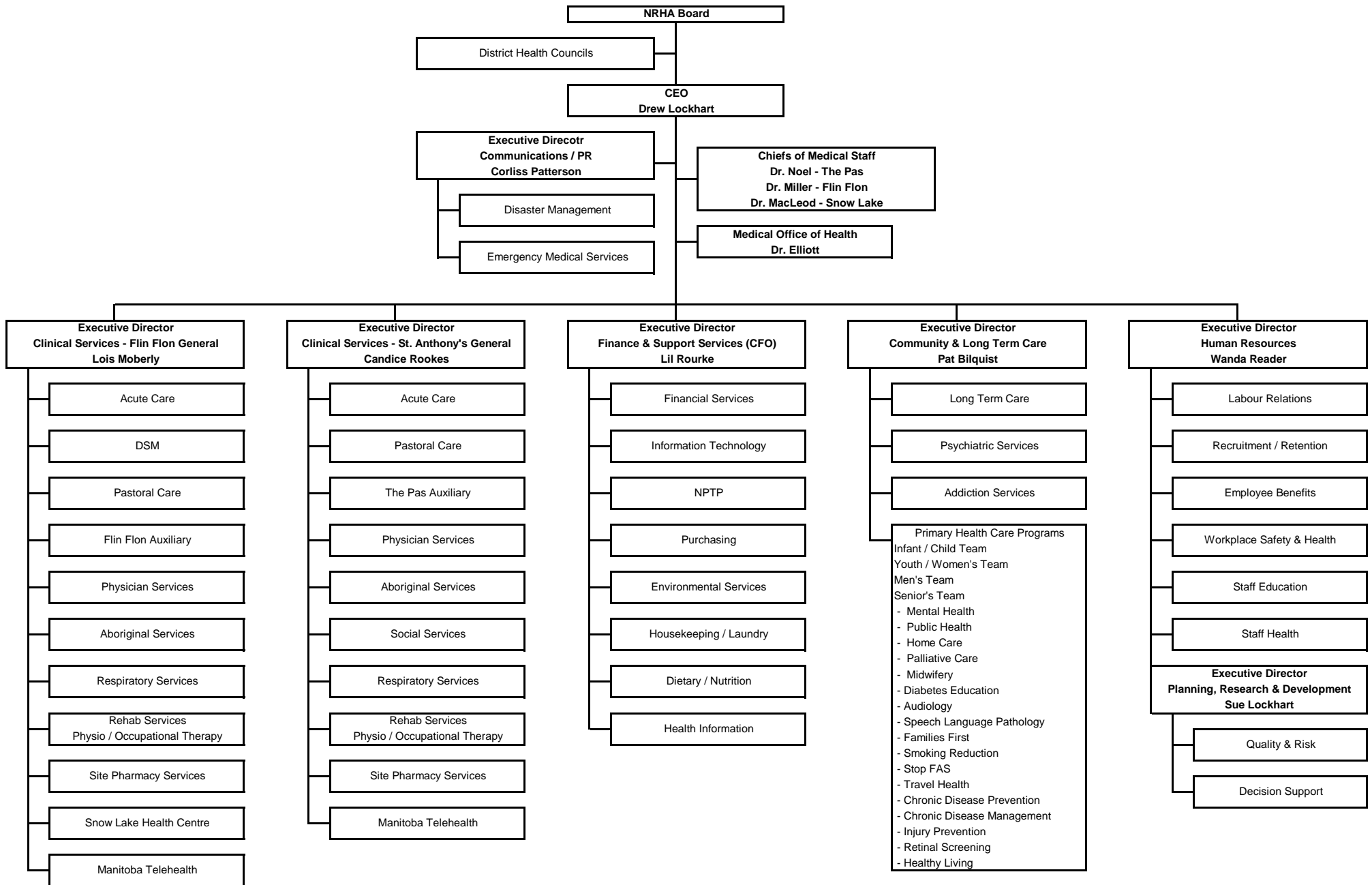
Board of Directors

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)

**NOR-MAN REGIONAL HEALTH AUTHORITY
Organizational Chart**





NOR-MAN Regional Health Authority Service Overview

The NOR-MAN Regional Health Authority was established April 1, 1997 under the provisions of The Regional Health Authorities and Consequential Amendments (Bill 49). This Act sets out the conditions under which Regional Health Authorities (RHAs) are incorporated, as well as defining the duties and responsibilities of RHAs and the Minister of Health. Both parties are responsible for policy, assessment of health status and ensuring effective health planning and delivery.

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

Flon 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:

	Flin Flon General Hospital	St. Anthony's General Hospital	Snow Lake Health Centre
Aboriginal Liaison/Interpretative Services	✓	✓	
Chemotherapy	✓	✓	
Diagnostic Imaging - Radiology - Fluoroscopic Services - Ultrasound - CT	Itinerant ✓ ✓	✓ ✓ ✓ ✓	✓
Dialysis	4 stations	8 of 10 stations (operational)	
Emergency Services	✓	✓	✓
Infection Control	✓	✓	Itinerant
Dietitian Services	✓	✓	Itinerant
Palliative Care Services	✓	✓	✓
Medicine	✓	✓	✓
Obstetrics	✓	✓	
Laboratory Services - Transfusion Medicine - Hematology including Coagulation - Chemistry including Urinalysis - Microbiology - ECG - Stress and Event recording - Holter Monitoring	✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓
Operating Room/Surgery - emergent surgery - elective surgery - day surgery	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	
Pharmacy Services	✓	✓	Itinerant
Psychiatric Unit		✓	
Special Care Unit	✓	✓	
Occupational Therapy	✓	Vacant	
Physiotherapy - Acupuncture – Pain Modality	✓	✓ ✓	
Respiratory Care	✓	✓	✓
Social Work		✓	

	Flin Flon General Hospital	St. Anthony's General Hospital	Snow Lake Health Centre
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

	NRHA Owned Ambulance Service	First Nation Owned Ambulance Service	Community Owned Ambulance Service
Flin Flon	Station		
Creighton	Serviced by Flin Flon		
Denare Beach	Serviced by Flin Flon		
Snow Lake	Station		
Cranberry Portage	Station		
Sherridon	Serviced by Cranberry Portage		
The Pas	Station		

	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:

	Flin Flon General Hospital	St. Anthony's General Hospital	Snow Lake Health Centre
Family Practice	✓	✓	✓
Emergency Medicine	✓	✓	✓
Obstetrics	✓	✓	
General Surgery	✓	✓	
Anesthesia	✓	Itinerant	
Internal Medicine	Regional	✓	
Psychiatry	Regional	✓	Regional
Psychogeriatrics	Itinerant	Itinerant	Itinerant
Adult & Adolescent Psychiatry	Itinerant	Itinerant	Itinerant
Pediatrics	Itinerant	Itinerant	Itinerant
Pediatric Dental	Itinerant	Itinerant	

