

ANISHININIIW NANADOWI'KIKENDAMOWIN



HEALTH OUTCOMES OF OUR PEOPLE



Sioux Lookout
First Nations
Health Authority

October 2019

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www.slnha.com

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Data Sources

Parts of this material are based on data and information compiled and provided by CIHI. However, the analyses, conclusions, opinions and statements expressed herein are those of the authors, and not necessarily those of CIHI.

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This publication is based in part on data from the First Nations and Inuit Health Branch (FNIHB). This includes data submitted through the Service Administration Log (SAL), a database for FNIHB managed Nursing Stations. It also includes reportable diseases forwarded to FNIHB from the provincial reportable disease system.

Ownership

The data in this report is owned collectively by the First Nations in the Sioux Lookout area with SLFNHA.

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For further inquiry

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GLOSSARY

Approaches to Community Wellbeing: First Nations governed public health system for 31 rural and remote First Nations supported by SLFNHA.

Cardiovascular disease: Also called diseases of the circulatory system, illnesses that affect the heart and blood vessels.

Diabetes: An illness caused by high blood sugars.

Emergency department visit: When a community member registers with an emergency department in a hospital.

Hospitalization: When a community member is assigned a bed within a hospital, outside of the emergency department.

Genitourinary disease: Also called diseases of the urinary system, illnesses that affect the kidneys, bladder, and urethra.

Ischemic heart disease: Also called coronary artery disease, illnesses caused by blockage of the arteries that supply blood to the heart muscle. Can lead to a heart attack.

Musculoskeletal disease: Also called diseases of the musculoskeletal system, illnesses that affect the muscles and skeleton/bones.

Medevac: When a community member is transported out of a community for medical reasons using emergency transportation (e.g. Ornge).

Morbidity: Another word to describe illness and disease (not including death).

Mortality: The number of deaths in a given time or place.

Prevalence: The proportion of people in a population who have a particular condition at a given point or period in time.

Reportable disease: Certain infectious diseases that health care providers and laboratories must report to public health.

Respiratory disease: Illnesses that affect the airways (lungs and breathing). Includes things such as asthma, chronic obstructive pulmonary disease (COPD) and pneumonia.

Schedevac: When a community member is transported out of a community for medical reasons using pre-scheduled flights.

Stroke: The sudden death of brain cells due to lack of oxygen. Caused by decreased blood supply to the brain and can cause changes in speech, balance, memory, etc.



CONTENTS

8	Creating this Report
10	Using this Report
11	Background
13	Setting the Context
14	Report Highlights
15	Overview
15	Mortality
16	Nursing Station Visits
17	Emergency Department Visits
20	Hospitalizations
24	Cardiovascular Disease
28	Respiratory Disease
32	Chronic Disease
35	Diabetes Highlight
38	Injuries
50	Infectious Diseases
57	Final Thoughts
58	References

CREATING THIS REPORT

This report was created for Sioux Lookout area First Nations. It is intended to inform community leadership and health planners of the current health status of adults age 20 and above. The

measures in this report were selected based on the data that we had access to and common practice across the public health sector in Ontario.

How we defined the age groups

In this report, we have included information on adults age 20 and above. Because the health of a 20-year-old can be very different than the health of a 60-year-old, we have included the age groupings of 20-39, 40-59, and 60 and

above wherever possible. Health outcome data on children and youth under the age of 20 is available in “Niiniicaniisiinanak Miina Ooskatiisak Miinooayawiin Tiipaciimowwin - Our Children and Youth Health Report.”

Limitations with the data sources

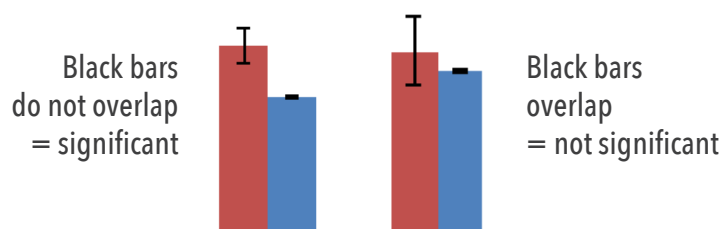
Appendix A summarizes data sources and limitations. The main limitations include:

- Data has been collected based on geographical identifiers (postal codes). This means that if a community member has listed their home address as off-reserve, they might not be included in the dataset.
- Some data sources did not include data for all of the communities. For example, nursing station data is only available for 19 communities.
- Emergency department visits and hospital admissions are documented differently between Manitoba and Ontario. This means that how we categorized things was slightly different for the two jurisdictions.

How we analyzed the data

- Percentages or rates were used to describe most of the data. When appropriate and possible, data is compared to the province of Ontario.
- Rates calculated # per 1,000 means that if a community has 1,000 people then # would have the condition.
- The total population included in this report is less than 30,000 people, a relatively small number when calculating population rates. This means that a small change in the absolute number of people with a health problem may result in a big change in the rate from year to year. This can sometimes be misleading when looking at changes over time.
- Statistical significance was determined using 95% confidence intervals, which are the small black lines shown on the bars of the bar graphs. If the confidence interval

of one rate does not overlap with another rate (e.g. between the rate in men and the rate in women), the difference between the rates is considered statistically significant (i.e. that there is a 95% chance that this difference did not occur by accident). If the intervals do overlap, they could be statistically significant but further analysis is needed.



SLFNHA has taken all reasonable steps to ensure that the information presented here is a true reflection of the data held in the databases accessed. SLFNHA does not control how complete or accurate the original data is. Comparisons of information contained in this report with information obtained from other databases or at other times may identify differences.

Example

If the rate of diabetes in a community is found to be four per 1,000 people, then in a community of 1,000 people four people would have diabetes; or in a community of 2,000 people, eight people would have diabetes. Similarly, in a community of 500 people, two people would have diabetes.



USING THIS REPORT

Using the information

- **Laying the foundation** – this report can support your community in understanding needs in health and wellness. It may help you identify gaps and help to inform community members on health outcomes so that they can improve services.
- **Focusing prevention efforts** – the information in this report can help us to focus our efforts in promoting wellness and preventing illness.
- **Evaluating programming** – the goal of many programs and services is to improve the health of community members. This report can be used to help evaluate programs and services and see how they are impacting the health of community members.
- **Advocating** – the numbers in this report can be used to strengthen funding proposals and as a tool for advocating for improved social determinants of health and health services.

Beyond the numbers

The information in this report presents one way of viewing and measuring health outcomes – a western numerical way. Focusing only on numbers sometimes misses:

- **Wholistic** – First Nations in Sioux Lookout area view health and wellness as connection to land, language, culture, ancestors, and family. A report that only includes numbers cannot capture all of this. The measures in this report were chosen because they are typical of what is measured in the public health system (therefore allowing comparisons) and because they are what we could currently access.
- **Indigenous ways of knowing** – We value Indigenous ways of knowing and recognize that numbers sometimes take space away from the important information held in stories and oral culture. By defining our health using qualitative (words) and quantitative (number) methods we solidify the realities communities are facing and share our stories. Focusing on numbers of illness in this report, we recognize that the report is a product of a western scientific approach.
- **Experience of illness** – Numbers sometimes do not capture the individual, family, or community experience of illness. We recognize that statistics sometimes represent the pain and suffering associated with illness. It is this suffering we are hoping to prevent.
- **Roots of health inequity** – Most of the poor health outcomes experienced by First Nations in Sioux Lookout area are a direct result of colonization, assimilation policies, legislation, and systemic racism. This must be remembered and emphasized when interpreting the numbers in this report.

BACKGROUND

SLFNHA is a regional First Nation governed organization that works towards improved health outcomes for First Nations in Sioux Lookout area. Approaches to Community Wellbeing (ACW) is the public health department at SLFNHA and supports communities in building capacity and providing services in promoting health and preventing illness.

ACW is rooted in the values outlined by the First Nations involved in its creation. These values include the teachings of our people, language, history, family, wholistic, honour choices and accept differences, share knowledge, connection to the land, supportive relationships and collaboration.

Since 2012, access to statistics on the health status of our communities has been recognized as a priority by the Sioux Lookout area Chiefs

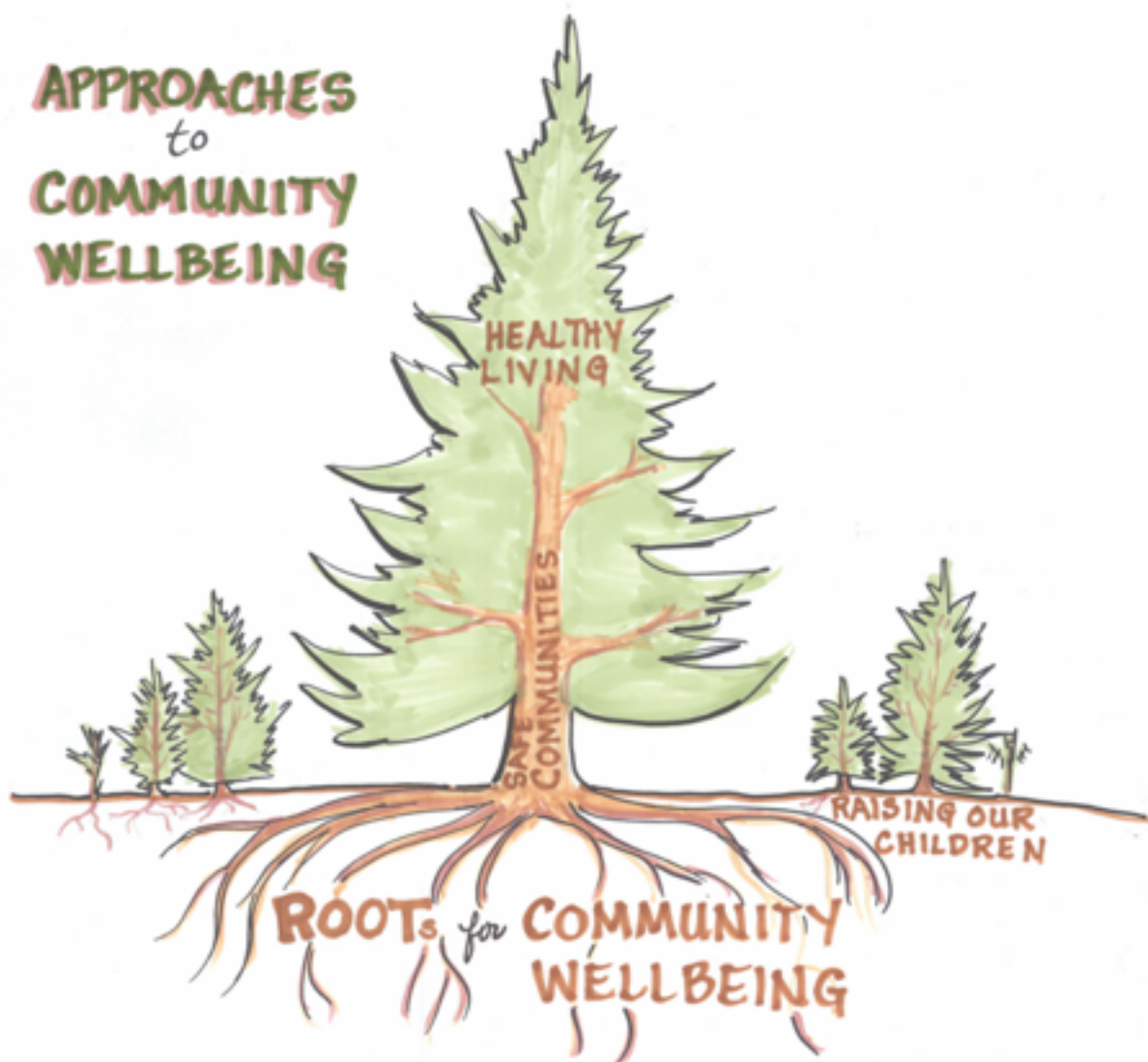
in Assembly. **Resolutions #12-07: Health monitoring surveillance and #15-25: Health data management mandated SLFNHA to access health data on behalf of the communities it serves and start to create reports on the health status of the region.**

ACW is the lead department at SLFNHA that is supporting this work.

In 2018, ACW released its first health status report “Niiniicaniisiinanak Miina Ooskatiisak Miinooyawiiin Tiipaciimowwin - Our Children and Youth Health Report”. The Our Children and Youth Health Report presented summary data for 31 communities on the health status of age 19 and under. This report, the "Anishininiw Nanadowi'kikendamowin - Health Outcomes of Our People," aims to complement the Our Children and Youth Health Report by focusing on ages 20 and above.



APPROACHES to COMMUNITY WELLBEING



VISION

The Anishinabe people of this land are on a journey to good health by living healthy lifestyles rooted in our cultural knowledge.

SETTING THE CONTEXT

Many factors affect the health and wellness of Sioux Lookout area First Nations. They include geography, food security, housing, education, multi-generational trauma, language, climate change, and other determinants of health.

Sioux Lookout area First Nations have strong connections to family, community, and the land. Ojibway, Oji-Cree, or Cree are spoken and promoted in all the communities and are often taught in primary schools. Traditional activities like trapping and fishing are common in many communities, and elders share their stories and histories with their families.

Health care services are provided by multiple levels of government. This complicates access to health services and continuity of care for Sioux Lookout area First Nations. The main source of primary care and first point of health care services for 24 communities is their federally funded nursing station. Emergency services are accessible only by plane for 25 communities, or by driving 45 minutes to three

hours for the remaining seven communities.

Decades of racist government policy and legislation has left communities with crumbling and inadequate infrastructure. This means that basic needs, such as clean drinking water and safe housing, are not met, and directly impacts the health and wellbeing of First Nations

SLFNHA would like to highlight that each community included in this report is unique and distinct. While many communities have shared history in terms of colonization, assimilation policies, and systemic racism, communities have different languages/dialects, traditions, and strengths. These differences are also seen in the health outcomes of communities in the region. This means that a regional summary statistic does not necessarily truly reflect the experiences of an individual community.

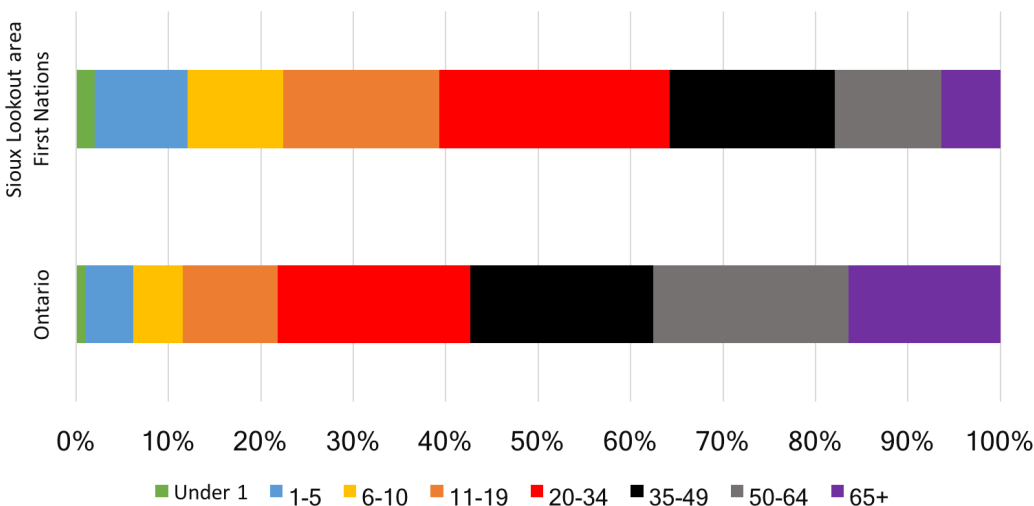
Population

First Nations in the Sioux Lookout area have a young population (Figure 1.0). In 2016, 39% of the population was under the age of 20, and

61% of the population was age 20 and above. Since 1991, the population of Sioux Lookout area First Nations has grown by 74%.

Figure 1.0:
Sioux Lookout area
First Nations and
Ontario population
by age, 2016

Source: First Nations and
Inuit Health Information
System; Statistics Canada.
Table 17-10-0005-01
Population estimates on
July 1st by age and sex.



