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## 4.1 PURPOSE

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It is vital that regional health authorities have a fundamental knowledge of their communities.

This technical document: *North Eastman Health Association (NEHA) Inc. Community Health Assessment 2003-2004* provides a comprehensive assessment of the health status of North Eastman (NE) residents during a particular time period. It includes consumer participation as well as other quantitative data providing evidence-based information. This will assist health planners in making decisions about health services in North Eastman.

### **A Community Health Assessment (CHA) can be used for several purposes:**

- To provide baseline information and the ability to compare information over time about the health status of our residents and the clients we serve.
- To direct decisions for regional health plans and program planning to create programs and services specifically designed to improve the community health status and quality of life of residents of NE region.
- To support ongoing partnerships within the community and within NEHA.
- The CHA assists in ensuring that programs are developing optimum health care outcomes to meet the needs of (NE) population.
- Provides evidence-based information in order to justify funding requests.
- To help set priorities and assist in health planning.
- Offers insight into the effectiveness of programs when information is compared over time.

## 4.2 WHAT IS A COMMUNITY HEALTH ASSESSMENT?

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The NEHA CHA project describes a community health assessment as follows:

"...a **dynamic ongoing** process undertaken to:

- identify the strengths and needs of the community,
- enable the community-wide establishment of health priorities, facilitate collaborative action planning directed at improving the community health status and quality of life."<sup>1</sup>

This definition serves to ground the CHA project, ensuring that the project operates within a very distinct and clear mandate.

## 4.3 NEHA RESPONDS TO PREVIOUS CHA IN 1997-98

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"The North Eastman Health Association is a progressive health services organization that is committed to developing and maintaining health services that are responsive to the needs of the residents of the region. Wherever possible, the priority for health service delivery is focused community based care with an emphasis on supporting individual, families and communities to maintain a high level of wellness." <sup>2</sup>

All performance measurement templates used within NEHA align with the Manitoba's Health Performance Measurement framework, the framework the CHA Report has used to report information.

Since the last CHA Report in 1998, NEHA has developed other performance measurements in order to comprehensively and clearly report on our health system's performance in order to assess the progress made towards achieving the Board Ends and Strategic Priorities.

The board ends statements were also developed in response to the 1998 CHA Report: <sup>3</sup>

### 1. Health Status

- a. North Eastman Health Association Inc. provides health care and services those enables all individuals, families and communities to pursue optimum health.
- b. Assistance is available to isolated and socio-economically disadvantaged communities to develop health programs and to improve health status.

### 2. Access to Services

- a. All residents have access to a full spectrum of integrated basic health services available within the region through a seamless single point of entry.
- b. Residents have timely access to services required, but not available in the Region.

### 3. Healthy Lifestyles

- a. North Eastman Health Association Inc., as an integrated health system, provides leadership in the development of healthy communities through health promotion and education and through partnership with other human services providers and community stakeholders.

### 4. Healthy and Productive Staff

- a. North Eastman Health Association Inc., as a health system, is a healthy and productive environment for people to work in.
- b. Trust, confidence, safe and supportive work places, a commitment to excellence, and effective, efficient service delivery characterize this environment.

The region then developed a strategic plan to achieve these ends through a series of regional strategies. These indicators are categorized as strategic indicators and operational indicators.<sup>4</sup>

### **Strategic Indicators**

- Defined as leading as they look at the progress towards fulfillment of Board Ends and Strategic Priorities
- Linked to actions
- Not stagnant and may change as strategies change
- A main component of our performance measurement system and NEHA Scorecard

### **Operational Indicators**

- Generic data that we want to consistently measure and monitor
- They review past performance
- Able to highlight what the organization has accomplished over time

NEHA's organizational measurement indicators and the indicators described in the CHA report create a comprehensive data base that allows evidence based decisions to be made from the organization's leadership and program teams. Continual measurement of the health status of NE residents as well as the organization is now functional.

The following summarizes some of the actions NEHA has completed, or are currently underway to the issues identified previously:<sup>5</sup>

- ◆ Primary Health Care Centres developed in Oakbank, Whitemouth, and Beausejour.
- ◆ Adult Day Program and Services to Seniors program expansion to include a wider geographic area of the region.
- ◆ Emergency Medical Services – increased full-time and part-time positions for staff.
- ◆ Primary Health Care Nurse (Nurse Practitioner) located in Oakbank and Beausejour with outreach clinics held in our northern communities and Whitemouth.
- ◆ Increased PCH beds in region with the addition of a 40 bed PCH in Oakbank.
- ◆ Exploring the development of supportive housing services in Pine Falls, Pinawa and Lac du Bonnet.
- ◆ Focus on community wellness, health promotion and disease prevention has been enhanced with the addition of Wellness Facilitators Practitioners and Dietitians.
- ◆ Public Health program expansion to include: Immunization Coordination, Baby First Program and Travel Health Clinic.
- ◆ Injury prevention strategy is being developed. Strategies have been implemented such as bicycle helmet safety seminars, Child/Infant car seat safety inspections and education.

- ◆ Increase access to northern communities through a Telehealth site in Pine Falls.
- ◆ Mental Health Housing and Proctor Services are being further developed with the hiring of a Housing Coordinator (Nov 2003).
- ◆ Modest increase to Community Mental Health Worker positions to attempt to address increasing demands for these services.
- ◆ Telepsychiatry consultation services were piloted at the Pine Falls site (Dec –March 2004) to increase services primarily to northern and First Nation's communities.
- ◆ Services are being improved for persons with co-occurring mental illness and substance use disorders as part of a provincial strategy.
- ◆ A Regional Intersectoral Committee is currently conducting research to identify gaps in crisis services in North Eastman.
- ◆ A pediatric dental surgery program has been developed and will soon be implemented at Beausejour Hospital (Summer 2004).
- ◆ Palliative Care services has developed further through training of staff and volunteers.
- ◆ Developed and launched a diabetes management website to provide education for the public as well as other health care providers.
- ◆ Recently appointed Primary Health Care Manager to work with the Wellness Facilitators to further health promotion throughout the Region.
- ◆ Development of the Northern Health Planning Team, a forum for dialogue and health services planning with residents and other service providers in northern road accessible communities.
- ◆ Participation by the Regional Diabetes Team in a Telehealth research project with Berens River, one of five federally funded research projects across Canada.
- ◆ Development of the Regional Diabetes Program. The prevalence of diabetes is very high in the region, especially among persons of aboriginal heritage. The program includes development of a range of strategies including prevention, screening and treatment.
- ◆ Formation of the Regional Early Child Development Committee for development of parent-child supports through the region.
- ◆ Consultation with experts in care for persons with Alzheimer's Disease and other dementias for the enhancement of resident focused programs for the elderly.
- ◆ Efforts to recruit health care professionals to the region resulted in several medical, nursing and allied health vacancies being filled.