	Flin Flon General Hospital	St. Anthony's General Hospital	Snow Lake Health Centre
Radiology	Regional	✓	Regional
Endoscopy	Itinerant		
Physical Med & Rehab		Itinerant	Itinerant
Orthotics		Itinerant	
Ophthalmology		Itinerant	
Dermatology	Telehealth	Telehealth	Telehealth
Medical Officer of Health	✓	✓	✓

NRHA Physicians

Physician Name	Flin Flon	The Pas	Snow Lake	Specialists
Dr. Noel		✓		
Dr. Pinder		✓		
Dr. Brennan		✓		
Dr. Nahvi		✓		
Dr. Rhoma		✓		
Dr. DoulatyariAzar		✓		
Dr. Malik		✓		
Dr. Al-Shibani		✓		
Dr. Nguyen		✓		
Dr. Oliaei		✓		
Dr. Menzies		✓		
Dr. Sethi	✓			
Dr. Kucparic	✓			
Dr. Groenewald	✓			
Dr. Mahdi	✓			
Dr. Shnishah	✓			
Dr. Shibany	✓			
Dr. Thwala	✓			
Dr. Elyas	✓			
Dr. Kinsley	Itinerant			Surgery
Dr. Fahim	✓			
Dr. Ahweng	Itinerant	Itinerant		Surgery
Dr. Anozie	Itinerant			Surgery
Dr. Debnath	Itinerant			OBS

Physician Name	Flin Flon	The Pas	Snow Lake	Specialists
Dr. Karimu	Itinerant	Itinerant		OBS/GYN
Dr. Mathew	Itinerant			Endoscopy
Dr. Singh	Itinerant	Itinerant		OBS / Surgery
Dr. Relling	Itinerant			OBS
Dr. Turner	Itinerant			Anesthesia
ROTA		✓		ER
ROTA		✓		Anesthesia
Dr. MacLeod			✓	
Dr. Skelly			✓	
Dr. Kostyk				Internal Medicine
Dr. Medd	Itinerant	✓		Psychiatrist
Dr. Rhyno	✓	Itinerant		Psychologist
Dr. Mabin		✓		Radiologist
Dr. Elliott	Itinerant	Itinerant		M.O.H
Dr. Keddy-Grant	Itinerant	Itinerant	Itinerant	Dermatologist
Dr. Landers	Itinerant			Psychiatrist Community Mental Health – Adults -
Dr. Chochinov	Consultation	Consultation		Psychiatrist Community Mental Health – Adults
Dr. Skinner	Itinerant	Itinerant		Psychiatrist Community Mental Health – Child & Adolescent
Dr. Campbell	Consultation	Consultation		Psychiatrist Community Mental Health –Seniors

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
- Youth/Women’s
- Men’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)

	Flin Flon	The Pas	Snow Lake	Cranberry Portage	Sherridon/ Cold Lake	Cormorant
24-hour Home Care	✓	✓	✓			
Adult Day Program – SPORT/Fun Seekers	✓	✓				
Assessment/Care Planning & Coordination of Services	✓	✓	✓	✓	✓	✓
Audiology Screening	✓	✓	✓	✓	✓	✓
Birthday Club	✓	✓				
Birth Control Options	✓	✓	✓	✓	✓	✓
Block Care Program	✓	✓				
Blood Pressure Monitoring	✓	✓	✓	✓	✓	✓
Blood Sugar Testing	✓	✓	✓	✓	✓	✓
Cervical Screening (PAP Tests)	✓	✓	✓	✓	✓	✓
Child Development Screenings	✓	✓	✓	✓	✓	✓
Child Health Clinics	✓	✓	✓	✓	✓	✓
Chronic Disease Management Programs	✓	✓	✓			
- Heart to Heart	✓	✓				
- Ticker Challenge	✓	✓				
- Get Better Together	✓	✓	✓			
Chronic Disease Prevention	✓	✓	✓	✓	✓	✓
Chronic Disease Prevention Initiative	✓	✓	✓	✓		✓
Clinical Breast Exam	✓	✓	✓	✓	✓	✓
Communicable Disease Follow-up	✓	✓	✓	✓	✓	✓
Companion Care	✓	✓	✓	✓		
Congregate Meal Program	✓	✓				
Co-Occurring Disorders Initiative (CODI)	✓	✓	✓	✓	✓	✓
Diabetes Education	✓	✓	✓	✓	✓	✓
Diabetes Complication Assessments	✓	✓	✓	✓	✓	✓
Diabetes Risk Factor Assessment	✓	✓	✓	✓	✓	✓

	Flin Flon	The Pas	Snow Lake	Cranberry Portage	Sherridon/ Cold Lake	Cormorant
Dietitian Counseling - Community - Diabetes/Chronic Disease	✓ ✓	✓ ✓	✓ ✓	✓ ✓		✓ ✓
Emergency Contraception (Morning after pill)	✓	✓	◆	✓		✓
Exercise Program – Movement that Matters	✓	✓				
Family First Home Visitors	✓	✓	✓	✓	✓	✓
Family Life Education	✓	✓	✓	✓	✓	✓
FAS Mentor Program	✓	✓				
FASD Assessments/Services and Counseling		✓				
Harm Reduction Strategy (in development)	✓	✓	✓	✓	✓	✓
Health Education Programs	✓	✓	✓	✓	✓	✓
Health Promotion Programs	✓	✓	✓	✓	✓	✓
Healthy Aging Clinics	✓	✓	✓			
Heart Health Programs	✓	✓				
Hepatitis C Counseling	✓	✓	✓	✓	✓	✓
Hepatitis C Education	✓	✓	✓	✓	✓	✓
Hepatitis C Testing	✓	✓	◆	✓		
HIV Counseling	✓	✓	✓	✓	✓	✓
HIV Education	✓	✓	✓	✓	✓	✓
HIV Testing	✓	✓	◆	✓		
Home O ₂ Program	✓	✓	✓	✓	✓	✓
Home Care Appeal	✓	✓	✓	✓	✓	✓
Home Care – Nursing	✓	✓	✓	✓	✓	✓
Home Care Services	✓	✓	✓	✓	✓	✓
Home Care Supplies and Equipment	✓	✓	✓	✓	✓	✓
Home IV Program	✓	✓				
Home Nutrition Program	✓	✓	✓	✓	✓	✓
Home Phlebotomy	✓	✓				
Home Support	✓	✓	✓	✓	✓	✓
Immunization Programs – Institutes and Facilities	✓	✓	✓	✓	✓	✓