REPORT HIGHLIGHTS

Community members age 20 and above from Sioux Lookout area First Nations are:

- Seen in the emergency department 2.5 times the Ontario rate (despite nursing stations being the first point of access).
- Admitted to hospital 2.5 times the Ontario rate.
- Admitted to hospital for respiratory disease 2.5 times the Ontario rate.
- Admitted to hospital for chronic diseases 2 times the Ontario rate.
- Admitted to hospital for diabetes 4 times the Ontario rate.
- Admitted to hospital for infectious and parasitic diseases 6-7 times the Ontario rate.

In addition:

- Injuries are the leading cause of visits to the emergency department and hospital admissions.
- Almost one quarter of people age 20 and above have diabetes.
- Half of the hospital admissions for respiratory disease are related to pneumonia.
- Men are admitted to hospital at a higher rate than women for ischemic heart disease.
- Falls account for the majority of hospital admissions related to unintentional injury.

OVERVIEW

This report includes information on both mortality and morbidity. Mortality means the number of deaths in a certain time or place. Morbidity means the illness caused by a disease (but not including death). In this report we have measured morbidity by looking at health service usage – why and how often people seek care at nursing stations, emergency departments, and are admitted in hospitals.

The data on mortality includes people living

both on and off reserve and is for all ages. In comparison, the data on morbidity includes people living only on reserve and is for ages 20 and above. These calculations were done differently as data on mortality was accessed through Mamow Ahyamowen – a partnership of 77 First Nations in northern Ontario that is working to provide health data to First Nation communities (1). The data on morbidity was calculated internally at SLFNHA.

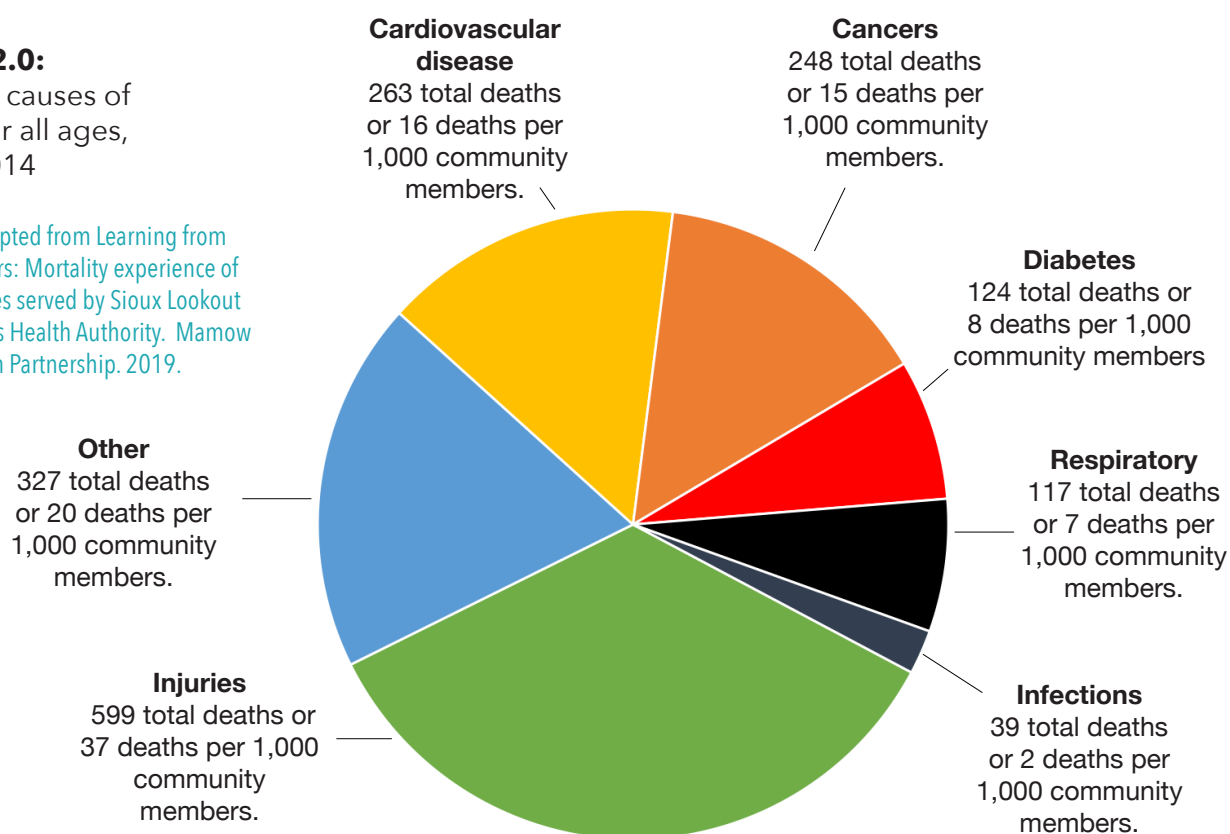
Mortality

Between 1992 and 2014, there were 1,930 deaths among Sioux Lookout area First Nations. This is a rate of 120 deaths for every 1,000 people. **64% of all deaths occurred before the age of 65 compared to 22% for Ontario overall.**

Injuries was the leading cause of death followed by diseases of the circulatory system and cancers. **The rate of death from injuries was 5.2 times higher than the provincial rate.**

Figure 2.0:
Leading causes of death for all ages, 1992-2014

Source: Adapted from Learning from our ancestors: Mortality experience of communities served by Sioux Lookout First Nations Health Authority. Mamow Ahyamowen Partnership. 2019.



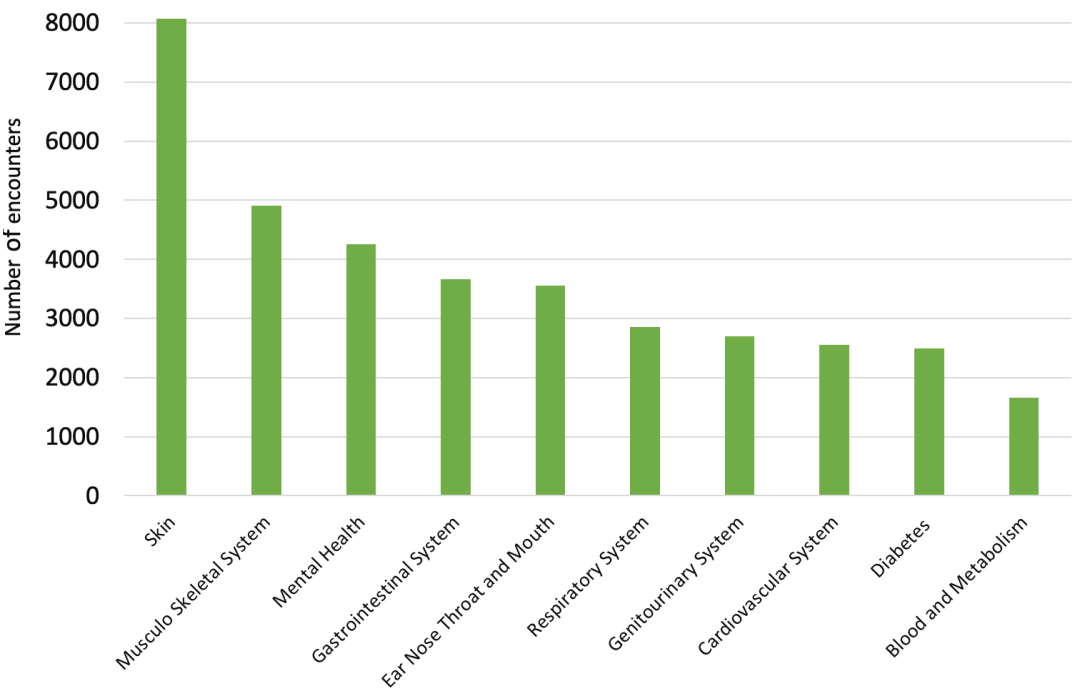
Nursing Station Visits

For 27 of the communities included in this report, the first point of care when they are sick or injured is a community nursing station or health centre. It is also the focus of primary care and preventive care. Nineteen nursing stations submit data to First Nations and Inuit Health Branch on the reasons that people are seen. This data only includes encounters with nurses, not with community physicians.

Conditions relating to the skin had the highest number of encounters at nursing stations (Figure 2.1). This was followed by musculoskeletal concerns (i.e. muscle and bone problems) and mental health.

Figure 2.1:
Number of nursing station encounters by primary disease category for age 20 and above, 2015-2017

Source: Service Administration Log, First Nations and Inuit Health Branch – Ontario Region.



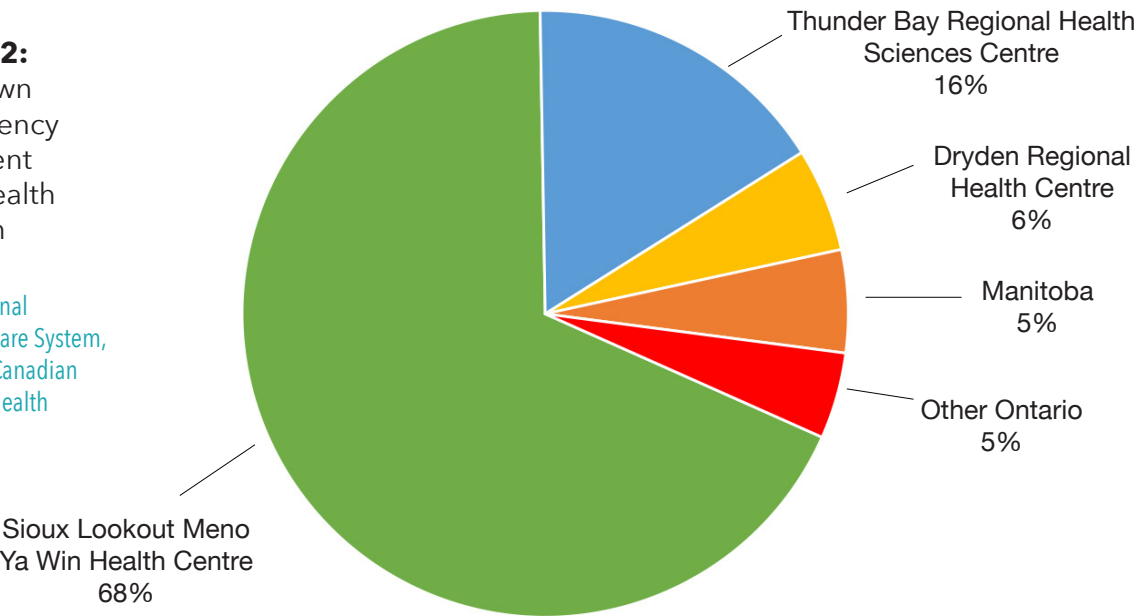
Emergency Department Visits

In 2016, there were 7,507 visits to emergency departments made by people over the age of 20 from Sioux Lookout area First Nations – this includes hospitals in both Ontario and Manitoba [excludes visits related to pregnancy and non-disease reasons] (Figure 2.2).

For most of these visits, individuals were first seen and assessed in the community nursing station/health centre. They then had to fly (either by medevac or schedevac) to the emergency department for further assessment and management.

Figure 2.2:
Break down of emergency department visit by health institution

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

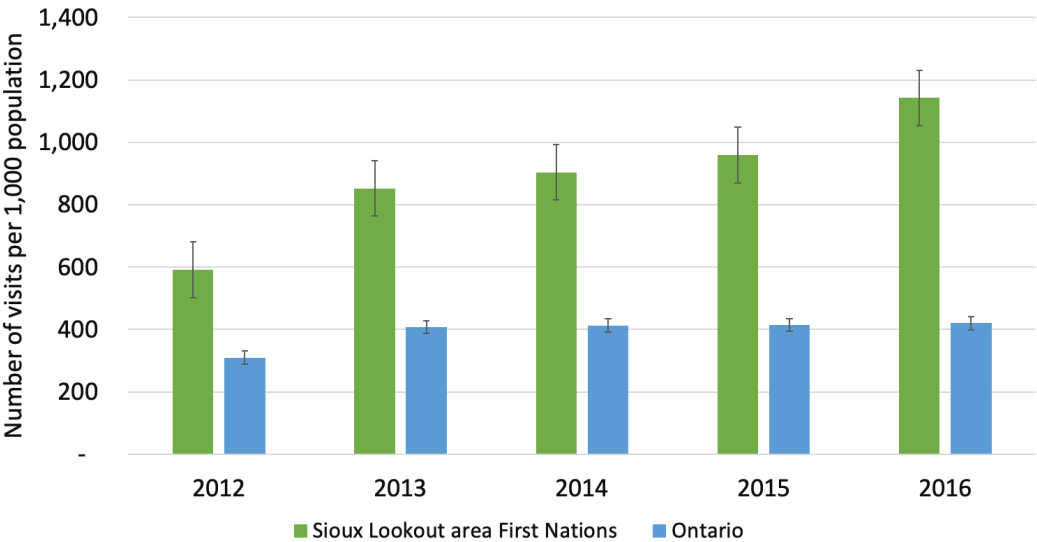


The rate at which individuals over the age of 20 from Sioux Lookout area First Nations are seen in the emergency department is 2.5

times the provincial rate (Figure 2.3). There was no statistical significant difference between the rate for men and women.

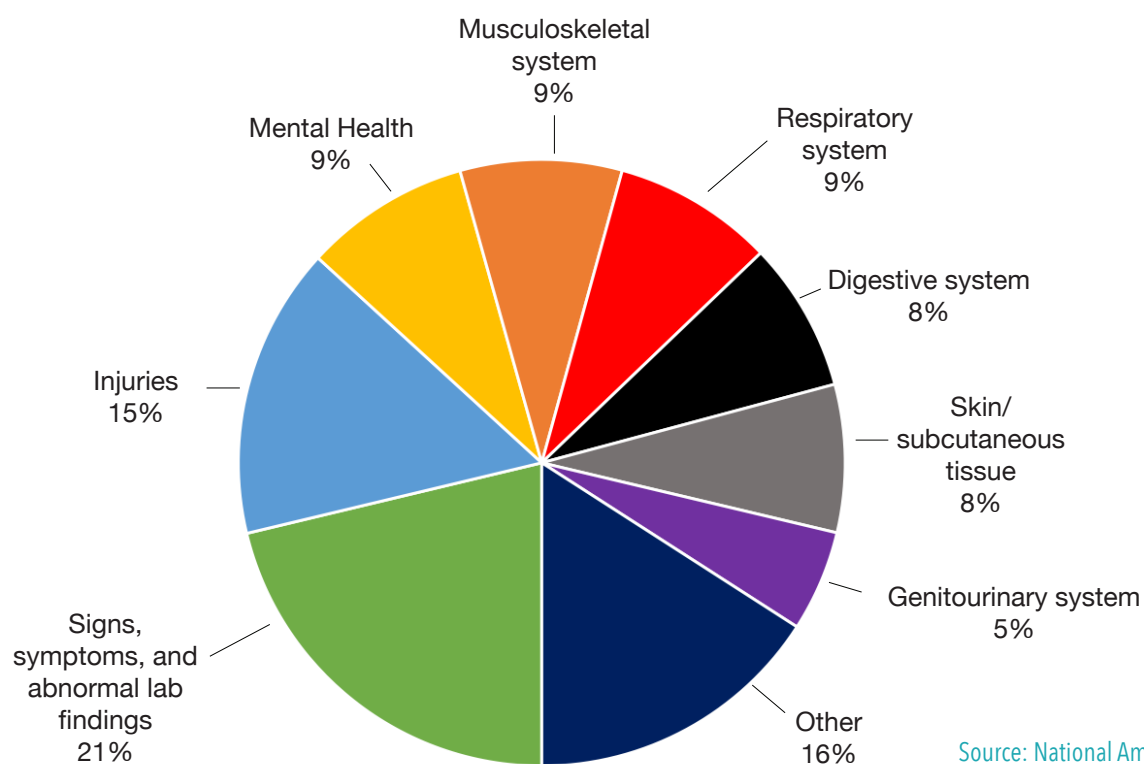
Figure 2.3: Rate of emergency department visits for all causes among people age 20 and above, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.



The most common reason that people age 20 and above were seen in the emergency department was for injuries (Figure 2.4).

Figure 2.4: Reasons for emergency department visits for people age 20 and above, 2012-2016



Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

Explanations

Injuries: This includes both unintentional and intentional injuries. It includes poisonings, overdoses, assault, harm to self, and others.