## 4.4 2003 – 2004 CHA PROCESS

Since 2001, two NEHA representatives have been attending the Community Health Assessment Network (CHAN). CHAN is a provincial group, chaired by Manitoba Health staff which directs and coordinate the CHA process in Manitoba.

The current CHA process in NEHA officially began January 2003 when the CHA Research and Project Coordinator was hired. She began attending the CHAN meetings. With the hiring of the CHA coordinator, progress began in the development of teams within NEHA to assist with the project. Judy Coleman, Vice President of Programs and Services was responsible for overseeing the project.

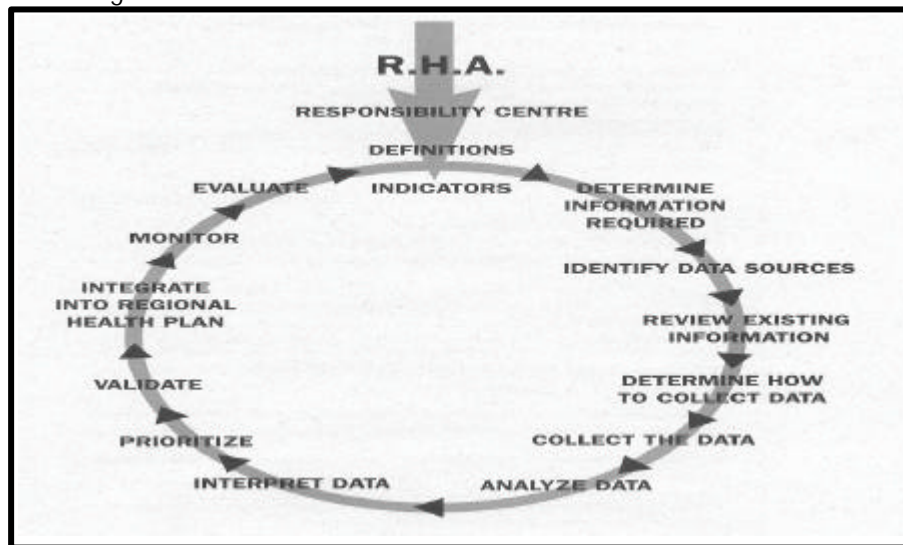
The CHA project assistant was hired in June 2003.

Refer to Appendix 4-1 for a copy of the CHAN Terms of Reference.

The 2003-2004 CHA project followed the Manitoba Health Community Health Needs Assessment Guideline. A schematic drawing of this process is provided below. June 1997, p. 21.

Figure 4.1 CHA Assessment Guideline

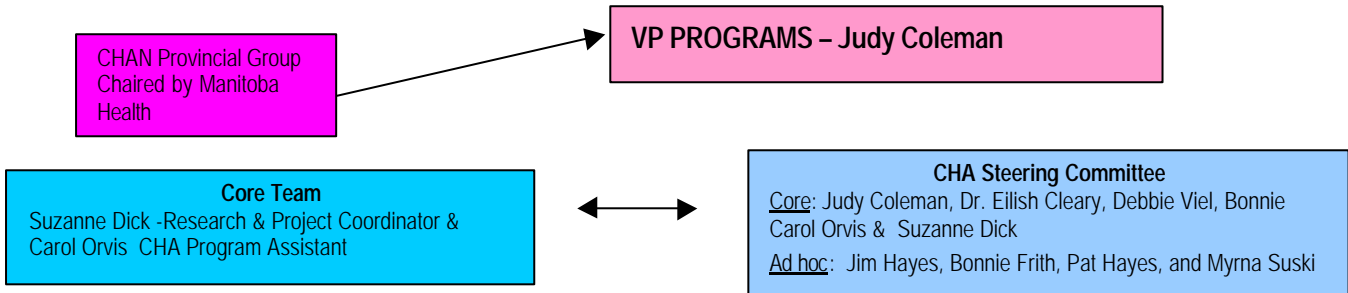
The indicators required in the report were pre-determined by the Working Indicator Group (WIG) a subcommittee of CHAN. There are over one hundred and sixty indicators that were collected specific to North Eastman region.