	Flin Flon	The Pas	Snow Lake	Cranberry Portage	Sherridon/ Cold Lake	Cormorant
Immunization Programs - Schools	✓	✓	✓	✓	✓	✓
Influenza Vaccine Clinics	✓	✓	✓	✓	✓	✓
Injury Prevention Education	✓	✓	✓	✓	✓	✓
Integrated Supported Housing		✓				
Menopause Counseling	✓	✓	✓	✓	✓	✓
Menopause Education	✓	✓	✓	✓	✓	✓
Mental Health – Assessment Services	✓	✓	✓	✓	✓	✓
Mental Health – Housing Support	✓	✓	✓	✓	✓	✓
Mental Health Health Promotions	✓	✓	✓	✓	✓	✓
Mental Health – Promotion / Psychoeducation Services	✓	✓	✓	✓	✓	✓
Mental Health – Referral Service	✓	✓	✓	✓	✓	✓
Mental Health – Therapy / Counseling / Support Services	✓	✓	✓	✓	✓	✓
Midwifery Services		✓				
Mobile Mammography Program	✓	✓	✓			
Nutrition Information / Education	✓	✓	✓	✓	✓	✓
Ostomy Program	✓	✓	✓	✓	✓	✓
Palliative Care Services	✓	✓	✓	✓	✓	✓
Parenting Education	✓	✓	✓	✓	✓	✓
Pediatric Speech Language	✓	✓		✓		
Personal Care Assistance	✓	✓	✓	✓	✓	✓
Personal Care Home Placement	✓	✓	✓	✓	✓	✓
Postpartum Visits	✓	✓	✓	✓	✓	✓
Pregnancy Option Counseling	✓	✓	✓	✓	✓	
Pregnancy Testing	✓	✓	◆	✓	✓	✓
Prenatal Classes	✓	✓	✓	✓	✓	✓
Preschool Clinics	✓	✓	✓			
Psychogeriatrics Services	✓	✓	✓	✓	✓	✓
Reproductive Health Education	✓	✓	✓	✓	✓	✓
Respite Care	✓	✓	✓	✓	✓	✓
Retinal Screening Vision Program	✓	✓	✓	✓	✓	✓
School Health Programs	✓	✓	✓	✓	✓	✓
Self/Family Managed Care	✓	✓	✓	✓	✓	✓
Smoking Cessation Programs	✓	✓	✓	✓	✓	✓

	Flin Flon	The Pas	Snow Lake	Cranberry Portage	Sherridon/ Cold Lake	Cormorant
Social Outings for Seniors (SOS)	✓	✓				
STD Education	✓	✓	✓	✓	✓	✓
STD Counseling	✓	✓	✓	✓	✓	✓
STD Testing	✓	✓	◆	✓		✓
STD Tracing	✓	✓	✓	✓	✓	✓
Suicide Prevention Initiative	✓	✓	✓	✓	✓	✓
Support to Seniors in Group Living (SSGL)	✓	✓				
Support Services to Seniors	✓	✓	✓	✓	✓	✓
Support Services to Senior Centres	✓	✓	✓	✓	✓	✓
Supportive Housing	✓	✓	✓	✓	✓	✓
Travel Health Program	✓	✓	✓	✓	✓	✓
Tobacco Reduction Programs	✓	✓	✓	✓		
Tobacco Prevention Programs	✓	✓	✓	✓	✓	✓
Walking Buddies	✓	✓	✓	✓	✓	✓
Well Baby Clinics	✓	✓	✓	✓	✓	✓
Well Teen Clinics	✓	✓	✓	✓	✓	✓
Well Women Clinics	✓	✓	✓	✓	✓	✓
Youth Health Services	✓	✓	✓	✓	✓	✓
Patient Safety						
- Patient Safety Education and Awareness Programs	✓	✓	✓	✓	✓	✓
- CI / CO Investigations	✓	✓	✓	✓	✓	✓
- Occurrence Reporting	✓	✓	✓	✓	✓	✓
- Med Reconciliation	✓	✓	✓	✓	✓	✓

Primary Health Care Services available on an itinerant basis in nursing station communities not operated by the NRHA:

	Grand Rapids / Misipawistik Cree Nation	Easterville / Chemawawin Cree Nation	Moose Lake / Mosakahiken Cree Nation	Opaskwayak Cree Nation	Pukatawagan / Mathias Colomb Cree Nation
Chronic Disease Prevention Initiatives	✓		✓	✓	
Diabetes Education Resource	✓	✓	✓		
District Health Councils	✓	✓	✓		
Health Education	✓	✓	✓	✓	
Health Promotion	✓	✓	✓	✓	
Heart to Heart				✓	
Home Care Services	✓	✓	✓		
Mental Health – Assessment Services	✓	✓	✓		
Mental Health – Housing Support	✓	✓	✓		
Mental Health – Promotion / Psychoeducation Services	✓	✓	✓		
Mental Health – Referral Service	✓	✓	✓		
Mental Health – Therapy / Counseling / Support Services	✓	✓	✓		
Mental Health	✓	✓	✓		
Midwifery			✓		
Mobile Breast Screening Services	✓				✓
Palliative Care	✓	✓	✓		
Retinal Screening Vision Program	✓	✓	✓	✓	✓
STD Case/Contact Tracing Support	✓	✓	✓	✓	✓
Tobacco Prevention	✓	✓	✓	✓	
Tobacco Reduction Programs	✓	✓	✓	✓	

NRHA Long Term Care Services

	Northern Lights Manor	Flin Flon PCH	St. Paul's Residence
Adult Day Care Program	✓		✓
Respite Care Bed	✓		✓
Resident/Family Advisory Council	✓	✓	✓

	Northern Lights Manor	Flin Flon PCH	St. Paul's Residence
Recreation Program	✓	✓	✓
Spiritual Care	✓	✓	✓
Hairdressing	✓	✓	✓
Nursing Service	✓	✓	✓
Meals Services	✓	✓	✓
Armchair Travel	✓	✓	
Supper Club			✓
Special Event Meals	✓	✓	✓
Pub Nights	✓	✓	
Adopt a Grandparent Program	✓	✓	✓
Pet Therapy	✓	✓	✓
Community Bathing Program	✓		✓
Movement That Matters	✓	✓	✓
Birthday of the Month	✓	✓	✓
Volunteer Meal Prep	✓	✓	
Special Events Programming	✓	✓	✓
Patient Safety			
- Patient Safety Education and Awareness Programs	✓	✓	✓
- CI / CO Investigations	✓	✓	✓
- Occurrence Reporting	✓	✓	✓
- Med Reconciliation	✓	✓	✓