Mental Health: This includes mood disorders (such as depression and anxiety), as well as other illnesses such as schizophrenia. It does not include self-harm.

Signs, Symptoms, and Abnormal Lab Findings: When someone is discharged from the emergency department or the hospital and the diagnosis is still unclear, it is coded as "Signs, symptoms and abnormal lab findings". Examples of this include cough, abdominal pain, swelling, etc.

Table 1.0: Leading reasons that people visit the emergency department by age group, 2012-2016

Age 20-39				
Top 5 Causes	Number of Visits			% of ED Visits (total=14273)
	Females	Males	Total	
Injuries	1450	1914	3364	23.6
Mental health	1356	1448	2804	19.6
Signs, symptoms and abnormal lab findings	1390	891	2281	16.0
Digestive system	727	423	1150	8.1
Skin/subcutaneous tissues	469	535	1004	7.0

Age 40-59				
Top 5 Causes	Number of Visits			% of ED Visits (total=10212)
	Females	Males	Total	
Signs, symptoms and abnormal lab findings	1202	969	2171	21.3
Injuries	728	859	1587	15.5
Mental health	374	530	904	8.9
Musculoskeletal system	460	421	881	8.6
Respiratory system	539	335	874	8.6

Age 60 and above				
Top 5 Causes	Number of Visits			% of ED Visits (total=5290)
	Females	Males	Total	
Signs, symptoms and abnormal lab findings	674	610	1284	24.3
Respiratory system	376	321	697	13.2
Injuries	328	234	562	10.6
Circulatory system	204	236	440	8.3
Musculoskeletal system	243	160	403	7.6

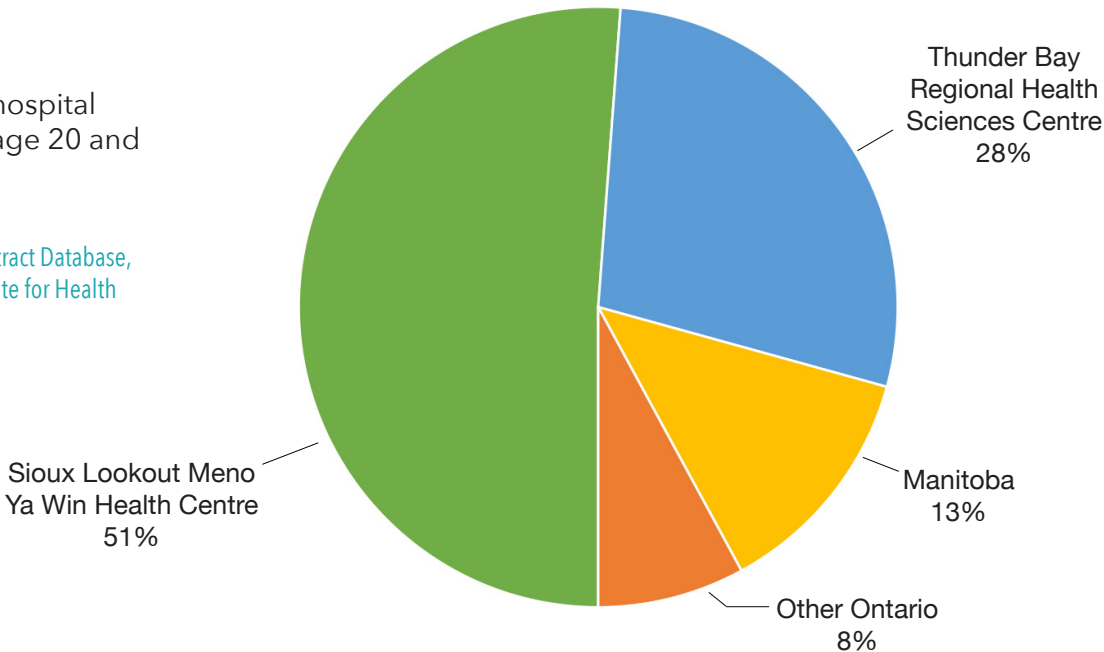
Hospitalization

In 2016, there were 1,359 admissions to hospital for individuals over the age of 20 from Sioux Lookout area First Nations (this excludes admissions for pregnancy or non-disease reasons).

The majority of hospital admissions happened in Ontario (Figure 2.5). In general, people that are critically ill are more likely to be admitted at the Thunder Bay Regional Health Sciences Centre or in Manitoba.

Figure 2.5:
Break down of hospital admissions for age 20 and above, 2016

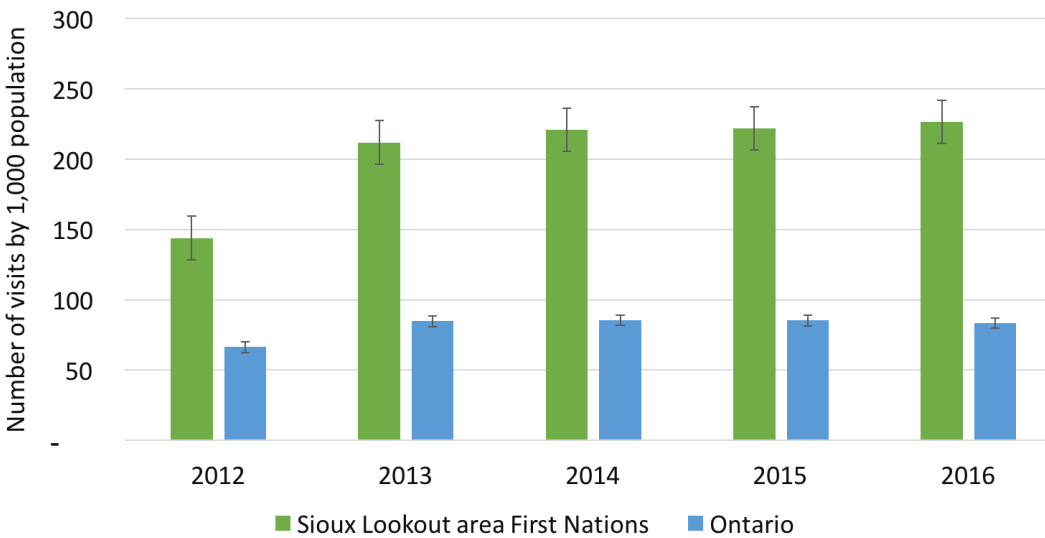
Source: Discharge Abstract Database, 2016, Canadian Institute for Health Information



The rate at which individuals over the age of 20 from Sioux Lookout area First Nations are admitted to hospital is 2.5 times higher than the Ontario rate (Figure 2.6). Women were admitted to hospital at a higher rate than men, even when excluding hospital admissions related to pregnancy and childbirth.

Figure 2.6: Rate of hospital admissions for all causes for age 20 and above, 2012-2016

Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information



The main reason that people age 20 and above were admitted to hospital was for injuries (Figure 2.7). This was followed by diseases of the digestive system.

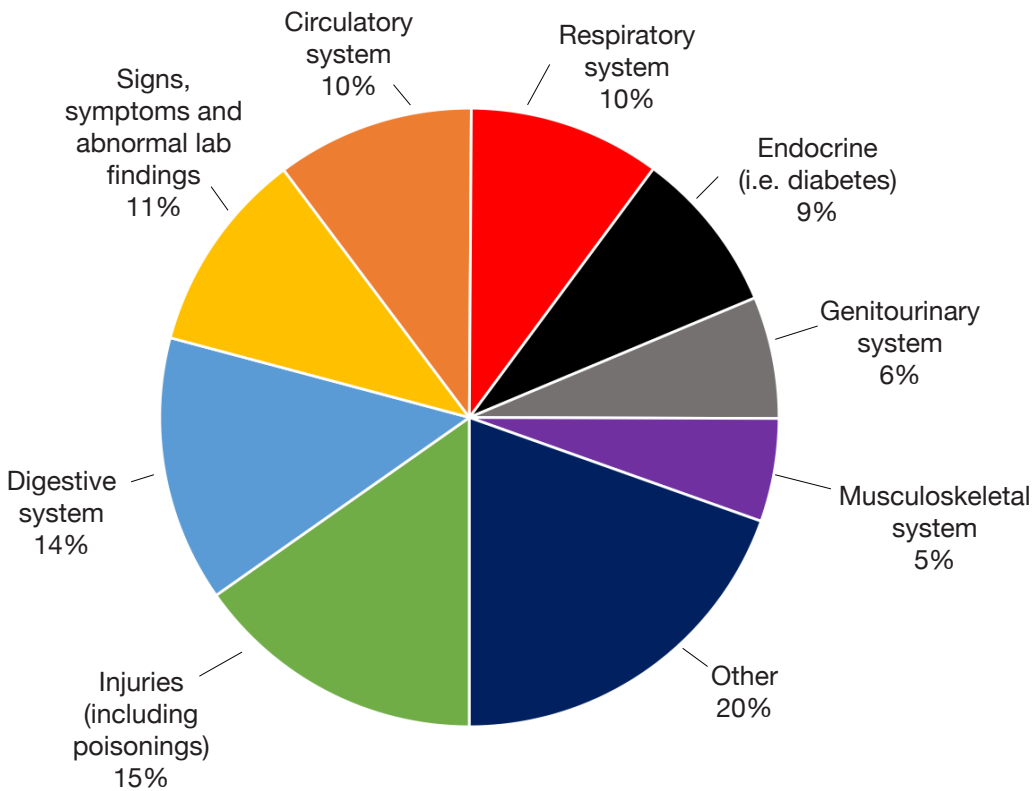


Figure 2.7: Leading causes of hospital admission for people age 20 and above, 2012-2016

Source: Discharge Abstract Database, 2016, Canadian Institute for Health Information



Table 2.0: Leading reasons that people are admitted to hospital, by age group, 2012-2016

Age 20-39				
Top 5 Causes	Number of Admissions			% of Admissions (total=1694)
	Female	Male	Total	
Injuries	194	236	430	25.4
Digestive system	172	80	252	14.9
Mental health	72	88	160	9.5
Signs, symptoms and abnormal lab findings	85	66	151	8.9
Genitourinary system	91	16	107	6.3

Age 40-59				
Top 5 Causes	Number of Admissions			% of Admissions (total=1925)
	Female	Male	Total	
Digestive system	180	134	314	16.3
Injuries	119	121	240	12.5
Signs, symptoms and abnormal lab findings	126	89	215	11.2
Circulatory system	73	128	201	10.4
Endocrine (e.g. diabetes)	92	102	194	10.1

Age 60 and above				
Top 5 Causes	Number of Admissions			% of Admissions (total=2187)
	Female	Male	Total	
Respiratory system	180	149	329	15.0
Circulatory system	138	189	327	14.8
Signs, symptoms and abnormal lab findings	125	125	250	11.4
Digestive system	111	130	241	11.0
Injuries	124	91	215	9.8



CARDIOVASCULAR DISEASE

Diseases of the circulatory system, also known as cardiovascular disease, includes illness related to the heart and blood vessels. It includes things such as heart attacks, stroke, rheumatic heart disease, heart failure, and arrhythmias (when the heart beats out of rhythm).

Emergency Department Visits

In 2016, there were 219 visits to the emergency department for cardiovascular disease. The rate of visits increased between 2012 and 2016 (Figure 3.0) and was highest among people over the age of 60 (Figure 3.1). There was no significant difference in the rate between men and women.

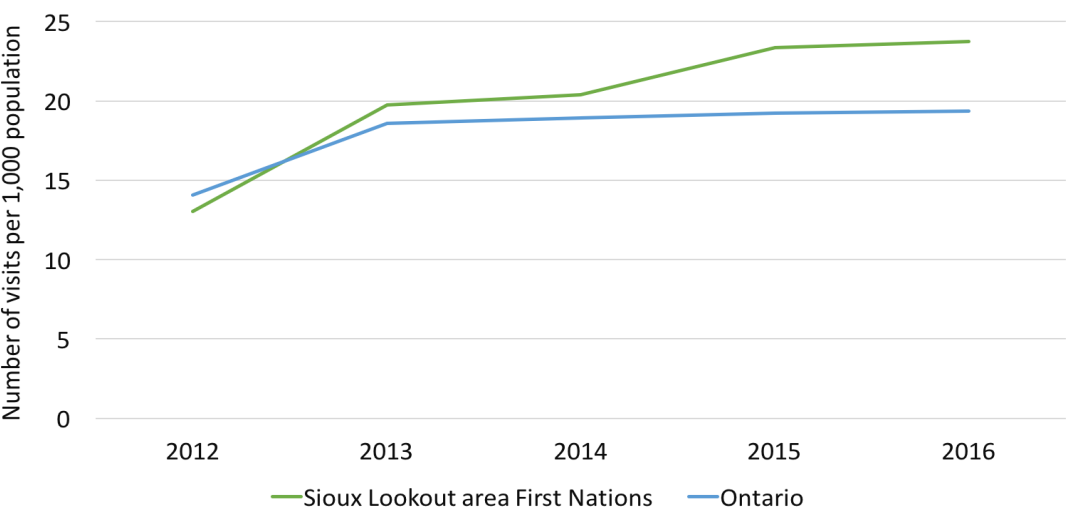


Figure 3.0: Rate of emergency department visits due to cardiovascular disease compared to Ontario, age 20 and above, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

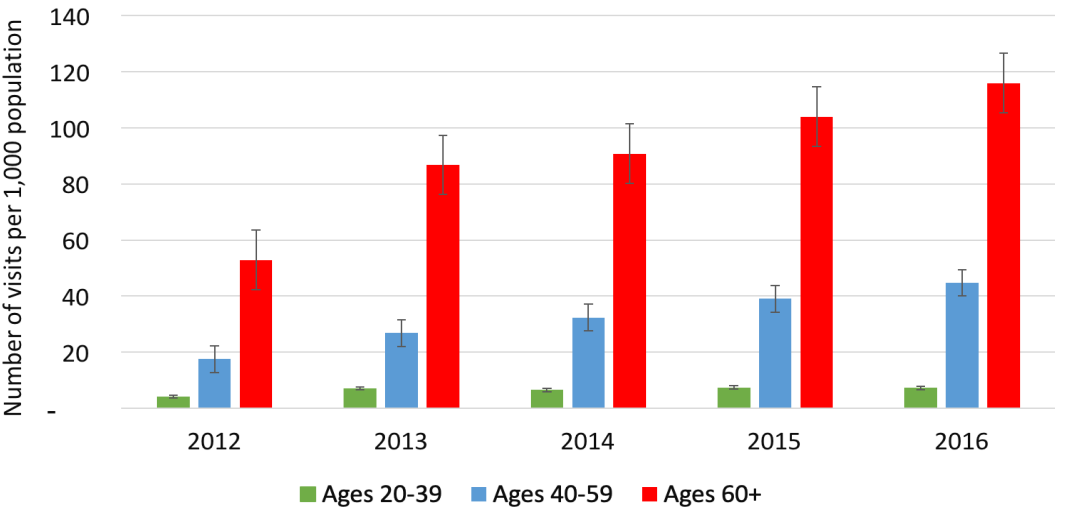


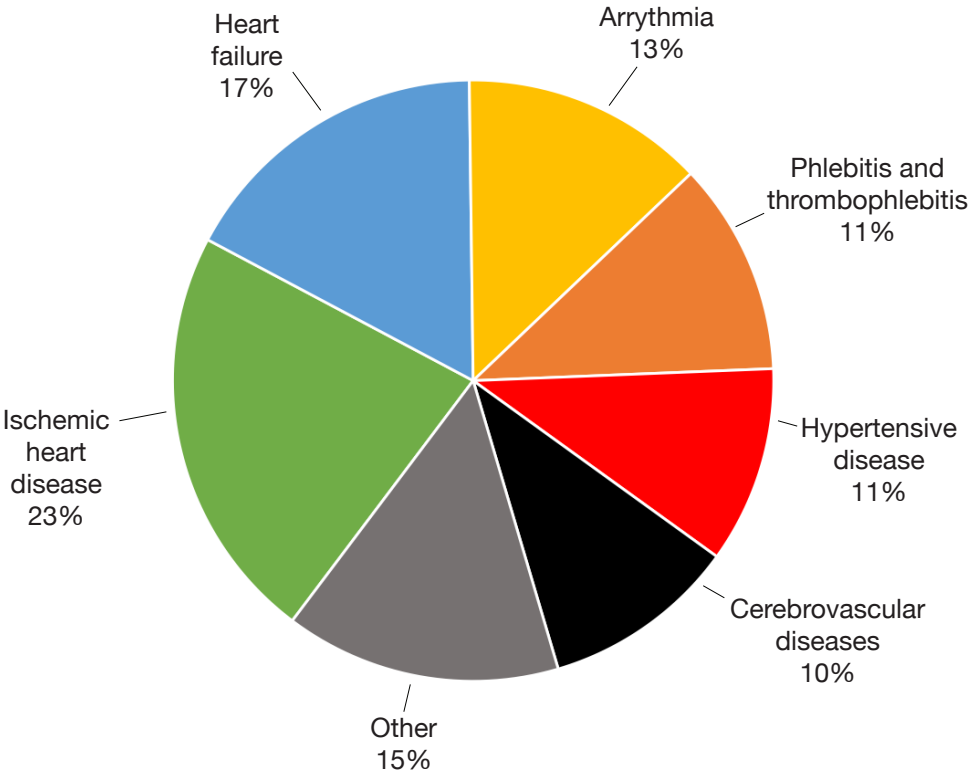
Figure 3.1: Rate of emergency department visits due to cardiovascular disease by age group, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

Ischemic heart disease accounted for 23% of all emergency department visits due to cardiovascular disease (Figure 3.2). This is followed by heart failure (17%) and arrhythmia (13%).