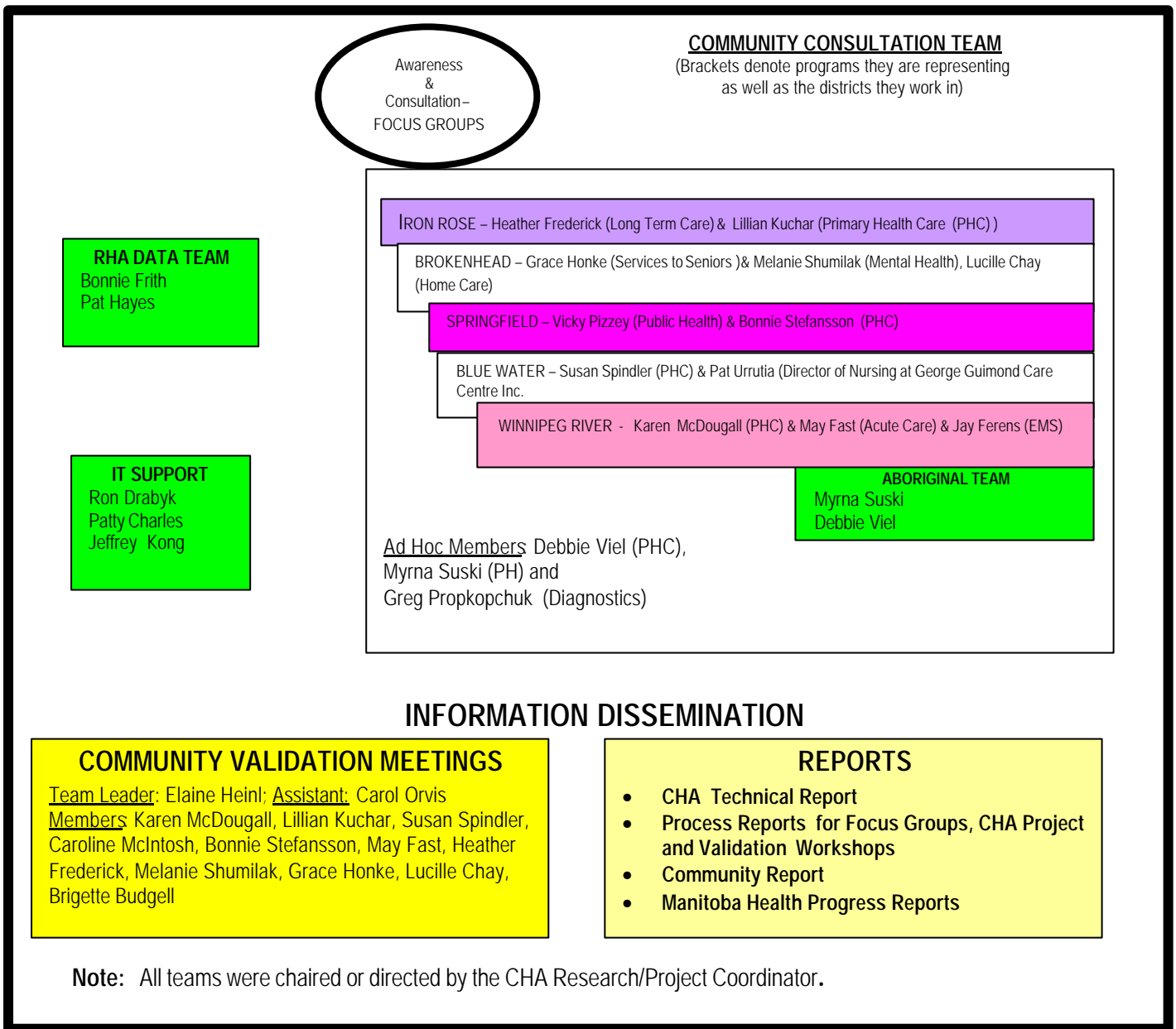
Source: Manitoba Health (1997) Community Health Needs Assessment Guideline.. June. Pg. 21.

The following provides an outline of the 2003-2004 CHA Team Structure

Figure 4.2 2003-2004 CHA STRUCTURE [Revised July 2004]



### DATA COLLECTION TEAMS



## 4.4.1 *Steering Committee*

The Core Steering committee's primary function was to make key decisions to steer the project. Members include the CHA Core Team, VP Programs and Services, Medical Officer of Health and the Manager of Primary Health Care. The initial meeting of the steering committee was held along with the ad hoc members. Discussion included the mobilizing NEHA staff resources, job descriptions, timelines, CHA structure, facilitation of Focus Groups, a review of the CHA indicators with special emphasis on the RHA indicators and budget.

Refer to Appendix 4-2 for a copy of the Steering Committee's Terms of Reference.

## 4.4.2 *Data Collection Teams*

### 4.4.2.1 *Regional Health Authority (RHA) Data Team*

The CHA Core team will help to coordinate the collection of this information. NEHA's program indicators that measure outcomes were one source of collecting RHA specific information. Most NEHA program managers were asked to contribute information. The Quality and Organizational Development Program provided a leadership role for this team.

### 4.4.2.2 *Information Technology (IT) Team*

The IT program within NEHA provided software support throughout the project. They have been a tremendous help ensuring that the information was safe and always came to the rescue when computer glitches arose.

### 4.4.2.3 *Aboriginal Team*

It was felt to be important to continue to have staff that was already familiar with aboriginal communities to be the liaisons for the CHA project within these areas. To this end, the team leaders were the Managers of Primary Health Care and Public Health. Membership also included a First Nation representative.

The team leaders conducted two Focus Groups, one youth and one adult session in Seymourville using the same target ages and questions that were used in all the other health districts.



#### 4.4.2.4 Community Consultation Team

This was a large and very active team consisting of representation from all program areas within NEHA.

It is the ultimate goal of this team to develop a template in which community consultation can continue within their respective programs once the CHA project has been completed. The need for the team to continue to meet as a resource for each other and their program is a question that the team and senior managers will need to answer.

Team members were offered education sessions in order to build consultation capacity within their respective programs. Some education sessions offered were:

##### Internal

- a) October 14- Topic- Focus Groups and Surveys –Presented by Dr. E. Cleary
- b) Gender Workshop- November 18. Presented by: Lissa Donner
- c) Dec 9- Topic- In the Beginning.... there is Consultation. Presented by Suzanne Dick.
- d) March 25 - Provincial Survey review with NEHA Management Team. Presented by Suzanne Dick.
- e) April 16- Validation Workshop Education Session for Validation Facilitators. Presented by Elaine Heintz, Suzanne Dick and Bonnie Frith.

External – Consultation team members were asked to volunteer if they wished to attend.

- a) January 15 – *Manitoba Health Data Analysis and Interpretation Workshop* – Two members of the Steering Committee attended, two members of the Consultation Team attended and the CHA Coordinator attended.
- b) February 10- *CIHI- Applying a Population Health Perspective to Health Planning and Decision Making*. Several NEHA staff members on various CHA Teams including the CHA Coordinator attended.
- c) April 6 - CHAN workshop on *Report Writing*. Two members from the Consultation Team, three members from the Steering Committee and CHA coordinator attended.