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 . 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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Catherine Hynes, Regional Manager Decision Support
NOR-MAN Regional Health Authority

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Fax: 204-687-6405

E-mail: chynes@normanrha.mb.ca

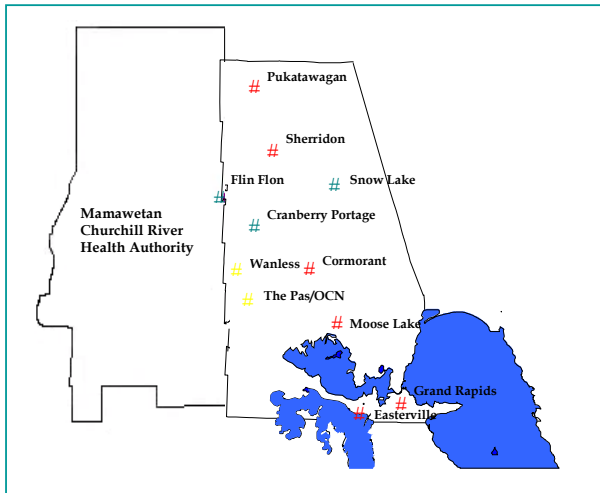
Website: www.norman-rha.mb.ca



QUALITY SCORECARD

VITAL STATISTICS - CLIENT/COMMUNITY FOCUS

March 2009



NOR-MAN Populations by Postal Code

Communities	Totals	Males	Females
R.M. of Kelsey	2,508	1,294	1,214
Snow Lake	915	470	445
Flin Flon	6,013	2,980	3,033
The Pas	7,060	3,500	3,560
Grand Rapids	685	338	347
Unorganized Territories	2,468	1,317	1,151
Opaskwayak CN	1,670	785	885
Misipawistik CN	425	222	203
Chemawawin CN	671	355	316
Mosakahiken CN	433	213	220
Mathias Colomb CN	1,242	615	627
NOR-MAN Total	24,090	12,089	12,001

Source: MB Health June 1, 2008

NOR-MAN RHA District by Community

- **District I** is comprised of the communities of Flin Flon, Snow Lake, Cranberry Portage
- **District II** is comprised of the communities of The Pas, Opaskwayak CN and RM of Kelsey
- **District III** is comprised of the communities of Cormorant, Sherridon/Cold Lake, Easterville, Chemawawin CN, Grand Rapids, Misipawistik CN, Moose Lake, Mosakahiken CN, Pukatawagan, Mathias Colomb CN

Mamawetan Churchill River Populations that may access health services in either Flin Flon or The Pas

Communities	Totals	Males	Females
Creighton	1,784	881	903
Denare Beach	840	450	390
Pelican Narrows	2,121	1,058	1,063
Sandy Bay	1,287	679	608
Sturgeon Landing	60	33	27
Flin Flon Saskatchewan	305	169	136
Peter Ballantyne CN	1,925	1,031	894

Source: SK Health June 30, 2008

District Health Councils

Role of District Health Council (DHC)

- District Health Councils were established to:
- Ensure community participation in local health issues
- Provide an opportunity for communication to take place between community members and the RHA
- Provide an opportunity for community input on local needs and priorities
- Be a catalysts to mobilize and support community participation and action on health issues

To become a DHC Member:

Please contact one of the following DHC Liaisons

- Don Gamache @ 623-9684 for **The Pas/OCN**
- Lesa Nordick @ 623-9664 for **Grand Rapids & Easterville**
- Christa McIntyre @ 687-1331 for **Flin Flon & Cranberry Portage**
- Fran Labarre @ 687-1355 for **Snow Lake & Sherridon/Cold Lake**
- Deanna Johnson @ 687-1369 for **Cormorant & Moose Lake**

2008 District Health Council Highlights:

Flin Flon:

- Hosted an Emergency Preparedness Community presentation, sponsored P.A.R.T.Y. program, sponsored the Body, Mind & Soul Women's Conference and purchased ERIK Kits for the community.

Cranberry Portage:

- Sponsored Healthy Snack Program for the Elementary School, assisted with the P.I.N.K. Project, sponsored a baseball league, and purchased equipment to promote active living for seniors.

Snow Lake:

- Sponsored the Winter Whoot Family Social, sponsored the 2008 Meet and Greet event, and sponsored an after school snack program at Family Resource Centre.

Easterville:

- Preliminary planning for a Chronic Disease Fair with the school.

Grand Rapids:

- Assisted with Culture Camp for youth, partnered with MB Hydro's fishing derby and awareness day for the Heart and Stroke Foundation, assisted with a "Family's first night" event on New Years Eve by working at the event and providing prizes for dance contests.

The Pas:

- Sponsored additional ERIK kits for seniors; assisted with the building and distribution of the kits, hosted the Colorectal Cancer Information and Support evening, heard presentations from The Pas Recycling Centre, NOR-MAN Manitoba Health Liaison, Community Dietitian, Chronic Disease Prevention and involved in the "Protect Your Pairs Program in The Pas."