Figure 3.2:
Top causes of emergency department visits due to cardiovascular disease for age 20 and above, 2012-2016.

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.



Explanations

Cerebrovascular disease: when there is decreased supply of oxygen to the brain. This could be caused by blocked blood flow to the brain or by bleeding in the brain. Examples include stroke.

Phlebitis and thrombophlebitis: when the blood vessels (veins) are inflamed. Also includes deep vein thrombosis (blood clot in the leg).

Ischemic heart disease: when there is decreased blood flow to the heart muscle. Can lead to a heart attack.

Heart failure: when the heart muscle is not pumping properly.

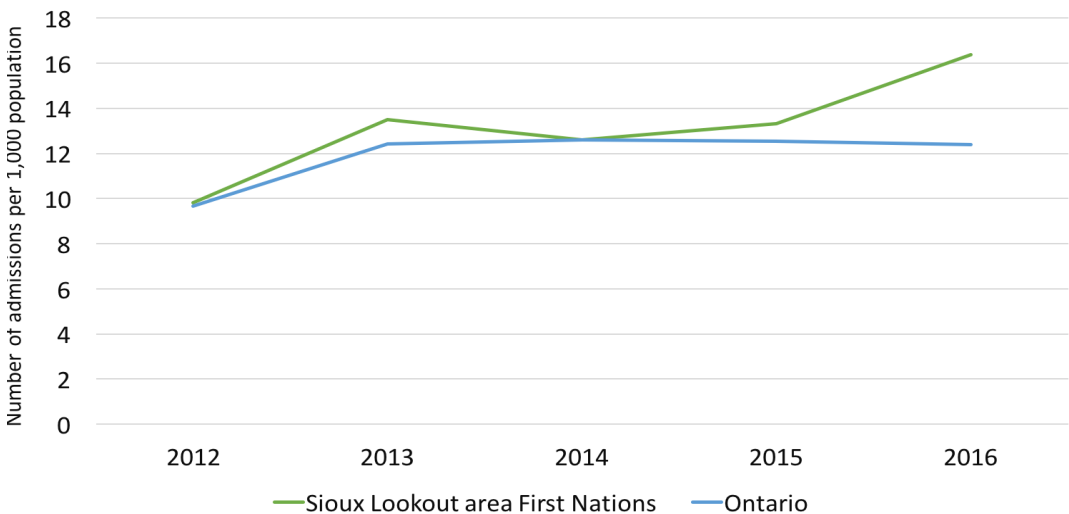
Arrhythmia: when the heart beats in an abnormal rhythm. Examples include atrial fibrillation and heart block.

Hospitalization

In 2016, there were 151 hospital admissions for cardiovascular disease. The rate of admission increased slightly between 2012 and 2016 and was highest among people age 60 and above

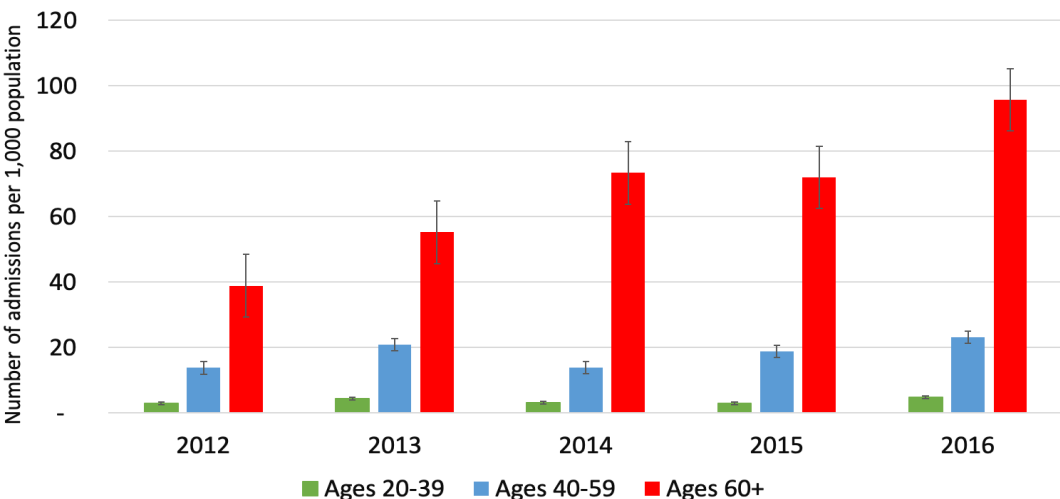
(Figure 3.3 and 3.4). Men had a statistically significant higher rate of admission to hospital compared to women.

Figure 3.3:
Rate of hospital admissions due to cardiovascular disease compared to Ontario, age 20 and above, 2012-2016



Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

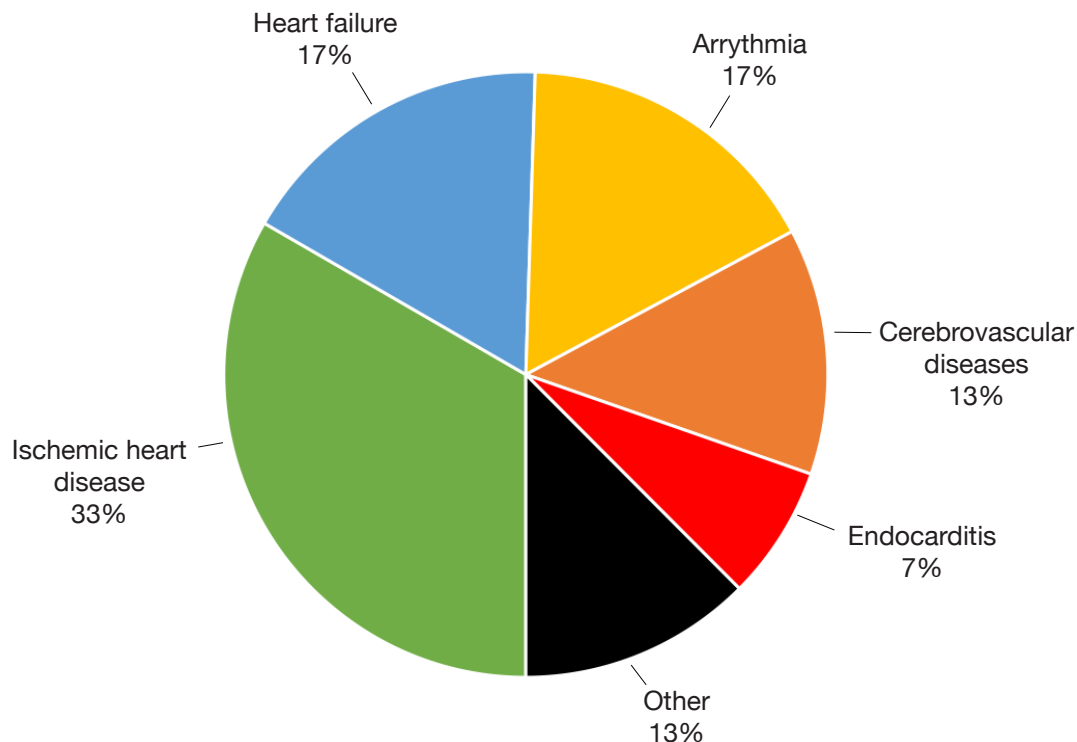
Figure 3.4:
Rate of hospital admissions due to cardiovascular disease by age group, 2012-2016



Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

Ischemic heart disease accounted for 33% of all hospital admissions related to cardiovascular disease (Figure 3.5). This was followed by heart failure (17%) and arrhythmia (17%).

Figure 3.5: Causes of hospital visits due to cardiovascular disease for age 20 and above, 2012-2016.



Source: Discharge Abstract Database, 2012-2016,
Canadian Institute for Health Information

Explanations

Endocarditis: When there is an infection of the heart valves or heart lining, and is usually caused by bacteria. Risk factors include using intravenous drugs and scarring from old heart valve damage.

RESPIRATORY DISEASE

Respiratory diseases include illnesses related to the lungs and breathing. It includes things such as asthma, chronic obstructive pulmonary disease (COPD) and pneumonia. Some of these

illnesses are considered chronic diseases (eg. COPD) whereas some of them are acute illnesses (e.g. pneumonia).

Emergency Department Visits

In 2016, there were 621 visits to the emergency department for respiratory diseases. The rate of visits to the emergency department was two times higher than the Ontario rate (Figure 4.0).

The rate was highest among people age 60 and above (Figure 4.1). Women had a higher rate than men for emergency department visits for respiratory disease.

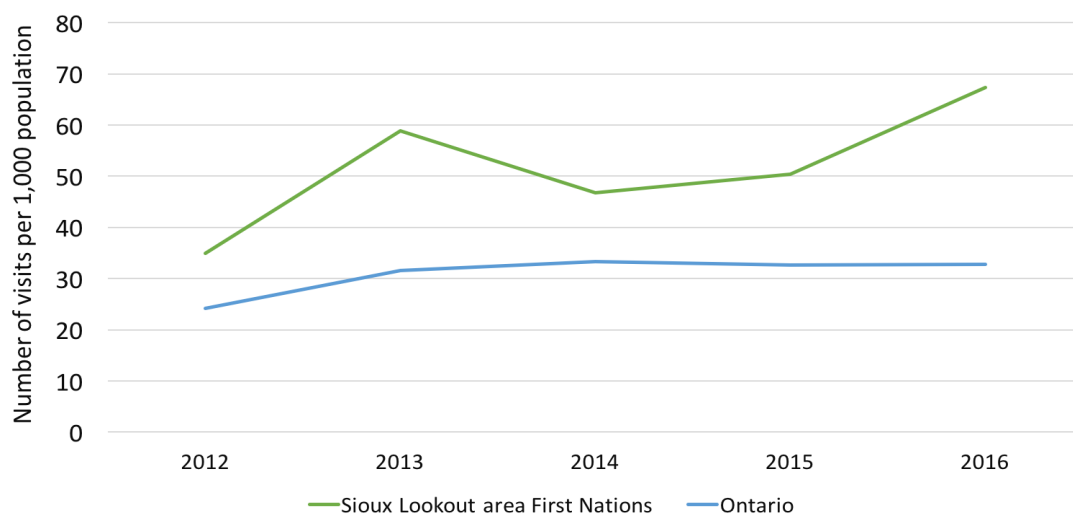


Figure 4.0:
Rate of emergency department visits due to respiratory disease compared to Ontario, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

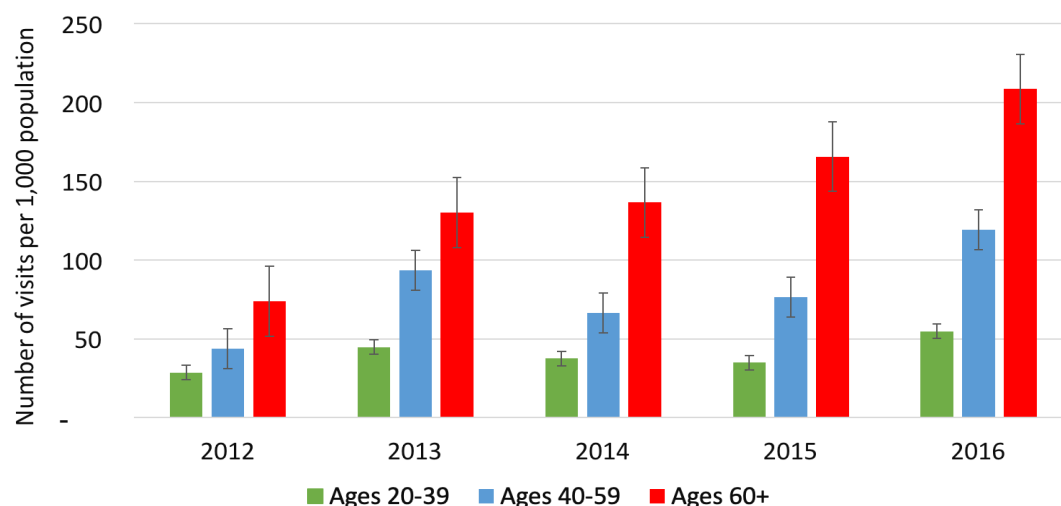
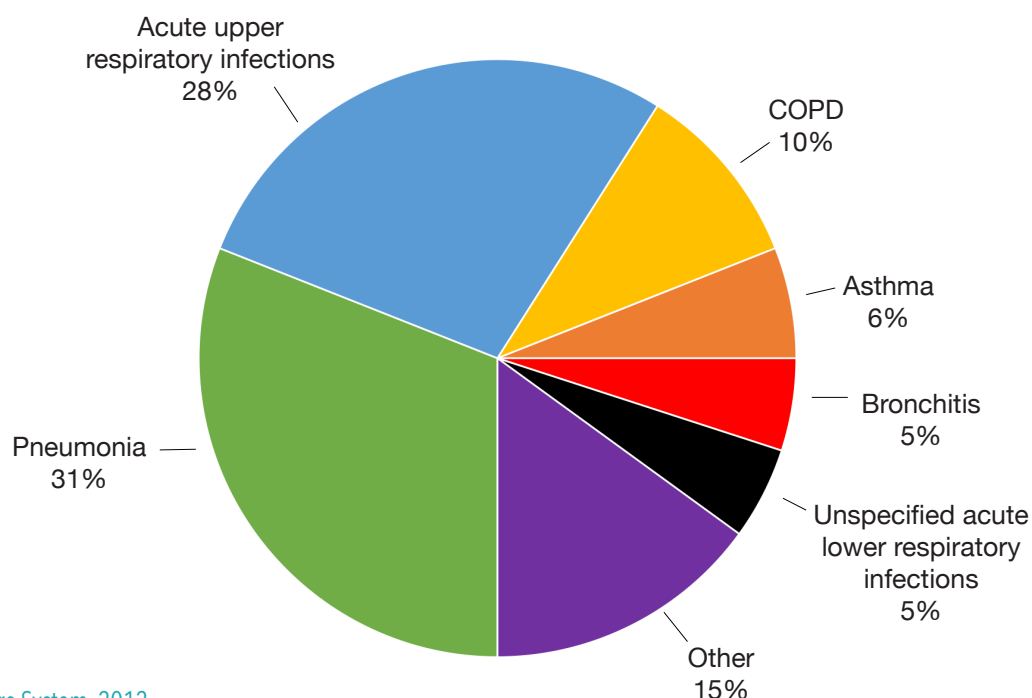


Figure 4.1:
Rate of emergency department visits due to respiratory disease by age group, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

Among emergency department visits that are due to respiratory diseases, one third was for pneumonia/influenza (Figure 4.2).

Figure 4.2: Top causes of emergency department visits due to respiratory disease for age 20 and above, 2012-2016.



Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

Explanations

Acute upper respiratory infections: when there is an infection in the upper airway (e.g. sinus, throat, nasal passages, etc.). Includes things such as sinus infections, throat infections, etc.