Refer to Appendix 4-3 for a copy of the Teams Terms of Reference.

### **4.4.3 Awareness**

It was important that both staff and members of the community knew about the role of the CHA project. Communication was coordinated through the Core Team. Any public documents were reviewed by the VP of Programs and the Director of Quality and Organizational Development.

#### Pamphlet

A CHA pamphlet was developed. The pamphlet was developed and distributed by the Consultation Team and the District Health Advisory Committee (DHAC) members and other staff. The pamphlet was featured on the NEHA web page.

#### Informational Meetings

The DHAC's and the consultation team were asked specifically to talk about the CHA project whenever there was an opportunity.

Project updates to the NEHA Board, specifically the Communications and Community Development Committee of the Board, to the DHAC to NEHA Regional Management, and to the subcommittee of the North Eastman Intersectoral Agency Committee.

A presentation about the project was delivered at the 2003 NEHA Annual General Meeting held in June at Victoria Beach and Whitemouth.

#### Presentations

A power point presentation about the CHA project's purpose and importance to residents and staff was created and circulated to program managers. The intent was that this be shared with their staff and within communities by programs who work in community outreach. For example: Public Health, Primary Health Care and Services to Seniors.

#### Articles

Generic articles were written for insertion in:

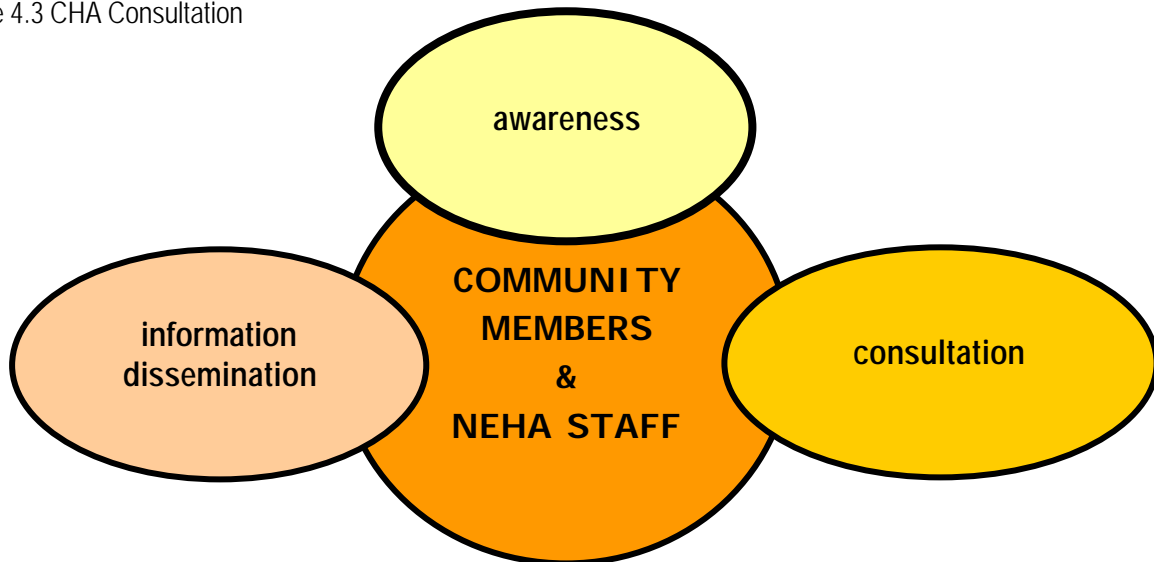
- The NEHA web site "Health Corner"
- The NEHA External Newsletter 'The Pulse'
- The NEHA internal newsletter 'The Breeze.'
- The 'Annual Report 2003' brochure
- Local newspapers

## 4.4 CONSULTATION

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Community consultation increases the community's awareness of health issues, and provides trust in the process that information is not only collected but shown to be utilized to the benefit of the population served.

Figure 4.3 CHA Consultation



The consultation team contributed to the development of ideas and assisted in the implementation of the focus groups and validation workshops.

### Focus Groups

Planning for Focus Groups began in April 2003. Questions were initially developed by the consultation team focusing around:

- questions that they would like answered by the community from their program perspective,
- questions that were outstanding from the previous CHA project,
- any missing information that would lend itself to this type of consultation.

Once the questions were developed, they were reviewed by the Steering Committee. The consultation team was asked to provide any community contacts to begin generating a list of possible participants.

A private researcher, Lesley Anne Fuga, was hired to facilitate the Focus Groups. For consistency, the CHA Program Assistant transcribed the information generated by each of the groups. The facilitator reviewed the information and provided it to the CHA Research and Project Coordinator. This was then formatted, ready to use within the CHA Report. Both the facilitator and the CHA Program Assistant reviewed the report information to ensure that the information reflected the meaning and tone of the Focus Groups.

Please refer to Section 5 for more details about the focus groups.

Validation Workshops – The planning for these workshops began in December 2003. The team leader was Elaine Heintz.

Please refer to Section 5 for more details about the validation workshops.

NEHA staff were continuously consulted and given sections of the report for review as it was developed. Statistical expertise was provided by Dr. Eilish Cleary, our Medical Officer of Health.

There was many staff not listed within the CHA structure who contributed to this process.

Please refer to Acknowledgment Section 2.

## **4.5 CHA FRAMEWORK - Manitoba's Health Performance Measurement Framework**<sup>6</sup>

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The CHA report used Manitoba's Health Performance Measurement Framework to provide a reference that guided the collection and interpretation of the information and identified key elements to be considered when assessing the health needs of our population. Within this framework is the Population Health Model.

### **4.5.1 Overview**

"The purpose of the Manitoba's Health Performance Measurement Framework is to provide a common frame of reference within which expectations<sup>1</sup> and performance measurement indicators/measures will be organized and/or developed. This framework will provide a "common lens" through which health system performance and population health status can be articulated, enabling a systematic assessment of progress toward outcomes, goals and objectives. Another key function will be to facilitate performance reporting. The framework has been designed so that it is congruent with work that is being done regionally, nationally and internationally in this area<sup>2</sup>, permitting health system performance measurement collaboratively with the RHAs.