Cormorant

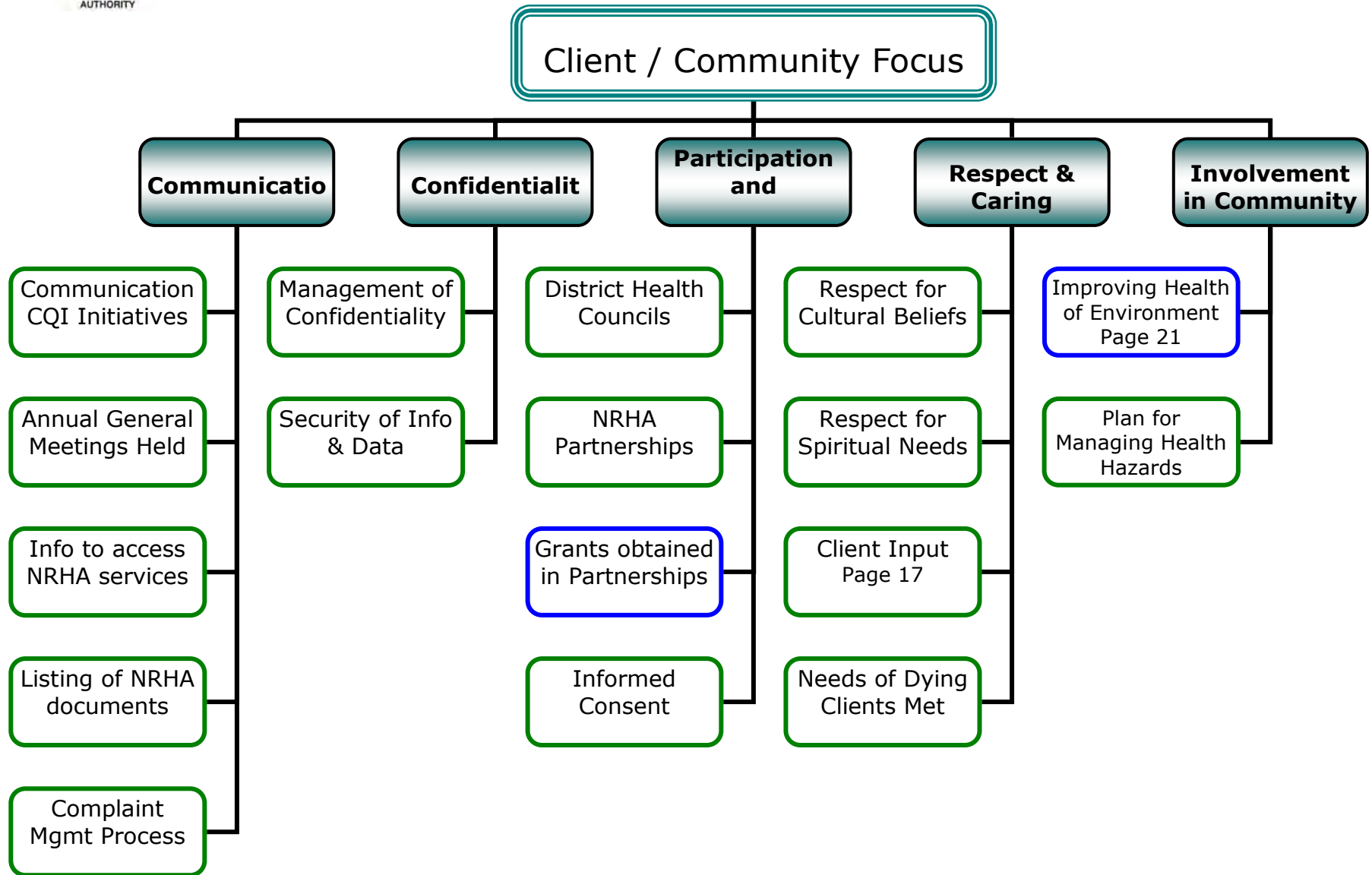
- Sponsored healthy snack during track and field day at Cormorant Lake School, sponsored breakfast for Métis Days and sponsored Protect Your Pairs.

Moose Lake

- Sponsored a community kitchen.



Quality Scorecard: Client / Community Focus March 2009



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



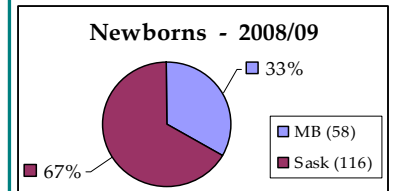
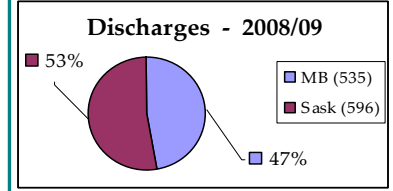
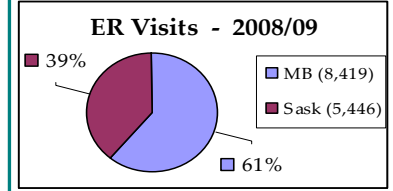
QUALITY SCORECARD VITAL STATISTICS ON RESPONSIVENESS

October 2009

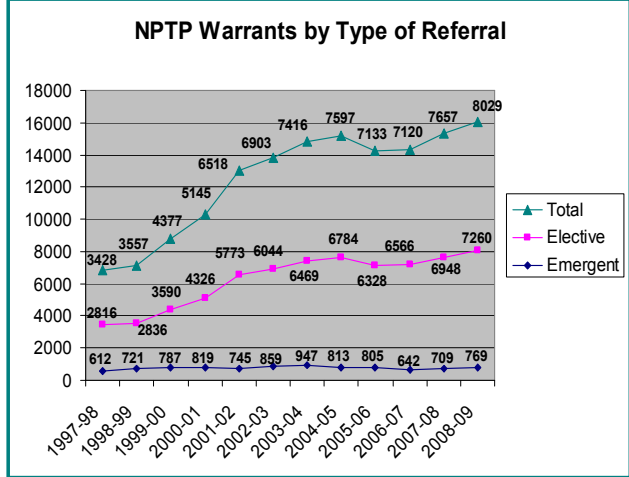
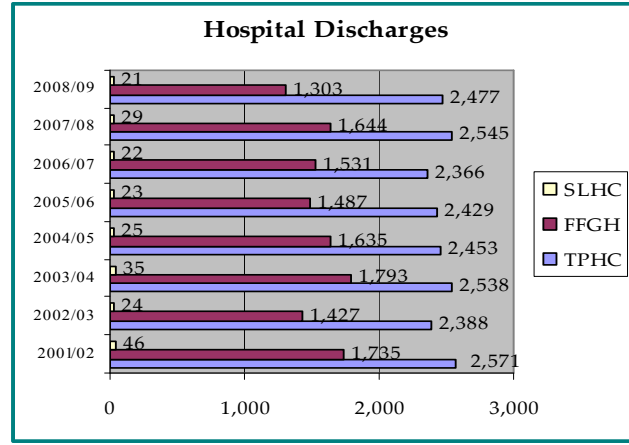
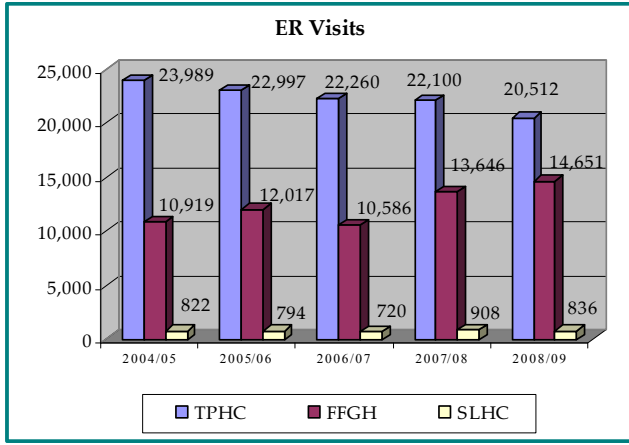
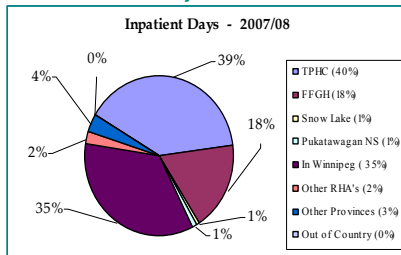
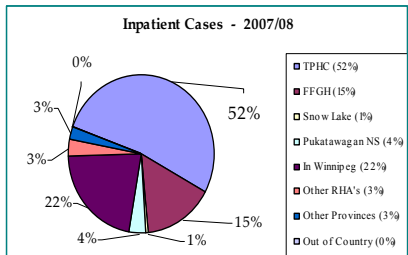
What EMS responded to in 2008?
% EMS Calls by Injury/Illness