Chronic Obstructive Pulmonary Disease (COPD): chronic lung disease caused by obstruction of lung airflow

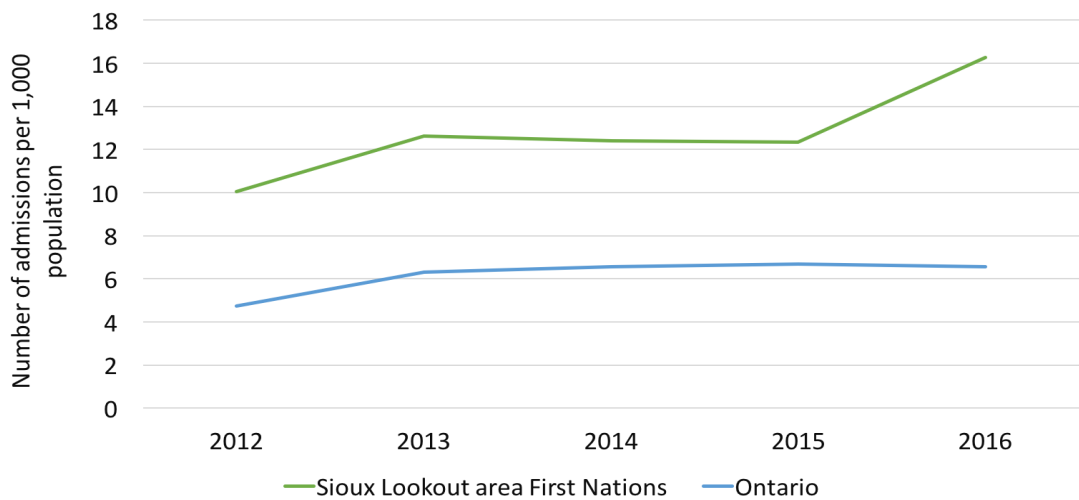
Bronchitis: inflammation of the lining of bronchial tubes, which carry air to and from your lungs.

Hospitalization

In 2016, there were 150 hospital admissions for respiratory disease. First Nations from Sioux Lookout area were admitted to hospital for respiratory diseases twice as often as the Ontario average (Figure 4.3). The rate of

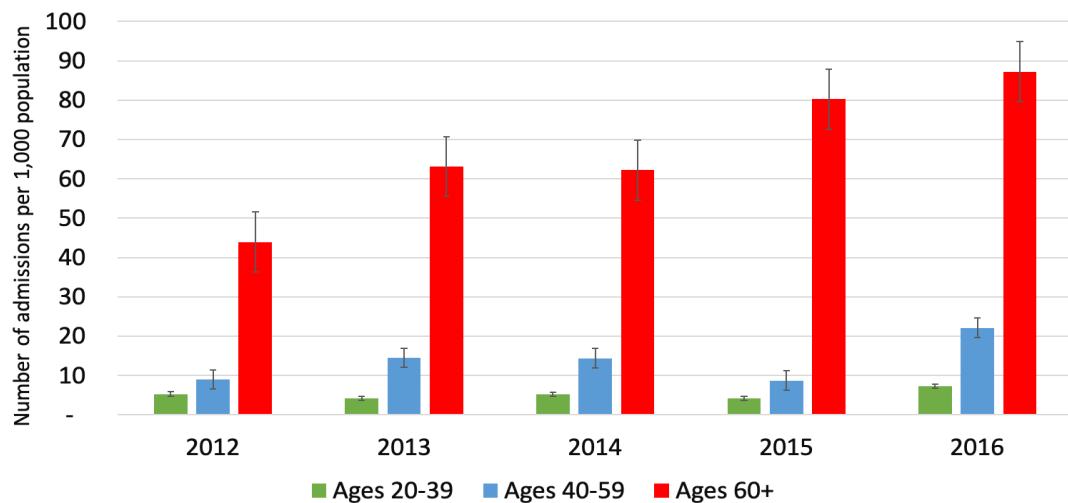
admission to hospital for respiratory disease was highest among people age 60 and above (Figure 4.4). Women had a higher rate of admission to hospital for respiratory disease compared to men.

Figure 4.3:
Rate of hospital admissions due to respiratory disease compared to Ontario, 2012-2016



Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

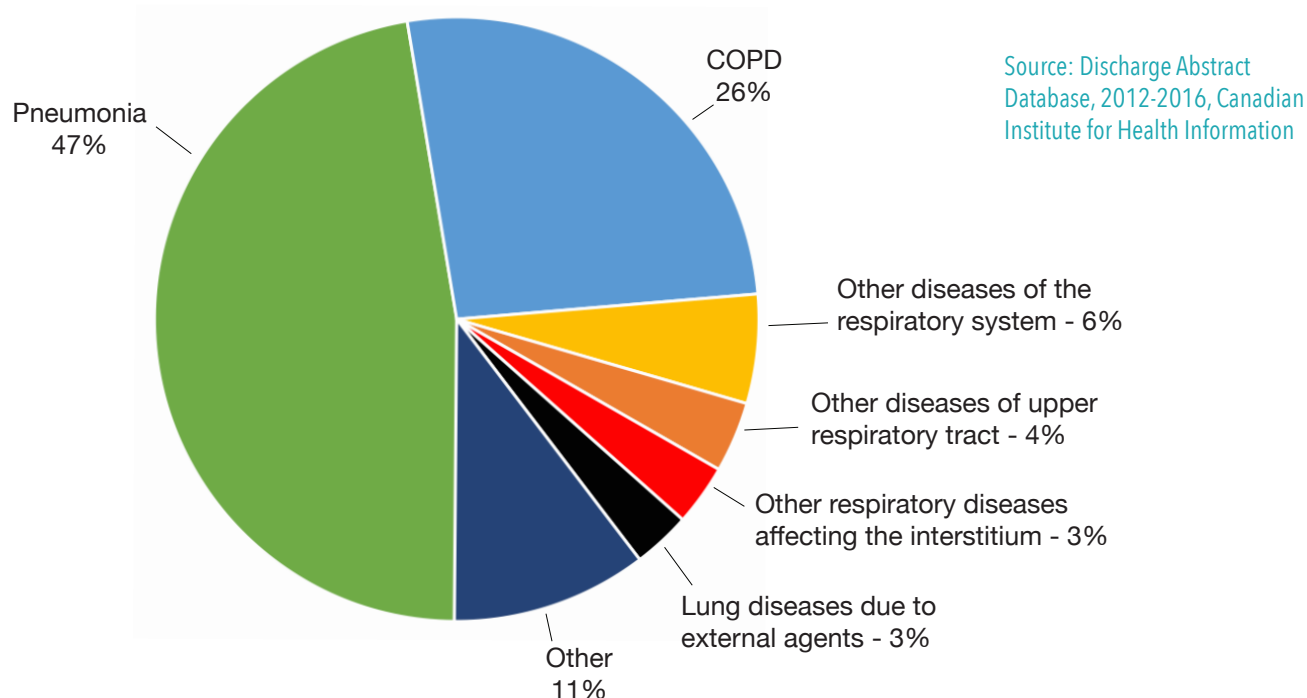
Figure 4.4:
Rate of hospital admissions due to respiratory disease by age group, 2012-2016



Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

Pneumonia accounted for 47% of all hospital admissions related to respiratory disease (Figure 4.5).

Figure 4.5: Causes of hospital admissions due to respiratory disease, 2012-2016



Explanations

Lung diseases due to external agents: when the lung is injured by breathing in chemicals, gases, fumes or vapours. Also includes illness caused by breathing in vomit or food.

Other respiratory diseases affecting the interstitium: includes illnesses such as pulmonary fibrosis and adult respiratory distress syndrome.

Other diseases of the respiratory system: when disease develops in the lungs from rheumatoid arthritis or other rheumatoid diseases. Also includes respiratory failure and lung illnesses that happen after surgery.

Other diseases of upper respiratory tract: when there is chronic illness of the upper respiratory tract such as chronic sinusitis or chronic tonsillitis. Also includes peritonsillar abscess.

CHRONIC DISEASES

Chronic diseases are illnesses that last for a long time and usually require ongoing attention or treatment. They include things like ischemic heart disease, chronic obstructive pulmonary disease (COPD), and diabetes. Chronic diseases can be well managed, meaning they don't limit someone's ability to do daily activities. They can also be progressive, meaning that they get worse over time, and affect people's daily life.

Many chronic diseases can be prevented. Chronic diseases have modifiable risk factors (e.g. things that people can control such as whether they smoke cigarettes) and non-modifiable risk factors (e.g. things that you cannot control such as your age or gender) (2). The most important modifiable risk factors for chronic disease include diet, physical activity, and cigarette smoking. In Sioux Lookout area

these risk factors are heavily influenced by geography, living conditions, income, and education – which in turn are influenced by colonization and loss of traditional practices required for health (3). This has resulted in high rates of cigarette smoking, poor diets, and low physical activity – all of which put people at higher risk of developing a chronic disease.

Once someone has a chronic disease, visits to the emergency department or hospital can be prevented if the disease is managed well. By understanding what the burden of chronic disease is, we can help to understand where to focus our efforts in keeping people healthy.

The chronic diseases highlighted in this section include ischemic heart disease, stroke, COPD, asthma, diabetes, and arthritis.

Emergency Department Visits

There were 1650 emergency department visits related to chronic disease throughout 2012-2016. The rate of visits to the emergency department for chronic diseases increased between 2012 and 2016, with the highest rate among people aged 60 and above (Figure

5.0). There were on average 330 emergency department visits each year during 2012-2016. There was no difference in the overall rate of visits to the emergency department for chronic diseases between men and women.

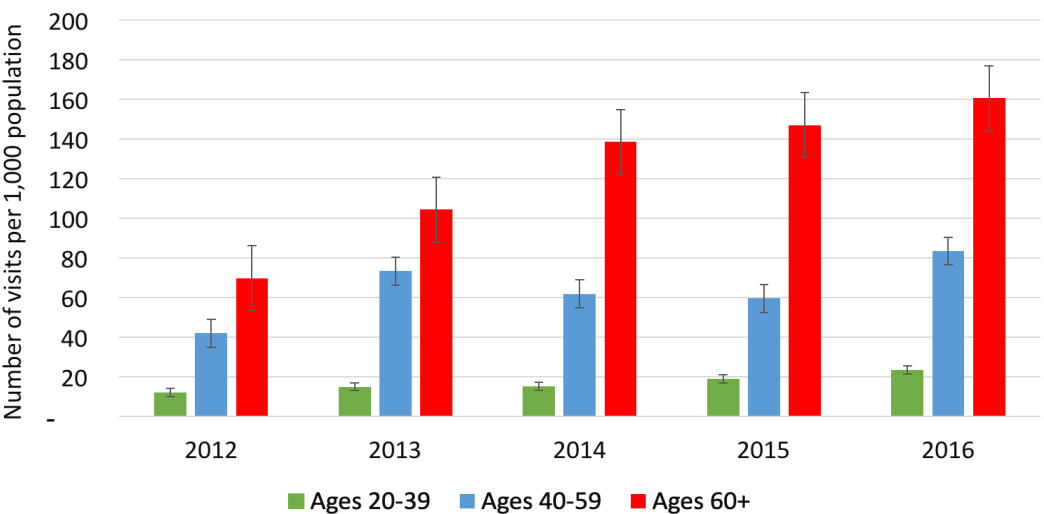


Figure 5.0: Rate of emergency department visits due to certain chronic diseases compared to Ontario, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

Diabetes had the highest rate of visits to the emergency department among chronic diseases (Figure 5.1) followed by arthritis.

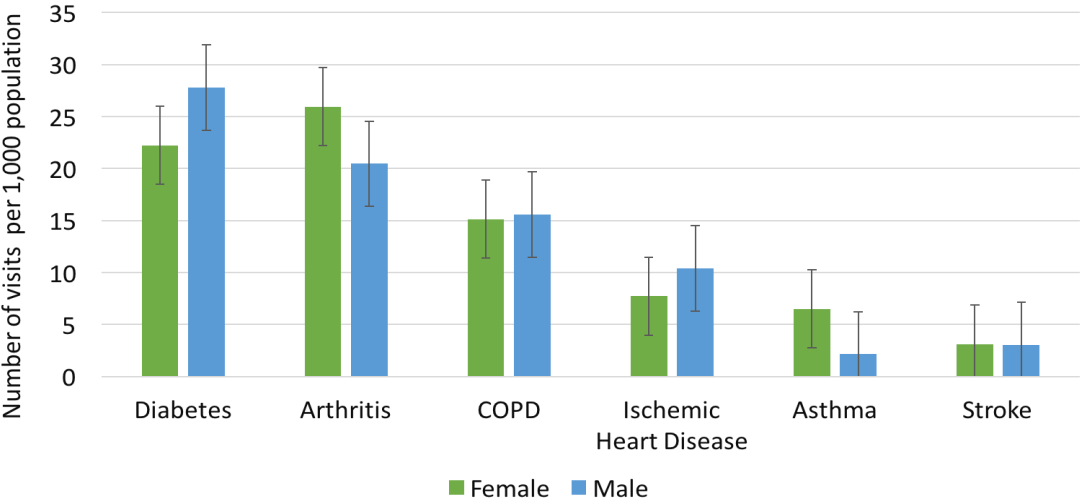


Figure 5.1: Rate of emergency department visits for certain chronic diseases by gender, 2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information

Hospitalization

There were 863 hospital admissions associated with chronic disease throughout 2012-2016, accounting for approximately 15% of all hospital admissions during this time period. **The rate of admission to hospital for certain chronic**

diseases was almost twice as high compared to the rate for Ontario (Figure 5.2). People aged 60 and above had the highest rate of admission to hospital for chronic disease (Figure 5.3).

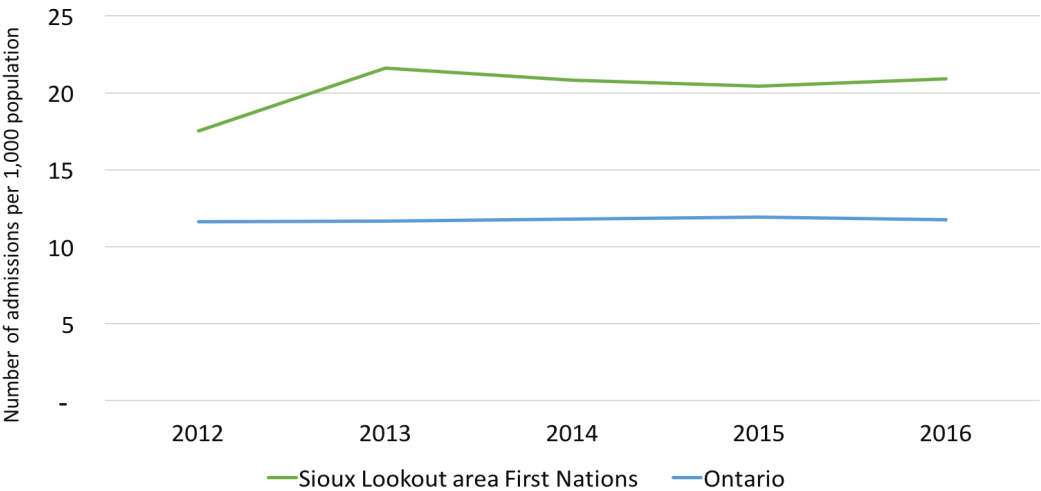


Figure 5.2: Rate of hospital admissions for certain chronic diseases compared to Ontario, 2012-2016

Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

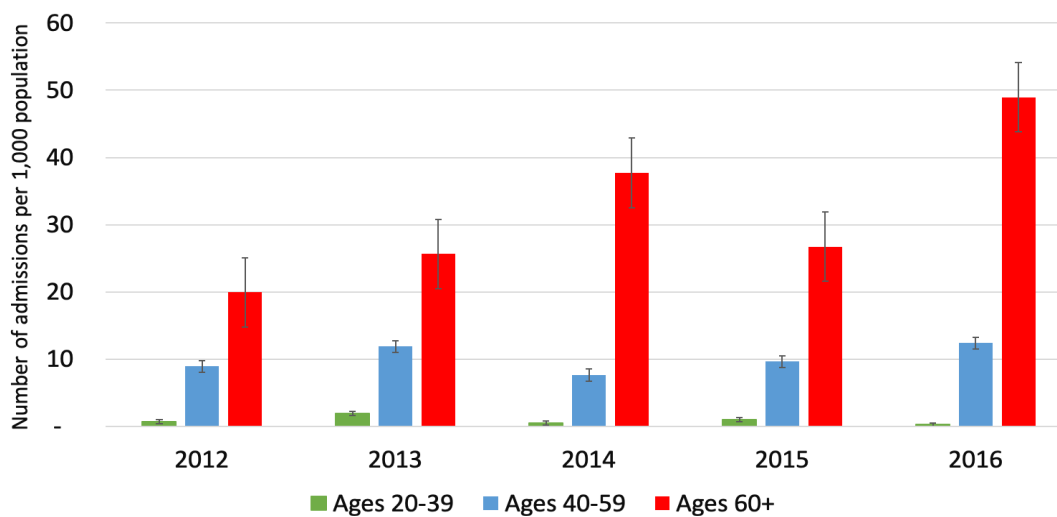


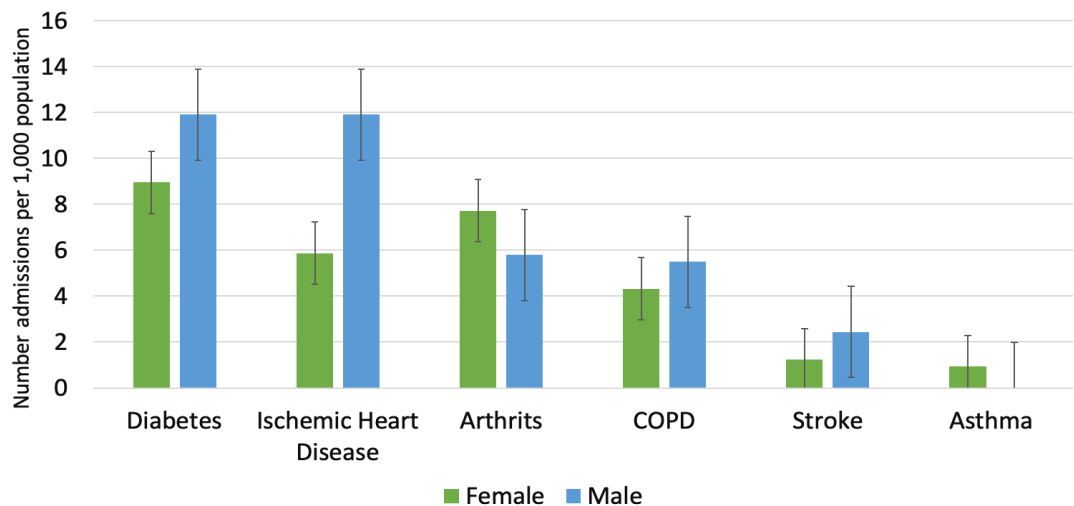
Figure 5.3:
Rate of hospital admission for certain chronic diseases by age group, 2012-2016

Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

Diabetes and ischemic heart disease had the highest rates of admission for chronic disease. Men had a significantly higher rate of admission to hospital for ischemic heart disease.

Figure 5.4:
Rate of hospital admissions for certain chronic diseases by gender, 2016

Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information



Jeremy Naveau, Brunswick House

DIABETES HIGHLIGHT

Diabetes mellitus, also known as diabetes, is an illness that is caused by high blood sugars. If diabetes goes unmanaged, it can lead to severe illness of the kidneys, heart, eyes, and other blood vessels. Addressing high rates of diabetes is a priority for many First Nations in Sioux Lookout area. Diabetes was the fourth leading cause of death between 1992 and 2014 (1). According to the Public Health Agency of Canada, diabetes is nearly three times greater for First Nations adults living on reserve and in northern communities in comparison to non-

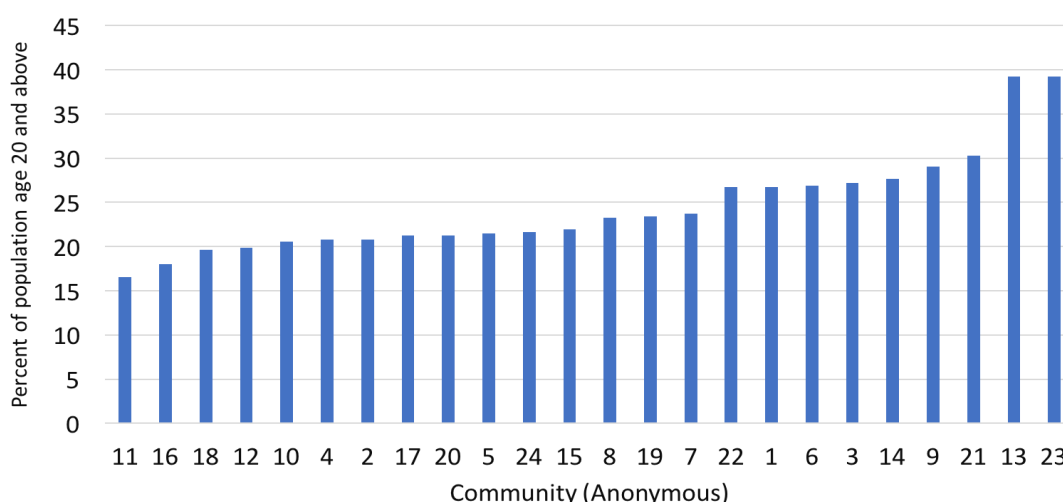
Indigenous adults (4).

In August 2019, the prevalence of diabetes among people aged 20 and above was 24%.

In other words, one quarter of people aged 20 and above were living with a diagnosis of diabetes. However, diabetes has not affected all communities equally. The range of diabetes prevalence across communities is wide, with the lowest at 16.5% and the highest at 39.3% (Figure 6.0).

Figure 6.0:
Percentage of people age 20 and above that have diabetes, August 2019.

Source: Northern physician practise, electronic medical record. Data extracted August 21, 2019.



Emergency Department Visits

When diabetes is not managed well, it can lead to illnesses that result in needing to be assessed at a hospital. There are many underlying factors that contribute to whether a person’s illness is managed well – for example, access to primary health care, access to adequate/affordable/healthy food, access to medication, mental and emotional health, and spiritual health to name a few.

First Nations from Sioux Lookout area age 20 and above were seen in the emergency department for diabetes at a rate 3 times the Ontario average (Figure 6.1). The rate of emergency department visits for diabetes was highest among people age 60 and above (Figure 6.2). In 2015 and 2016, men had a higher rate of emergency department visits for diabetes compared to women.

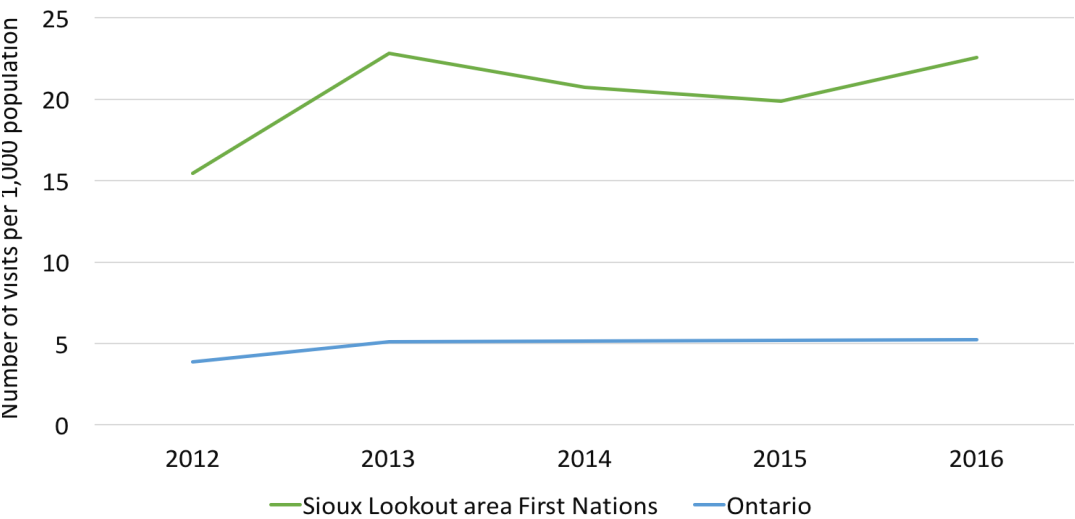


Figure 6.1: Rate of emergency department visits for diabetes compared to Ontario, age 20 and above, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

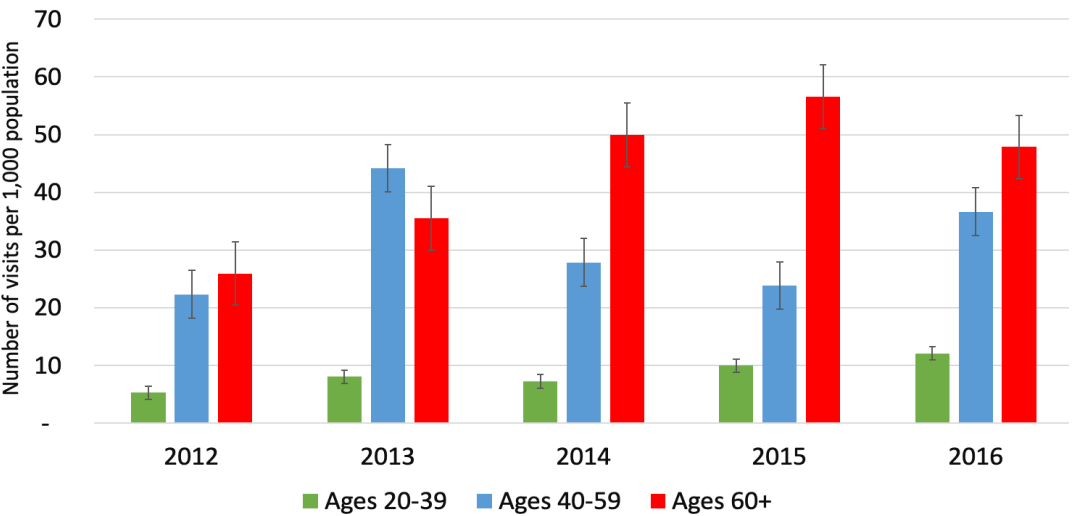


Figure 6.2: Rate of emergency department visits due to diabetes by age group, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

Hospitalization

Between 2012 and 2016, diabetes was the primary reason for 99 hospital admissions annually, or 7% of hospital admissions. **First Nations from Sioux Lookout area age 20 and above were admitted to hospital for diabetes at a rate 4 times the Ontario average** (Figure 6.3). The rate of hospital admission for diabetes was highest among people age 60 and above (Figure 6.4). There was no difference between men and women.

Because diabetes is a chronic illness that affects many parts of the body, it is difficult to determine exactly how much it influences admissions to hospital. For example, someone could be admitted to hospital following a heart attack, however, their heart attack could be as a result of having poorly managed diabetes for many years.

Figure 6.3:
Rate of hospital admissions due to diabetes compared to Ontario, age 20 and above, 2012-2016

Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

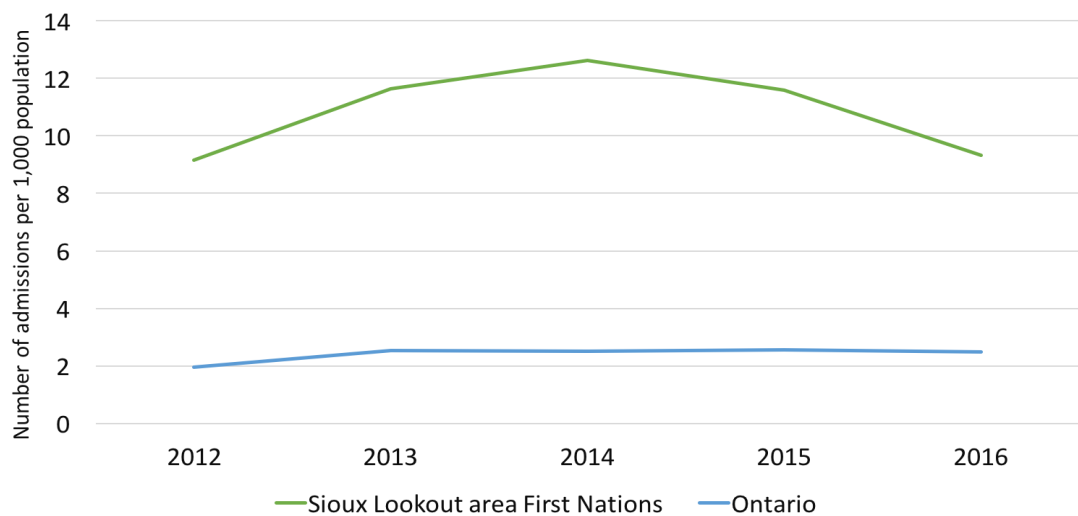
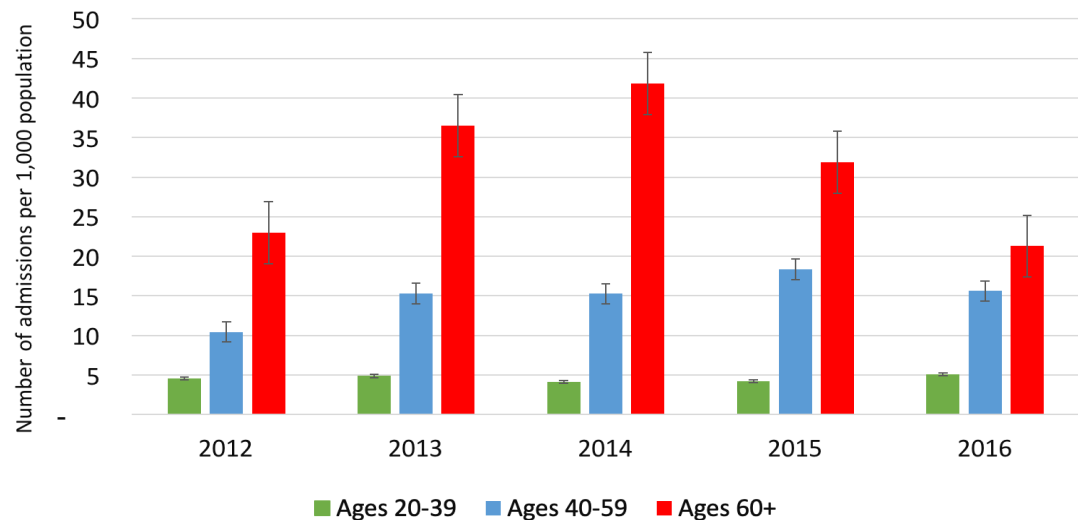


Figure 6.4:
Rate of hospital admissions due to diabetes by age group, 2012-2016

Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information



INJURIES

ALL INJURIES

Injury is the leading cause of death for First Nations in Sioux Lookout area. Between 1992 and 2014 there were 599 deaths that resulted from injury (1).

This section of the report focuses on the causes of injury that lead to emergency department visits and hospital admissions. We have divided injuries into unintentional (i.e. when a person is hurt by mistake) and intentional (i.e. when a person hurts another person or themselves on purpose).

There are many things that increase the risk of First Nations in Sioux Lookout experiencing

an injury. For example, poor infrastructure (e.g. homes, community buildings) increase the risk of injuries from falls or from broken building parts. Changing land conditions, due to things like climate change (ie. winter roads melting early) also increase the risk of injury (5).

Up to 90% of serious injuries are predictable and preventable (6). By understanding causes of injury, we can focus prevention efforts.

Emergency Department Visits

In 2016 there were 1,110 emergency department visits associated with an injury accounting for 15% of all emergency department visits. The rate of visits for injuries increased between

2012 and 2016 (Figure 7.0). First Nations from Sioux Lookout area age 20 and above were seen in the emergency department for the injuries 1.5 times the Ontario rate.