"Manitoba's Health Performance Measurement Framework" is a conceptual overview of the structure and process of performance measurement that links expectations, performance dimensions (broad categories within which performance measurement takes place), and performance measurement mechanisms to strategic outcomes and priorities.

Manitoba's Health Performance Measurement Dimensions describes the four broad categories across which performance measurement takes place (health status & determinants; health system performance; health system infrastructure; and, community & health system characteristics). Each has associated sub-categories that will assist in the development, collection, or reporting of more detailed information. The dimensions reflect the complexity and broad scope of the health care system and facilitate the development of expectations, such as policy, as well as indicators/measures."<sup>7</sup>

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<sup>1</sup> Desired results as set out in expected outcomes, goals, legislation, policy, standards, targets, benchmarks, and guidelines.

<sup>2</sup> Performance Measurement dimensions are based on the review of the following sources: CIHI's Health Indicators Framework, Australia's Proposed National Performance Framework, Manitoba Health's Report on the Health of Manitobans (in development), Health Canada's Advisory Committee on Population Health, the Canadian Council on Health Services Accreditation AIM Standards, and the Manitoba Regional Health Authorities proposed framework for reporting indicators.

Figure 4.4 Manitoba's Health Performance Measurement Framework

The framework's many categories have used a variety of other concepts or models for example: the World Health Organization's (WHO) International Classification of Functioning and disability (CHIDH-2, Beta 2 Version) and the Health System Performance category currently used by the Canadian Council on Health Services Accreditation (CCHSA).<sup>1</sup>

For the purpose of this report, the order of some of the categories has been adjusted to enhance readability. The basic framework has not been changed.

<b>Template</b>		November 9, 2001	
<b>Manitoba's Health Performance Measurement Dimensions</b>			
<b>Focus: _____</b>			
<b>Health Status and Determinants</b>			
<b>Status</b>			
Deaths	Health Conditions	Human Function	Well-being
<b>Determinants</b>			
Personal Health Practices & Lifestyle	Personal Resources	Living and Working Conditions	Environmental Factors
Healthy Child Development	Biology & Genetic Endowment	Culture	Gender
<b>Health System Performance</b>			
<b>1. Responsiveness</b>			
Availability	Accessibility	Timeliness	Continuity
<b>2. System Competency</b>			
Appropriateness		Competence	Effectiveness
Legitimacy	Efficiency	System Alignment	
<b>3. Client/Community Focus</b>			
Communication	Confidentiality	Participation and Partnership	
Respect and Caring	Organization Responsibility and Involvement in the Community	Acceptability	
<b>4. Work Life</b>			
Open Communication		Role Clarity	Participation in Decision Making
Learning Environment		Well-being	
<small>Note: The following dimensions ("Health System Infrastructure" and "Community &amp; Health System Characteristics") may reflect expectations, indicators or measures, or provide useful contextual information.</small>			
<b>Health System Infrastructure</b>			
Finances	Human Resources	Leadership	Information & Technology
			Physical Structure & Equipment
			Public Health Surveillance
			Research
<b>Community and Health System Characteristics</b>			
Population Demographics	Health Service Utilization (Rates)	Expenditures (Rates)	Other
<b>Note re: Governance and Management.</b>			
This is an important dimension and will be considered for inclusion in the framework pending further discussion with the Council of Chairs of RHAs.			
<small>Manitoba Health/Regional Health Authorities, Manitoba R:\My documents\MB Health Performance Measurement Framework Dimensions (Template).doc</small>			
			1

The following is a table portraying the categories within the framework.

**Note:** The brackets with wording in italics are the population health determinants as described in the Population Health Model.

Figure 4.5 Manitoba's Health Performance Measurement Framework Categories

<b>HEALTH STATUS</b>			
<b>Deaths</b>	<b>Health Conditions</b>	<b>Human Function</b>	<b>Well-Being</b>
"A range of age-specific and condition specific mortality rates, as well as derived indicators e.g. life expectancy and potential years of life lost." <sup>8</sup>	"Alterations or attributes of the health status of an individual which may lead to distress, interference with daily activities, or contact with health services; it may be a disease (acute or chronic), disorder, injury or trauma, or reflect other health related states such as pregnancy, aging, stress, congenital anomaly, or genetic predisposition. (World Health Organization (WHO))." <sup>9</sup>	"Levels of human function are associated with the consequences of diseases, disorder, injury and other health conditions. They include body function/structure (impairment), activities (activity limitations), and participation (restrictions in participation. International Classification of Functioning and Disability (ICIDH-2, Beta 2 Version)." <sup>10</sup>	"Broad measures of the physical, mental and social well-being of individuals." <sup>11</sup>
<b>DETERMINANTS OF HEALTH</b>			
<b>Personal Health Practices &amp; Lifestyle</b> <i>[Personal Health Practices &amp; Coping Skills]</i> <sup>12</sup>	<b>Personal Resources</b> <i>[Social Support Network]</i> <sup>13</sup>	<b>Living &amp; Working Conditions</b> <i>[Income, Income Distribution and Social Status and Employment and Working Conditions]</i> <sup>14</sup>	<b>Environmental Factors</b> <i>[Physical Environment]</i> <sup>15</sup>
"Aspects of personal behaviour and risk factors that epidemiological studies have shown to influence health status." <sup>16</sup>	"Measures the prevalence of factors such as social support and life stress that epidemiological studies have shown to be related to health." <sup>17</sup>	"Indicators related to the socioeconomic characteristics and working conditions of the population, that epidemiological studies have shown to be related to health." <sup>18</sup>	"Physical factors in the natural environment such as air, water and soil quality are key influences on health. Factors in the human – built environment such as housing, workplace safety, community and road design are also important factors." <sup>19</sup>
<b>Healthy Child Development</b>	<b>Biology &amp; Genetic Endowment</b>	<b>Culture</b>	<b>Gender</b>
"The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful." <sup>20</sup>	"The basic biology and organic make-up of the human body are fundamental determinants of health. Inherited predispositions influence the ways individuals are affected by particular diseases or health challenges." <sup>21</sup>	"Culture and ethnicity come from both personal history and wider situational, social, political, geographical and economic factors." <sup>22</sup>	"Gender refers to the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issue." <sup>23</sup>