	Medica 1	Falls	Violence	Motor Vehicle	Other
Grand Rapids	71%	5%	3%	14%	7%
Cranberry Portage	65%	11%	6%	6%	8%
Flin Flon	69%	14%	5%	5%	7%
The Pas	70%	8%	8%	6%	8%

Saskatchewan Residents



Where NOR-MAN Residents Access Hospital Services?



Newborn Bed Occupancy Rates

Years	FFGH	TPHC
2008/09	15%	23%
2007/08	15%	27%
2006/07	18%	25%
2005/06	18%	24%

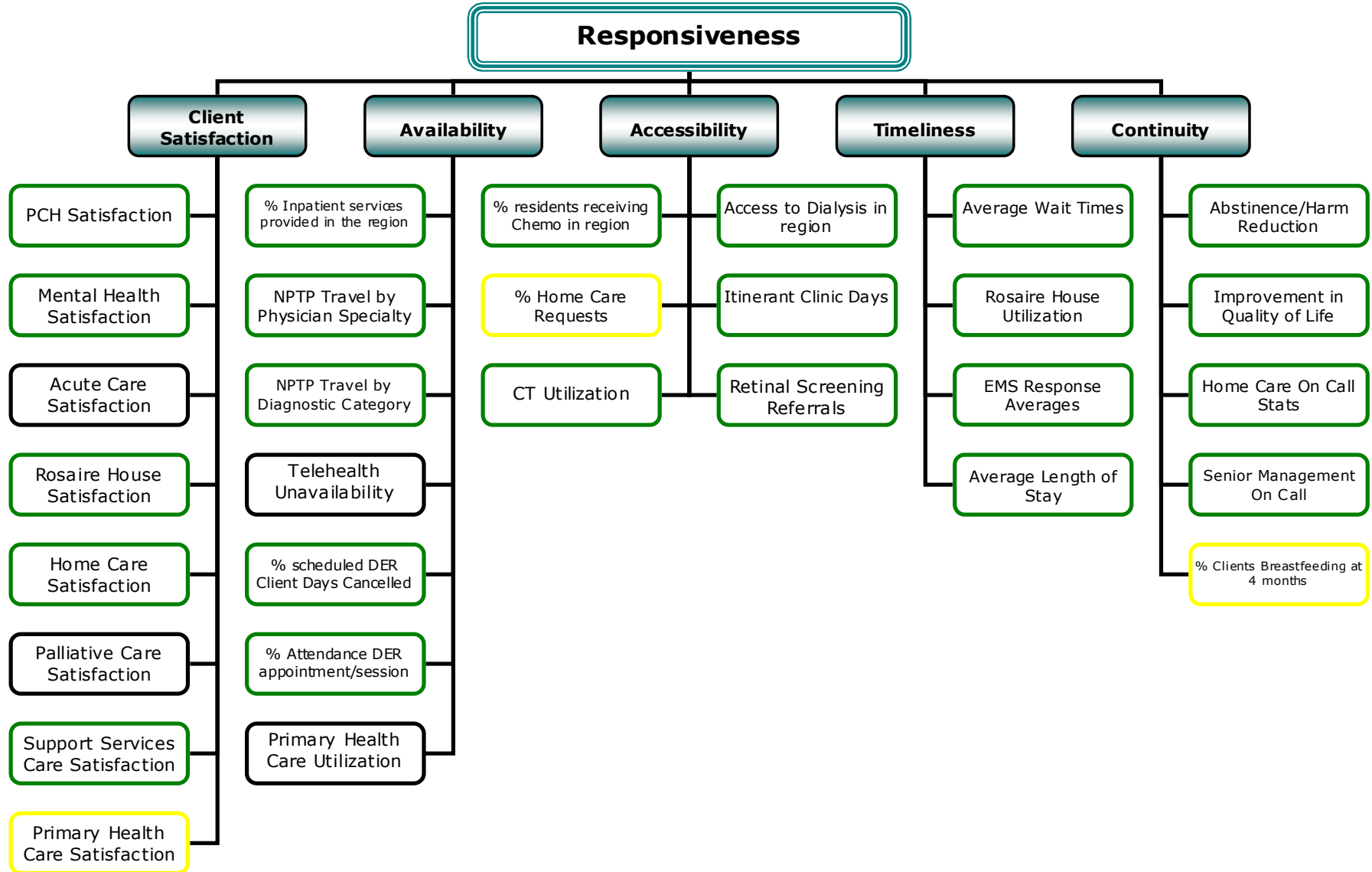
Hospital Bed Occupancy Rates

Years	FFGH	TPHC
2008/09	36%	57%
2007/08	44%	60%
2006/07	39%	57%
2005/06	51%	62%



Quality Scorecard: Responsiveness

October 2009



NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness

Colour Codes: Optimal; Good/ Ongoing CQI; Warning/Room for Improvement; Trouble/ Extensive Work Req'd; In Development



QUALITY SCORECARD

Vital Statistics on System Competency

December 2009

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 Niquanicappo, (OCN)
Gretta Redahl (Flin Flon)
Allan Rivard (La Ronge)
Doris Young (The Pas)

Corporate Office

84 Church Street
 Flin Flon, MB. R8A 1L8
 Phone: (204) 687-1300
 Fax: (204) 687-6405
nrha@normanrha.mb.ca

NOR-MAN RHA MISSION

Healthy People in Healthy Communities
“Working Together to Improve Our Health”

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.

NOR-MAN RHA Senior Management

Drew Lockhart, CEO
Pat Bilquist, Exec. Director, Community & Long Term Care
Susan Lockhart, Exec. Director, Planning, Research & Development
Lois Moberly, Executive Director of Clinical Services, Flin Flon General Hospital
Corliss Patterson, Exec. Director, Communications
Wanda Reader, Exec. Director, Human Resources
Candice Rookes, Executive Director of Clinical Services, St. Anthony’s Hospital
Lil Rourke, Exec. Director, Finance & Support Services

Visit our Website at:
www.norman-rha.mb.ca

Board Ends & Strategic Priorities

The NRHA Board of Directors has set out 4 Board Ends and related Strategic Priorities for the NRHA:

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.