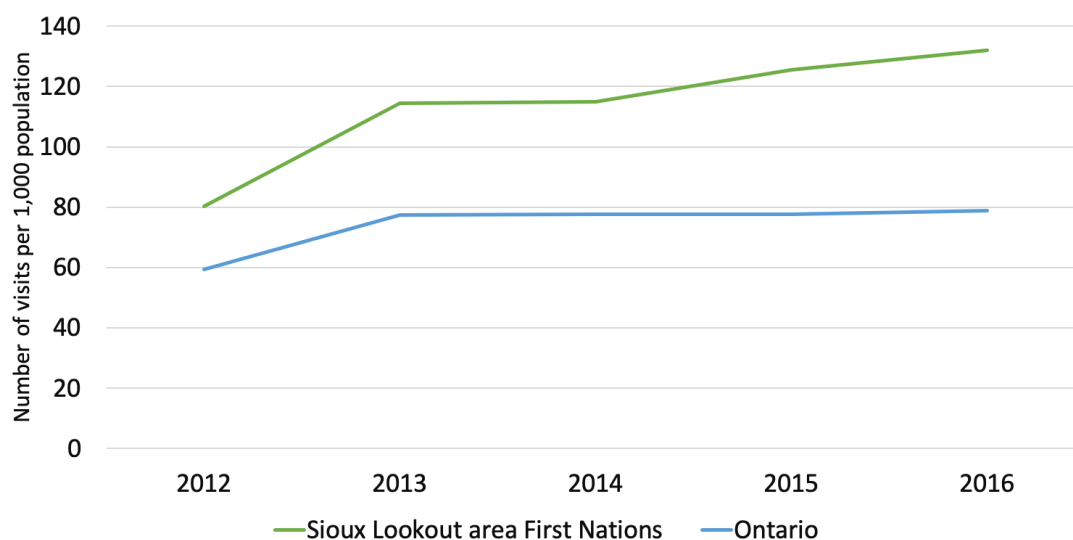


Figure 7.0: Emergency department visits associated with injury, age 20 and above, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

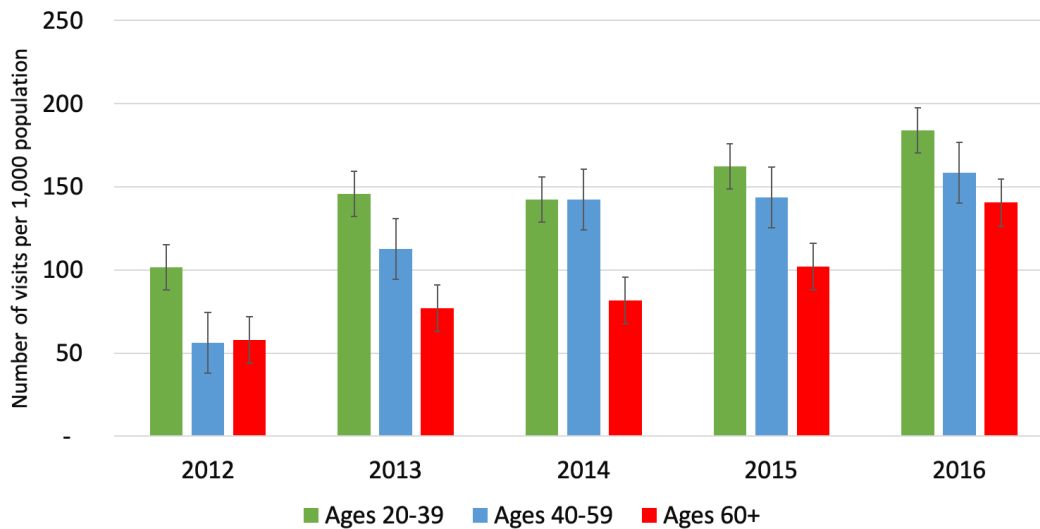


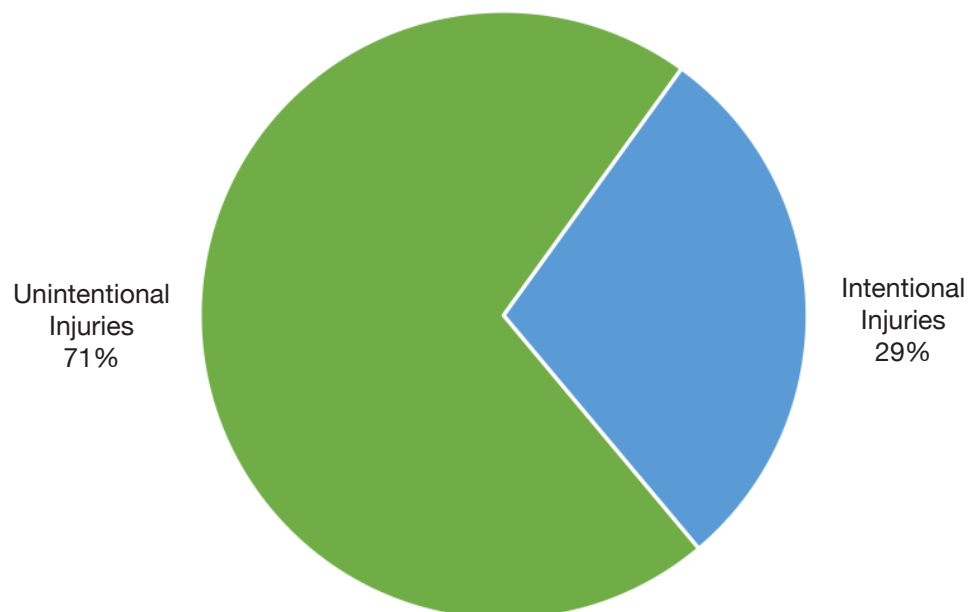
Figure 7.1:
Emergency department visits associated with injury by age group, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

Among emergency department visits associated with injury, 71% were from unintentional injuries and 29% were from intentional injuries (Figure 7.2).

Figure 7.2:
Emergency department visits associated with injury, proportion of unintentional versus intentional injury.

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

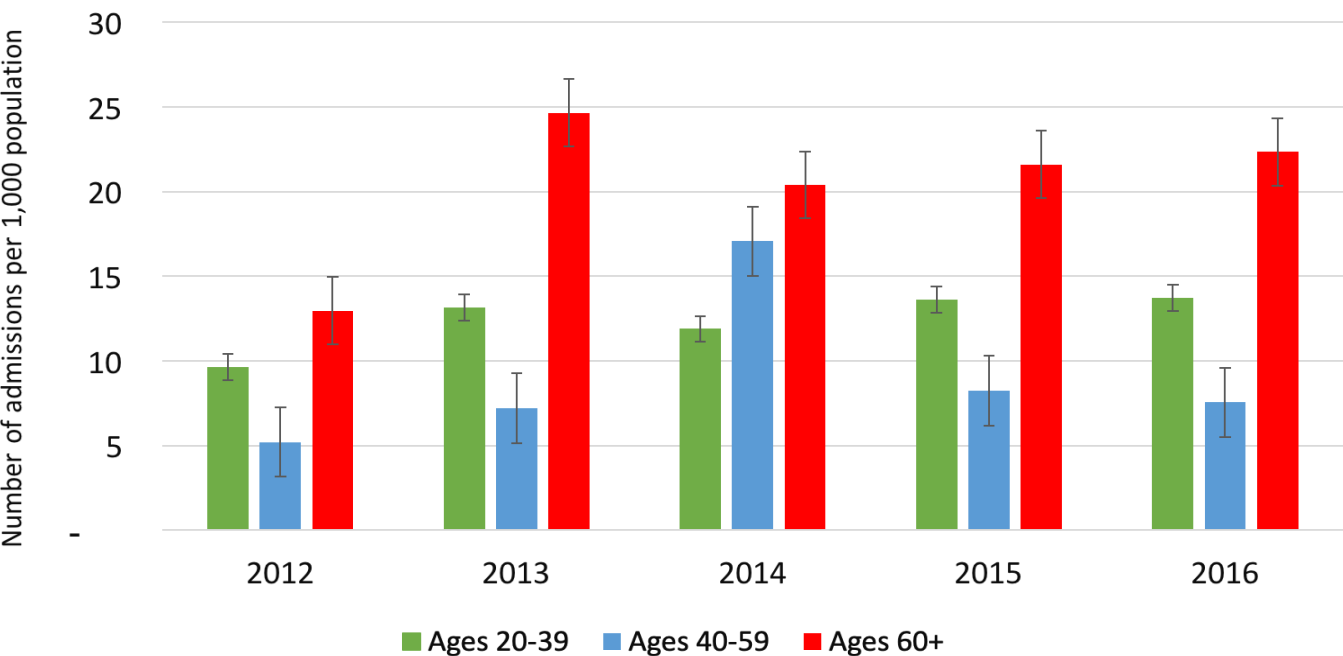


Hospitalization

In 2016, there were 86 hospital admissions as a result of injury, this is 6% of all hospital admissions. The rate of admission to hospital for injury remained relatively stable between

2012 and 2016 (Figure 7.3). There was no difference in the rate between men and women.

Figure 7.3: Rate of hospital admissions associated with injury for age 20 and above, 2012-2016



Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

Among hospital admissions associated with injury, 57% were from unintentional injuries and 43% were from intentional injuries (Figure 7.4).

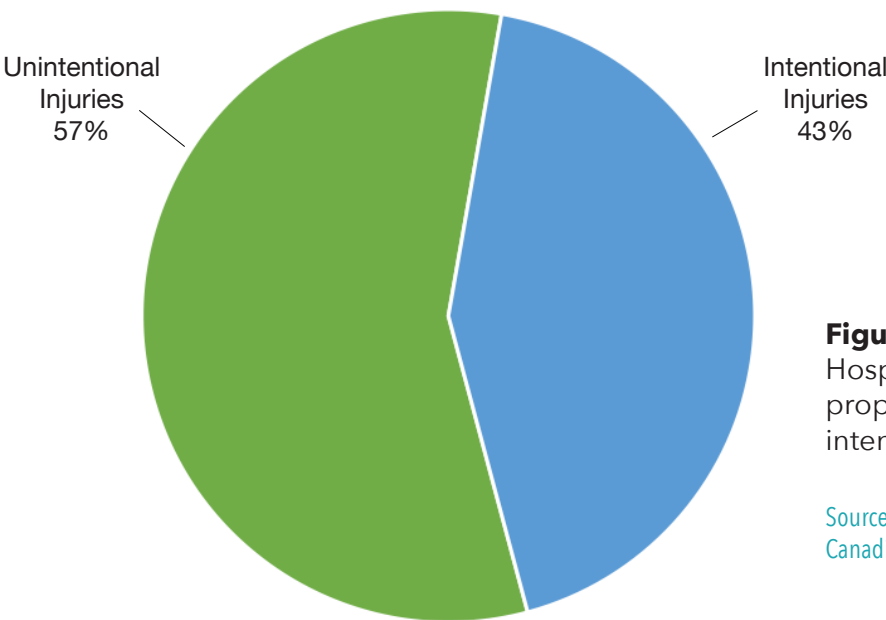


Figure 7.4: Hospital visits associated with injury, proportion of unintentional versus intentional injury.

Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information



UNINTENTIONAL INJURIES

Unintentional injuries happen by accident, and they include things such as tripping and falling down, car accidents, ski-doo accidents, being struck/hit by machinery or tools, and being struck/hit by other objects. Although they happen by accident, many unintentional injuries

can be prevented.

Unintentional injuries comprise the majority of visits to the emergency department for injuries and more than half of hospital admissions for injury.

Emergency Department Visits

In 2016, there were 833 visits to the emergency department for unintentional injuries accounting for 8% of emergency department

visits. There was an increase in the rate of visits between 2012 and 2016 (Figure 7.5).

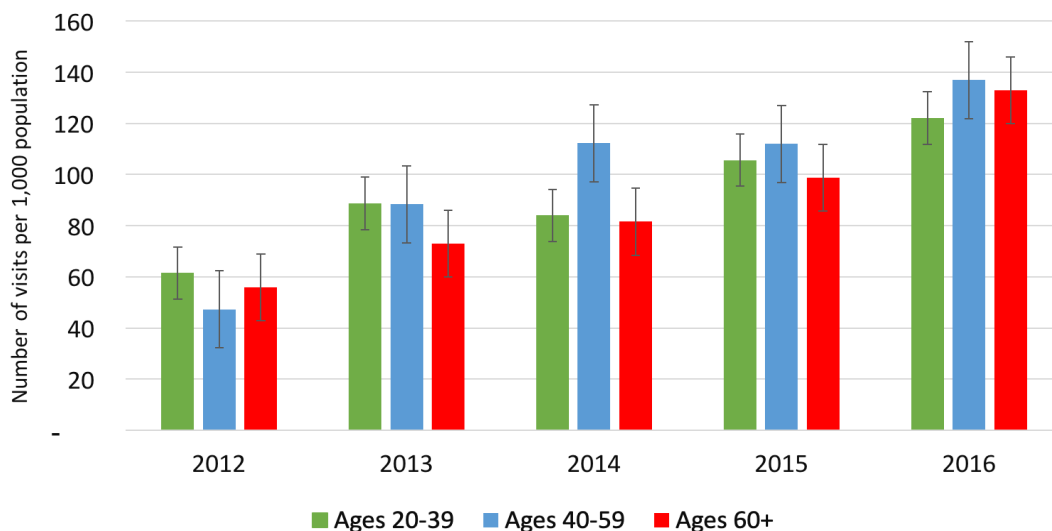
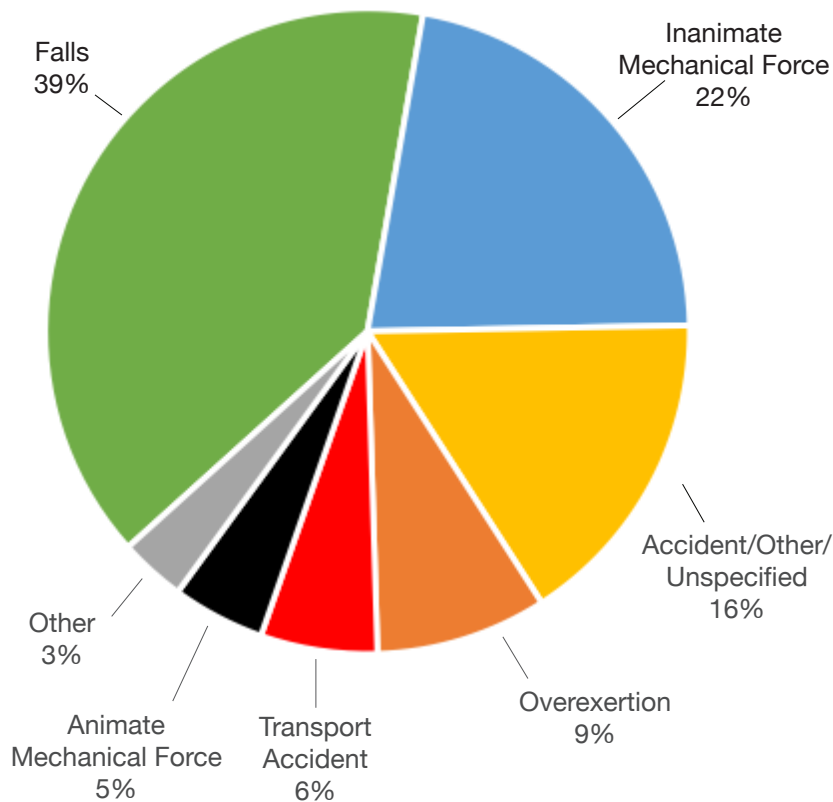


Figure 7.5:
Rate of emergency department visits from unintentional injury for age 20 and above, 2012-2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

Falls accounted for the largest number of visits to the emergency department for unintentional injuries (Figure 7.6).

Figure 7.6:
Top causes of unintentional injuries resulting in emergency department visits for people age 20 and above.



Source: National Ambulatory Care System, 2012-2016, Canadian Institute of Health Information

Of all unintentional injury emergency department visits 39% were for falls, 22% inanimate mechanical forces (contact with machinery or tools, being struck by an object, etc.), and 16 % unspecified or other accidents.