## HEALTH SYSTEM PERFORMANCE

*[Health Services as a Health Determinant]*

"Health services, especially those designed to maintain and promote health, prevent disease and injury and restore health, contribute to population health."<sup>24</sup>

**RESPONSIVENESS** – The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population (s), and to changes in the environment. Canadian Council on Health Services Accreditation (CCHSA).<sup>25</sup>

Availability	Accessibility	Timeliness	Continuity	Equity
"Services (s) and resources (e.g. financial, human, information, equipment) are available to meet the needs of the client and/or community population(s). " (CCHSA) <sup>26</sup>	"The ability of client / patients to obtain care/ service at the right place and the right time, based on respective needs." (CCHSA) <sup>27</sup>	"Services are provided and/or activities are conducted to meet client and/or community needs at the most beneficial or appropriate time." (CCHSA) <sup>28</sup>	"The ability to provide uninterrupted, coordinated care/service across programs, practitioners, organizations, and levels of care/service, over time."(CCHSA) <sup>29</sup>	"Decisions are made and services are delivered in a fair and just way." (CCHSA) <sup>30</sup>

**SYSTEM COMPETENCY** – The organization consistently provides services (s) in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost0effective use of resources. (CCHSA).<sup>31</sup>

Appropriateness	Competence	Effectiveness	Safety
"Care/service provided is relevant to the clients/ patients' needs and based on established standards." CCHSA) <sup>32</sup>	"An individual's knowledge and skills are appropriate to the care/ service being provided."(CCHSA) <sup>33</sup>	"The care/ service, intervention or action achieves the desired results." (CCHSA) <sup>34</sup>	"Potential risks of an intervention or the environment are avoided or minimized."(CCHSA) <sup>35</sup>

**CLIENT /COMMUNITY FOCUS** – The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities. (CCHSA)<sup>36</sup>

Communication	Confidentiality	Participation and Partnership
"All relevant information is exchanged with the client, family and/or community in a manner that is ongoing, consistent, understandable, and useful." (CCHSA) <sup>37</sup>	"Information to be kept private is safeguarded." (CCHSA) <sup>38</sup>	"The client and/or community actively participate as a partner in decision making, and in service planning, delivery, and evaluation."(CCHSA) <sup>39</sup>
Respect & Caring	Organization Responsibility & Involvement in the Community	Acceptability
"Politeness, consideration, sensitivity, and respect are incorporated into all interactions with the client and/or community. "(CCHSA). <sup>40</sup>	"The organization supports and strengthens the community and its development, and contributes to its overall health."(CCHSA) <sup>41</sup>	"All care/ service provided meets the expectations of the client, community, providers and paying organizations, recognizing that there may be conflicting, competing interests between stakeholders, and that the needs of the clients/ patients' are paramount. " (CCHSA) <sup>42</sup>

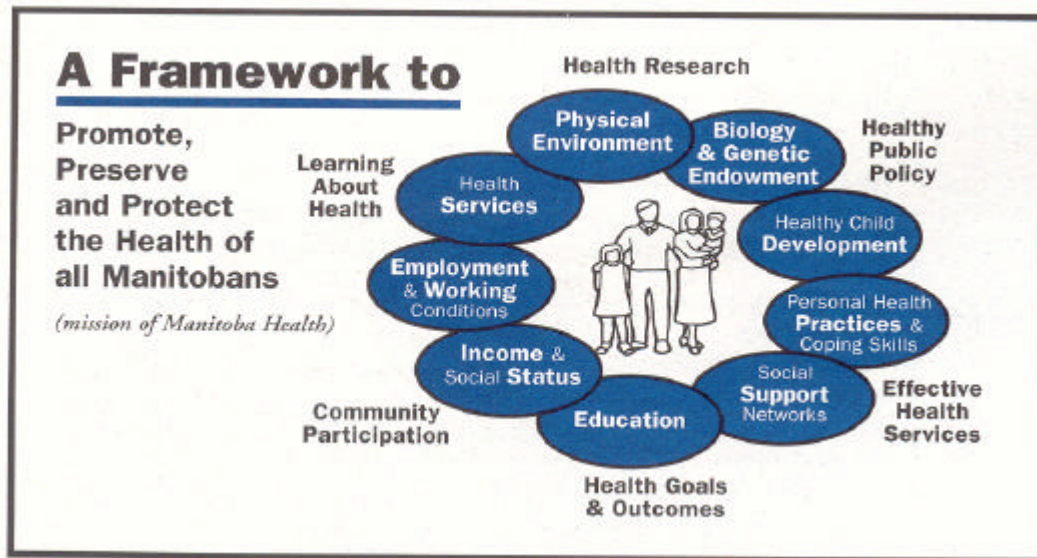
<b>WORKLIFE</b> – The organization provides a work atmosphere conducive to performance excellence, full participation, personal/professional and organizational growth, health, well being, and satisfaction. (CCHSA). <sup>43</sup>		
<b>Open Communication</b>	<b>Role Clarity</b>	<b>Participation in Decision Making</b>
"The organization fosters a climate of openness, free expression of ideas, and information sharing." (CCHSA) <sup>44</sup>	"Staff have a clearly defined job scope and objectives, and these are aligned with team and organization goals." (CCHSA) <sup>45</sup>	"Staff input is encouraged and used in decision making." (CCHSA) <sup>46</sup>
<b>Learning Environment</b>	<b>Well-being</b>	
"Staff creativity, innovation, and initiative is encouraged. The necessary training and development to attain organizational goals and personal/professional development objectives, is provided." (CCHSA). <sup>47</sup>	"The organization provides a safe, healthy, and supportive environment, recognizes staff contribution, and links staff feedback to improvement activities." (CCHSA) <sup>48</sup>	