OPTIMAL ACCESS TO SERVICES

- Increased on-site resources in our outlying communities.
- Improved access to service 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

HEALTHY PEOPLE

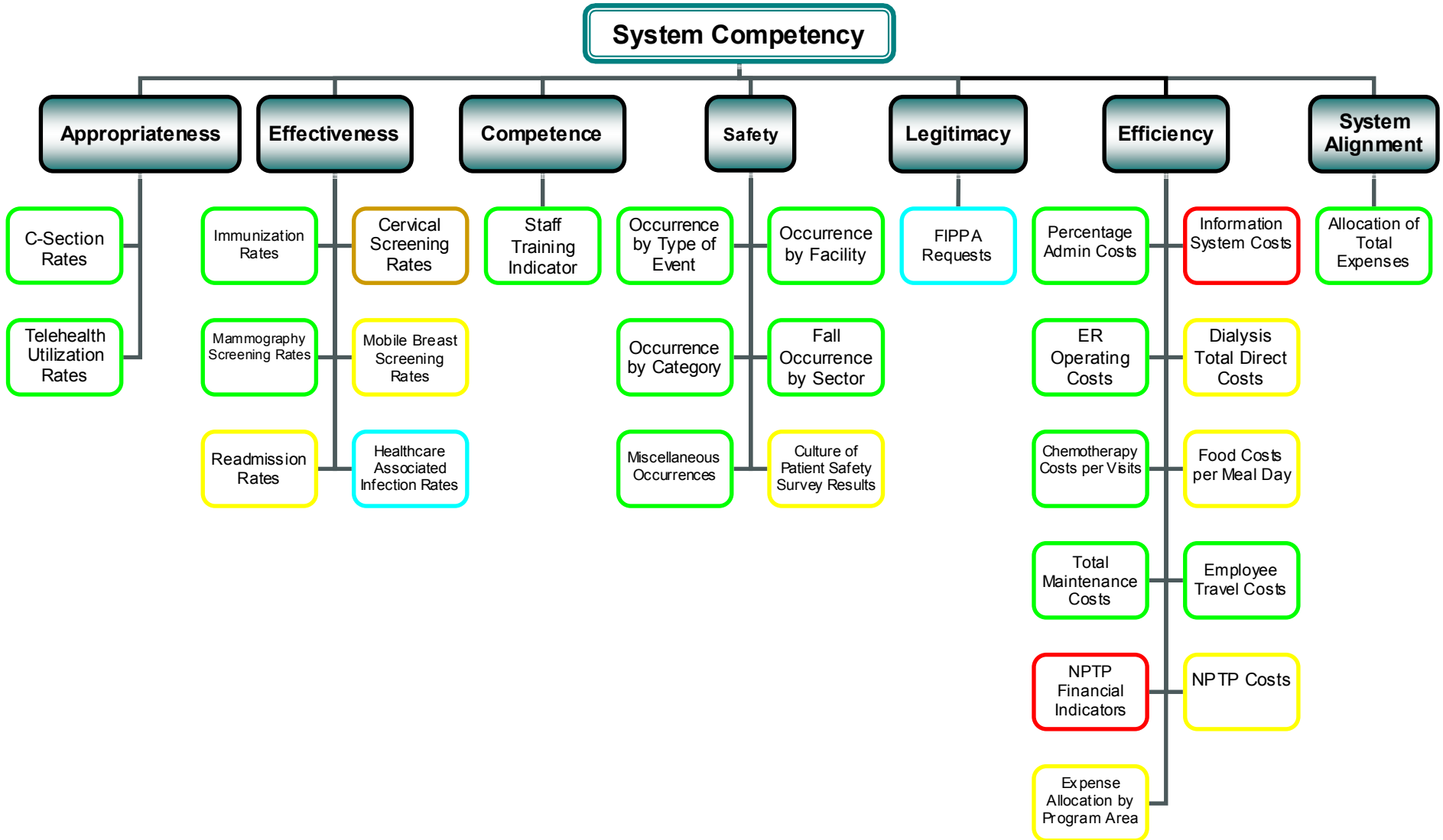
- Decreased incidence & prevalence of chronic illnesses (including but not limited to Diabetes, tobacco-related illness, Cancer, Cardiovascular, Renal).
- Increased awareness of Mental Health and Co-occurring Disorders initiative (CODI) and expansion of services accordingly.
- Reduced incidence of suicides.
- 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.



Quality Scorecard: System Competency December 2009



NOR-MAN Regional Health Authority Quality Scorecard: System Competency

Colour Codes: □ Optimal; □ Good/ Ongoing CQI; □ Warning/Room for Improvement; □ Data Limitations; □ Trouble/ Extensive Work Req'd; In Development

2009/2010 NRHA Community Health Assessment

Appendix F - NRHA Quality Scorecards - System Competency

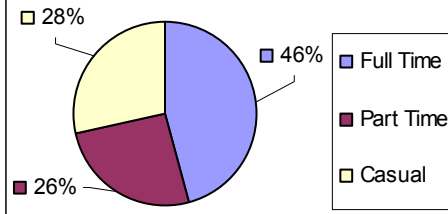


QUALITY SCORECARD

WORK LIFE: VITAL STATISTICS

(April 1, 2008 to March 31, 2009)
FEBRUARY 2010

TOTAL EMPLOYEE COUNT



Total Employee Count 975
 Total Full-Time 446
 Total Part-Time 254
 Total Casual 275

STAFF PROFILE BY GENDER

Male= 11%
 Female= 89%

% UNIONIZED STAFF

MB = NA
 NRHA =

PHYSICIAN PROFILE

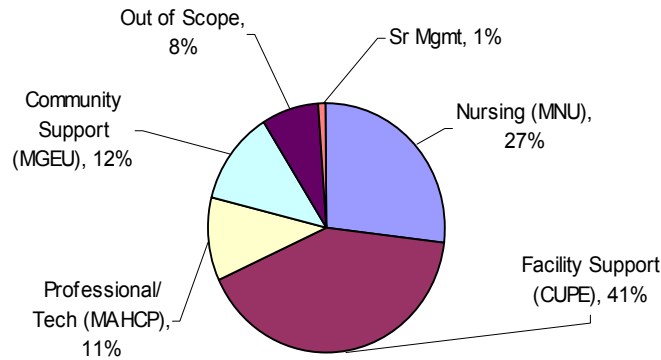
(As of January 2010)