**Note:** Health system Infrastructure and Community and Health System Characteristics may reflect expectations, indicators or measures or provide useful contextual information.<sup>49</sup>

<b>HEALTH SYSTEM INFRASTRUCTURE</b>						
<b>Finances</b>	<b>Human Resources</b>	<b>Leadership</b>	<b>Information &amp; Technology</b>	<b>Physical Structure &amp; Equipment</b>	<b>Public Health Surveillance</b>	<b>Research</b>
	"Health workforce structure and distribution." <sup>50</sup>	"Formal structure/processes of the organization." <sup>51</sup>			"Mechanisms." <sup>52</sup>	"Research funding and structures." <sup>53</sup>
<b>COMMUNITY &amp; HEALTH SYSTEM CHARACTERISTICS</b>						
<b>Population Demographics</b> <i>[Education as a health determinate]<sup>54</sup></i>	<b>Health Service Utilization</b>	<b>Expenditures</b>	<b>Other</b>			

## 4.6 POPULATION HEALTH MODEL

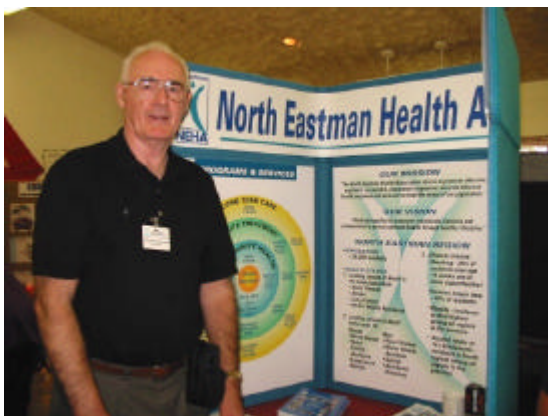
Figure 4.6 Population Health Model Framework



Source: Manitoba Health (1997). A Planning Framework to Promote, Preserve and Protect the Health Of Manitobans. Pg. 6

The above framework provides an outline of the population health model and its nine determinants that influence the health of our population. Within these determinants i.e. physical environment, biology and genetic endowment, healthy child development, personal health practices and coping skills, social support networks, education, income and social status, employment and working conditions and health services are health status indicators that tell a story about each determinant of health. The definition for each determinant is incorporated into the earlier Manitoba's Health Performance Measurement Framework table.

"The population health approach addresses the entire range of individual and collective factors that determine health with the overarching goal to maintain and improve the health status of the entire population and to reduce inequities in health status between population groups."<sup>55</sup>



### Population Health Goals

- To maintain & improve the health status of the entire population.
- To reduce inequities in health status between population groups.

As you read through the CHA you will clearly see disparities in health status between our health districts especially notable in Blue Water and Northern Remote health districts.

The following outcomes or benefits of a population health approach extend beyond health status outcomes:

- a) "more product contribution to overall societal development,
- b) ...less support in the form of health care and social benefits, and
- c) is better able to support and sustain itself over the long term. " <sup>56</sup>

## **4.7 ETHICS**

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A CHA involves research that collects and retrieves information about people. In order to protect the rights of the individual there must be fundamental guidelines to direct the process. It was important to the team that the risks to the individual be clearly identified and communicated to them orally and/or in writing. This was particularly important during the focus groups and the validation workshops.

The following outlines the processes in place to protect the individual.

### **4.7.1 *Personal Health Information Act (PHIA)***

The principles of PHIA are fundamental to the protection of personal information. All members who actively participated in the CHA project were given a copy of the article entitled 'A Brief summary for HEALTH RESEARCHERS', an excerpt taken from PHIA.

### **4.7.2 *NEHA Policies***

There are NEHA regional policies which guided this project.

- #12-4 Protection of Privacy During Use and Disclosure of Personal Health Information.
- #13-2 Privacy of Personal Information Under the Freedom of Information and Protection of Privacy Act.
- # 5-9 Research Access.
- # 5-10 Research Committee – NEHA.

### **4.7.3 *Guidelines Developed by CHAN***

A CHAN Ethics Sub-committee was established to assist in ensuring alignment with the ethical issues of accessing and using information.

[Refer to Appendix 4-4, CHAN Ethics Guidelines, August 25, 2003.](#)

## Focus Groups

A letter was given to every participant at the beginning of each of the Focus Group Workshops which explained how the information would be used. A concern that was discussed within the team was participants divulging personal information, as we would have no control as to how other participants might share this information outside the group. This issue was raised within each group, so they could evaluate for themselves exactly what information they were comfortable to share.

Please refer to Section 5 Appendix for a copy of the letter.

## Validation Workshops

Validation workshop participants were informed during the presentation that information discussed would be used in the CHA Report and that this report would be public document. They were assured that no names would be used.

## 2003 Provincial Survey

The survey was completed by an external agency, which was responsible for ensuring that ethical standards for use of the data were adhered to.

Refer to the document: Acumen Research (2004) Regional Health Authority Manitoba. Community Health Survey 2003 – North Eastman. January 12. Pg. 8.

## 4.8 HOW TO USE THE REPORT

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### 4.8.1 General Use

Information in this report has been collected to correspond with the geographical boundaries of NE region and NE health districts. It is recommended when the document is first used that the Introduction and Data Collection and Methodology Sections 4 and 5 be read for a general understanding of the projects intent, scope and limitations.

This report is meant to be used as a working document primarily for NEHA staff and partners for planning purposes. A public document has been created and distributed to the general public throughout NE region in English and French. The completed document is available through NEHA Corporate Office.

An *Executive Summary* is provided at the beginning of the report. If a member of the general public requests a more detailed account of the CHA Report the executive summary will be provided.

*Table of Contents* provides details of the report contents. Each Section is numbered separately corresponding with the section number, for example: Section 4 –3 is page 3 within Section 4. If there are any appendices included within the section these will be located at the end of the section.

*Acknowledgments* include a list of people who supported the project. We are very grateful for the assistance given this project from staff, community leaders and participants in our consultations. If there are any names left out we apologize, it was not intentional.

A *Summary & Conclusion* ends each section. There is a table in which issues are divided into 'Strengths and Issues having implications for health planning and delivery.' It is meant to provide planners with a quick overview of items that have been identified as areas that either could be monitored or are a potential concern.

Example:

Issues Having Implications for Health Planning & Delivery	
<b>Strengths</b>	<p><u>Terms:</u></p> <ul style="list-style-type: none"><li>• <u>Partner:</u> implies that if this is an action by NEHA it will require partnering with a community group/ agencies/ department.</li><li>• <u>Monitor</u> refers to an area of possible concern and monitoring will ensure it isn't missed if it changes.</li><li>• <u>NEHA if a program</u> may or could have some responsibility for this issue.</li></ul>

As population health is all encompassing many issues are not the sole responsibility of NEHA. This is where partners play a major role. It is to the credit of NEHA programs that there are partnership groups already in place and fully functional within each health district.

*References* are provided at the end of each section. References allow the reader to source out additional information on a particular subject.

## 4.8.2 Introduction – Section 4

This provides an overview of the CHA process, structure/team, framework, ethics and use of the report.

## 4.8.3 Data Collection & Methodology – Section 5

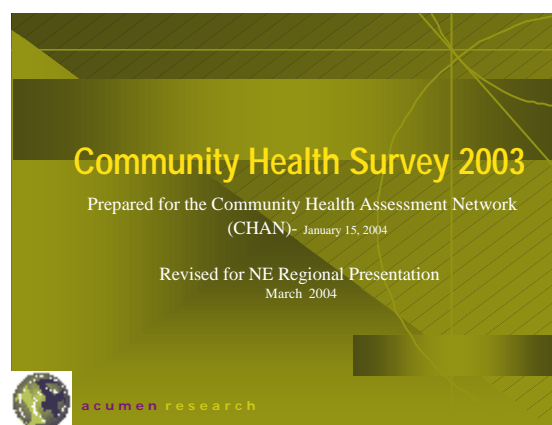
This section discusses the major data sources used in this report including their strengths and weaknesses. It is recommended that this section be read before any interpretation of the data is made.

## 4.8.4 Regional Information – Section 6

This refers to information that has been obtained at a Regional level. This section includes the following components from the Manitoba's Health Performance Framework:

- Community System Characteristics
- Health Status
- Determinants of Health

Focus group information is divided up into ages and districts. The 2003 Acumen Research Survey - NE Findings information is also provided and may be cross-referenced to the earlier NE Survey done in 1997 if there is a similar question.



It is highly recommended that the reader review Section 6 as it provides the most detailed account as to why an indicator is used and its definition. This section contains the most indicators, as many sources of data did not generate information at the district level.

Because NE is a very diverse region, it is important that planners and staff working in a particular district also cross reference any regional health district information to ensure a more complete and accurate picture of the indicator being discussed.

In Appendix 4-5 a copy of the "Diagnostic Categories" has been provided. At times in the report a diagnostic statistic will have an International Classification of Disease (ICD) –9. This list provides more detail about the diagnostic classification. At the time of writing, Manitoba Health is in the process of updating its disease classification to ICD-10.

#### **4.8.5 Health Services – Section 7**

This section covers health service information that has been obtained from both a regional and health district level. It was a conscious decision to put health district information in this section. This allows for cohesiveness in reviewing health services overall without having to jump to another section.

This section includes components of the Manitoba's Health Performance Framework:

- Health System Characteristics,
- Health System Performance – Responsiveness, System Competency, Client/Community Focus and Work Life.

Once more focus group information is divided up into ages and districts. The 2003 Acumen Research Survey - NE Finding information is also provided and may be cross-referenced to the earlier NE Survey done in 1997.

#### **4.8.6 Health Districts- Sections 8 through 13**

The health district section provides information related to a specific health district. You will see that in some graphs or tables other NE health district regions are included. This allows the reader to compare information to our other health districts, Manitoba and Rural South without having to go to another section. The narrative discusses only that health district.

Health district information is valuable for staff working exclusively in one health district, providing them with quick access to a variety of information. Information is more limited at the health district level; therefore it is advised to become familiar with what is available in the regional section.

This section includes the following components of the Manitoba's Health Performance Framework:

- Community System Characteristics
- Health Status
- Determinants of Health

The focus group information is described by age, but only includes information that arose from that particular health district. The validation workshop information includes the top three key issues identified as well as some discussions that arose from that health district only.

The 2003 Acumen Research Survey - NE Finding information was not included as this was collated at the regional level.

#### **4.8.7 Conclusion – Section 15**

At the end of the report, the Conclusion focuses on summarizing regional and district strengths, and highlights issues or trends that emerged using the Manitoba's Performance Measurement Framework as a template. It also summarizes resident suggestions raised during the focus groups, Acumen survey and validation workshops. To conclude this section, some ideas for further research are provided for consideration.

## 4.9 PRIORITY SETTING

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As indicated earlier this document describes many strengths as well as areas that have implications for health planning and delivery.

As planners, making decisions about determining priorities, many things need to be reviewed. A few of these include:

- Size of Problem
- Seriousness
- Effectiveness of Interventions

Specific questions to ask about a particular issue:

- How many people does it affect?
- Is it a growing and/or increasing problem?
- Can you measure it over time?
- Can something be done about it?
- Will there be a positive effect if something is done or a negative effect if nothing is done?
- Economic burden—cost to community?
- What will be the long term negative effect?
- What supports are needed for change?
- What will the impact be on current resources?
- Is it efficient use of resources?
- Severity of problem to person?
- Did the public raise this concern during consultations?
- What are the risks – legal & ethical?

## 4.10 SUMMARY / CONCLUSION

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The goal of the CHA Report is to provide NEHA staff, first and foremost, with a way of obtaining comprehensive, insightful and the most up to date evidence based information. It will assist them with planning for future health programs and services to meet the needs of NE residents.



*“Working together to create  
a healthy North Eastman”*

## 4.11 REFERENCES

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