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

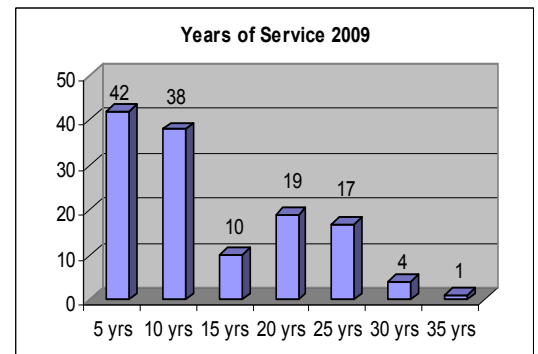
Regional Physicians:

*Internal Medicine -1 *Psychiatry -1
 *Medical Officer of Health - 1

Regional Staffing Profile



EMPLOYEE FACTS



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

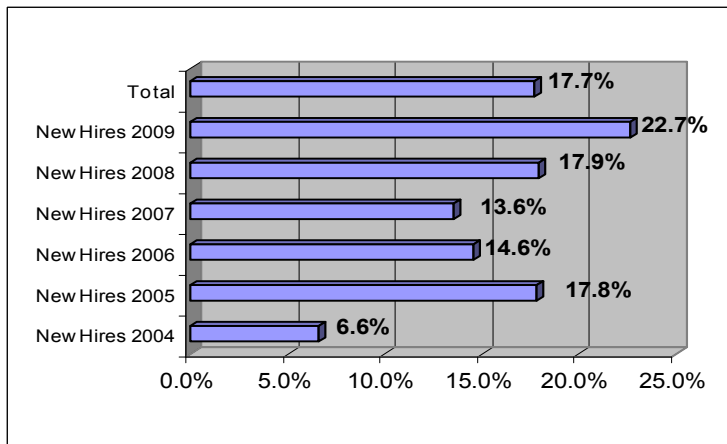
Avg. Vacation/Employee = 4.92 weeks

Regional Retirement Profile

116 potential retirements = 11.8%
 975 eligible employees

Volunteer Hours = 3,288
 (Flin Flon & The Pas)

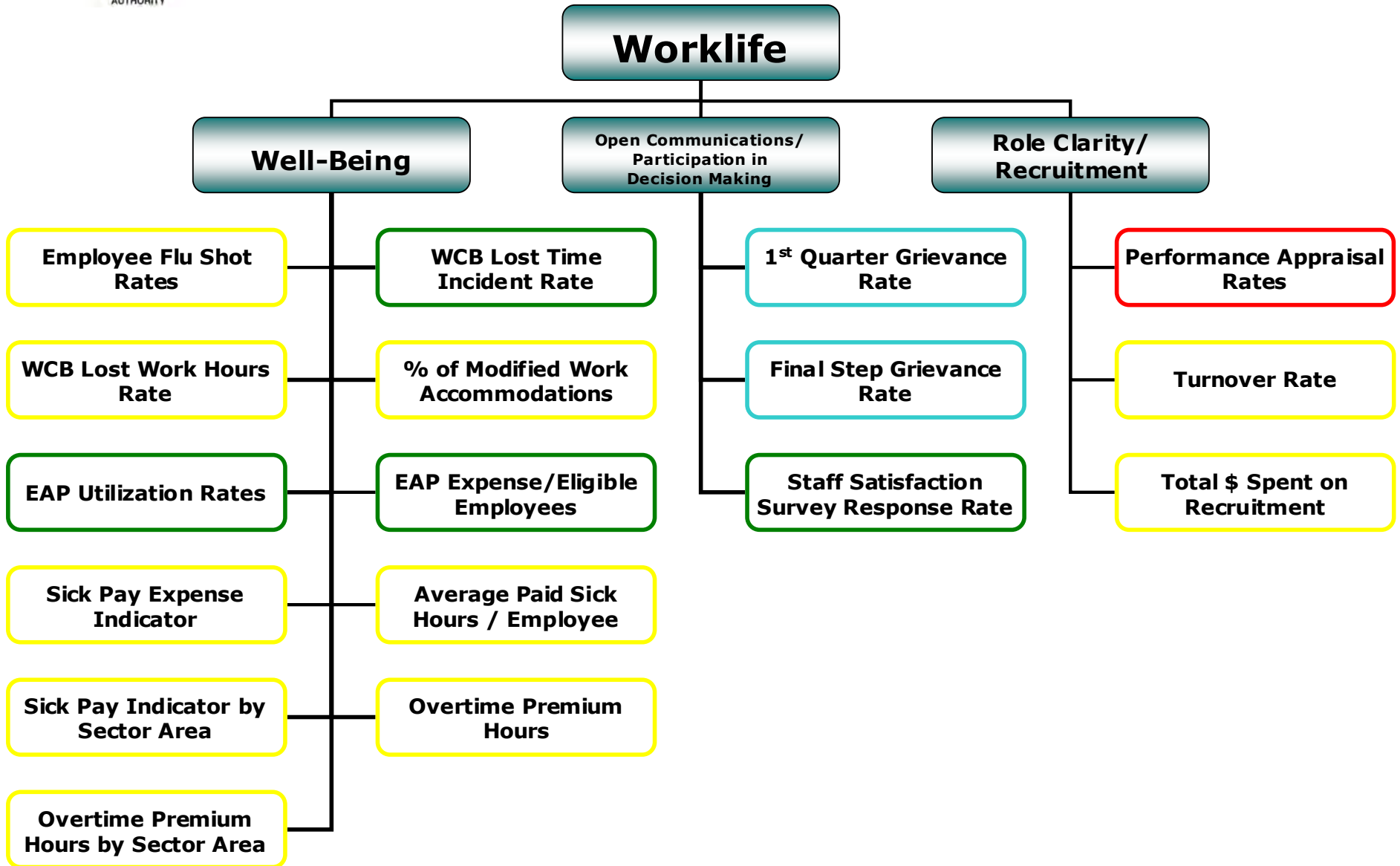
% WORKFORCE SELF-DECLARED ABORIGINAL





Quality Scorecard: Work Life

February 2010



NOR-MAN Regional Health Authority Quality Scorecard: Worklife

Colour Codes: Optimal; Good/ Ongoing CQI; Warning/Room for Improvement; Data Limitations; Trouble/ Extensive Work Req'd; Data Not Available / In Development

Accreditation Canada Required Organization Practices (2008)

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.



NOR-MAN Youth Health Survey

Quick Facts

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 active 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