Explanations

Animate Mechanical Force

Being struck/injured by an animal (e.g. dog)
Accidentally being struck by another person

Inanimate Mechanical Force

Includes being hit by machinery/tools/debris or other objects (e.g., explosions)

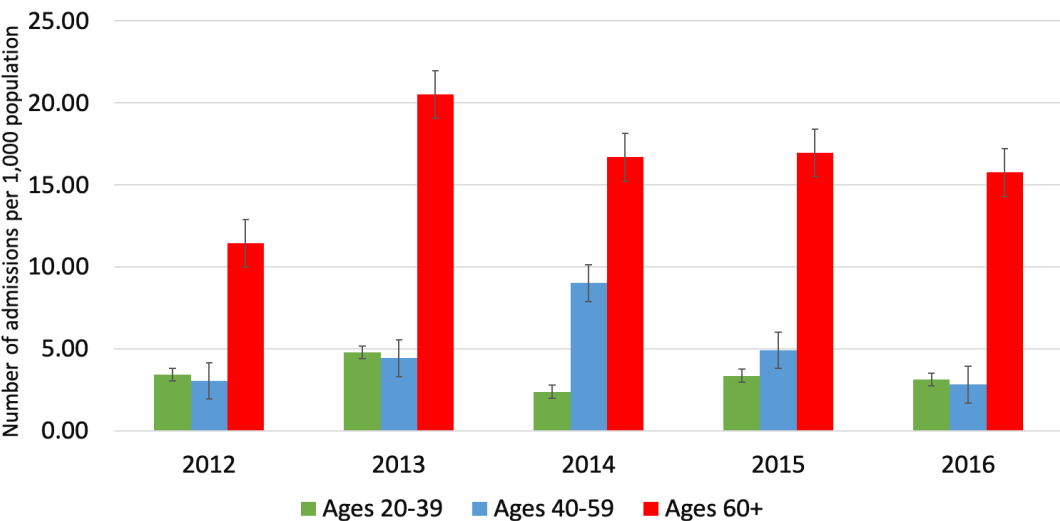
Hospitalization

In 2016, there were 44 hospital admissions for unintentional injuries. This accounted for 2% of overall hospital admissions. There was no significant change in the rate of admission

between 2012 and 2016 (Figure 7.7). Women over the age of 60 had the highest rate of admission to hospital for unintentional injury.

Figure 7.7:
Hospital admissions associated with unintentional injuries for age 20 and above, 2012-2016

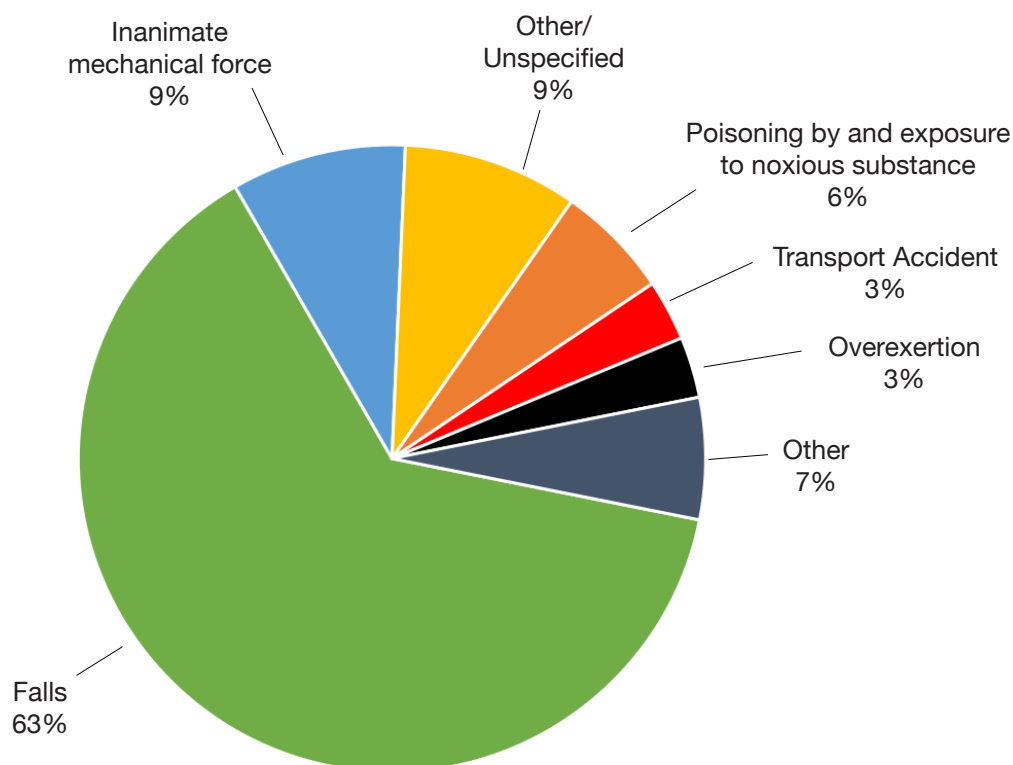
Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.



Chas, Sandy Lake

Falls accounted for the largest number of hospital admissions for unintentional injury (Figure 7.8). The rate of hospital admission for falls was twice as high among women compared to men.

Figure 7.8: Causes of unintentional injuries resulting in hospital admission for age 20 and above, 2012-2016.



Source: National Ambulatory Care System, 2012-2016, Canadian Institute of Health Information

INTENTIONAL INJURIES

Intentional injuries are things that happen from a deliberate act of harm to oneself or to another. The rate of visits to the emergency department and the rate of admission to

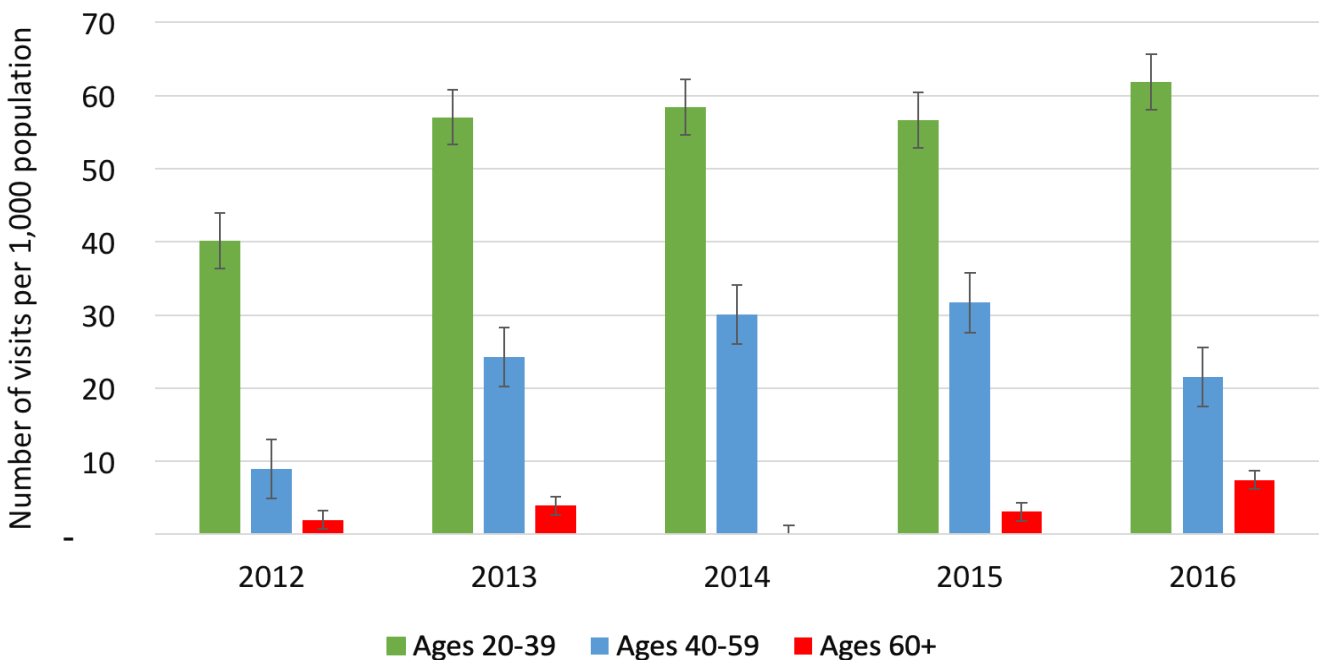
hospital for intentional injury has increased between 2012 and 2016 for people age 20 and above in Sioux Lookout area First Nations.

Emergency Department Visits

In 2016, there were 277 emergency department visits associated with intentional injury. This accounted for 2.6% of all emergency department visits. There was an increase in the

rate of visits between 2012 and 2016 (Figure 7.9), and was highest among people aged 20 to 39. There was no significant difference in the rate between men and women.

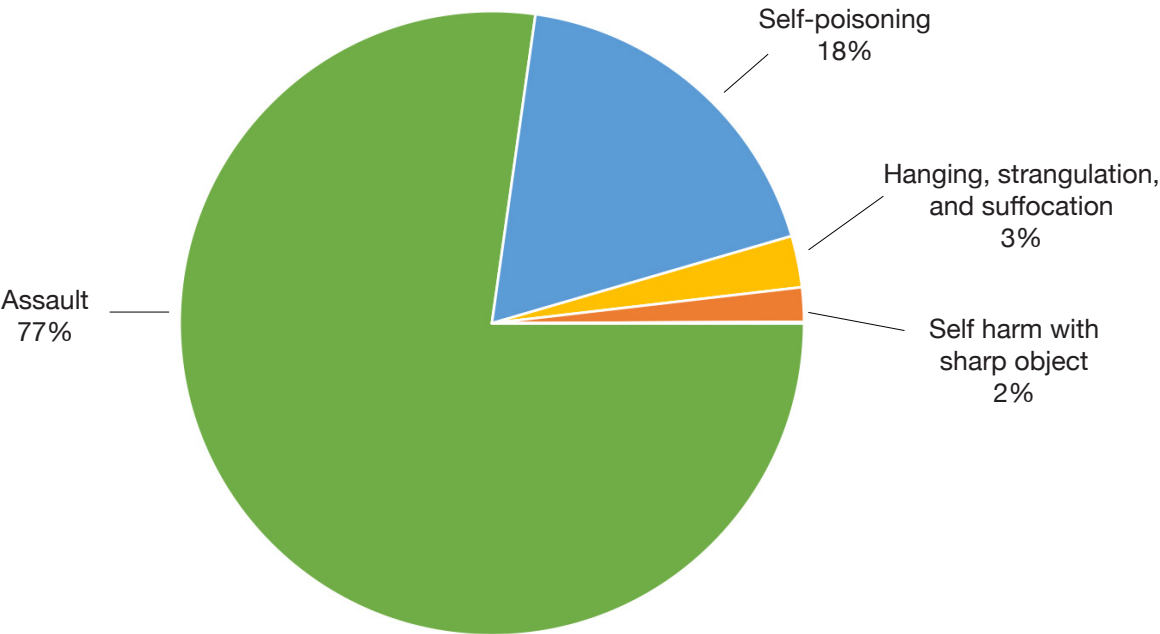
Figure 7.9: Rate of emergency department visits from intentional injury, 2012-2016



Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.

Assault accounted for the largest number of emergency department visits for intentional injury (Figure 7.10). Self harm accounted for the remaining visits (23%). Among visits for self harm, poisoning accounted for the majority of visits and was significantly higher among women compared to men.

Figure 7.10: Causes of intentional injuries resulting in emergency department visits for age 20 and above, 2012-2016.



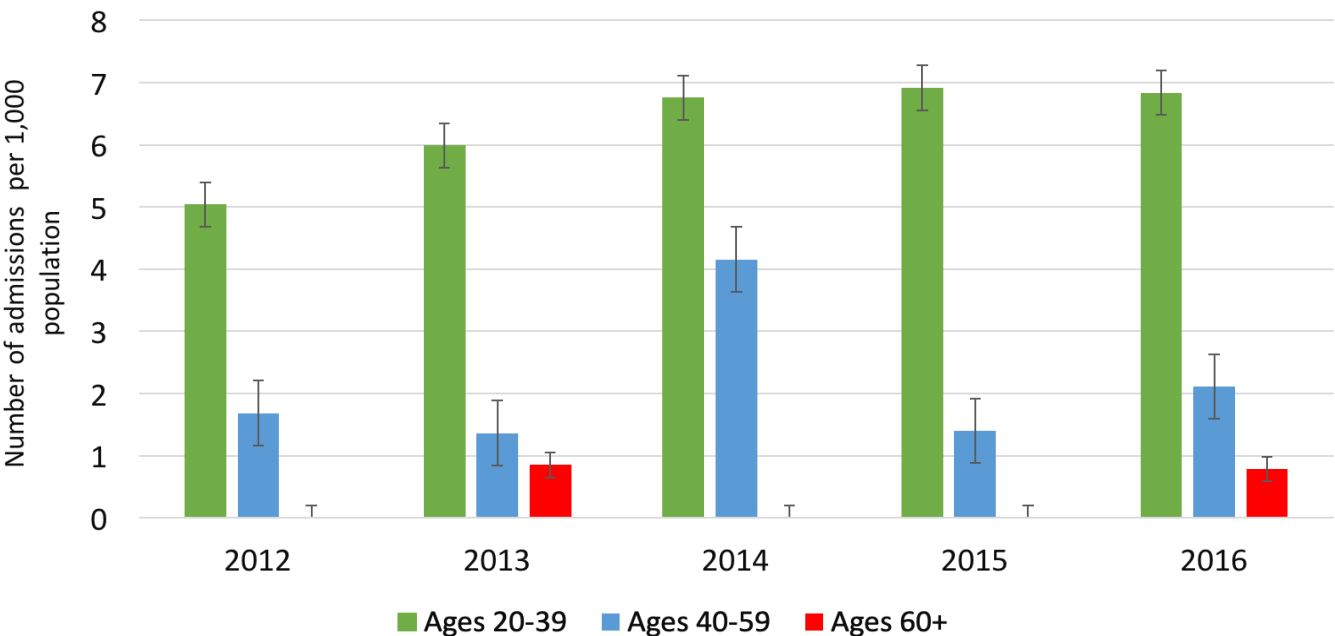
Source: National Ambulatory Care System, 2012-2016, Canadian Institute of Health Information

Hospitalization

In 2016, there were 42 hospital admissions associated with intentional injury. This accounted for 2% of all hospital admissions. There was an increase in the rate of hospital admissions between 2012 and 2016 (Figure 7.11)

and the rate was highest among people age 20 to 39. There was no significant difference in the overall rate between men and women.

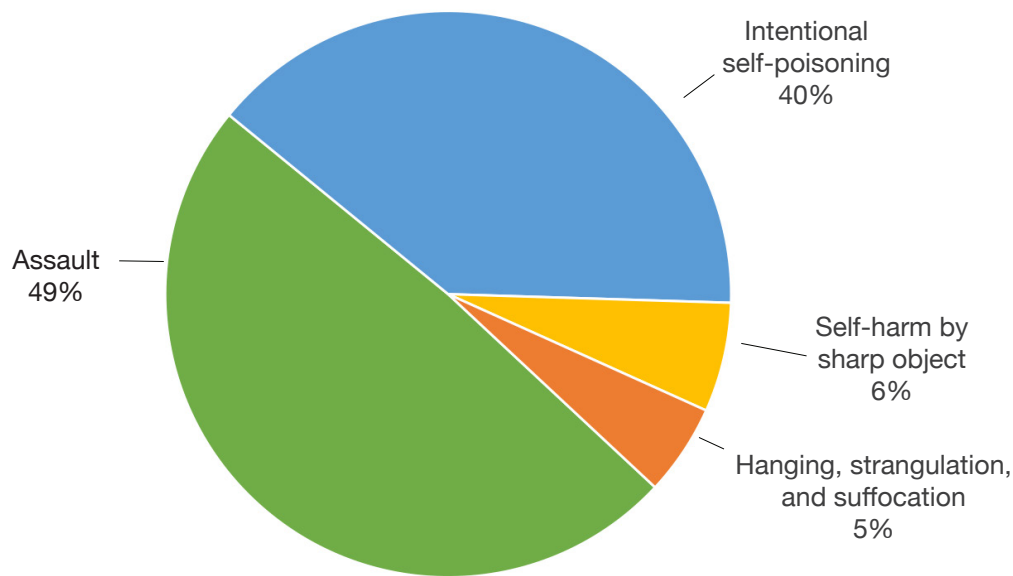
Figure 7.11: Hospital admissions for intentional injuries by age group, 2012-2016



Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

Assault accounted for the largest number of hospital admissions for intentional injury (Figure 7.12). Men had a significantly higher rate of admission to hospital for assault compared to women. Self harm accounted for the remaining hospital admissions attributed to intentional injury. Among admissions for self harm, poisoning accounted for the majority of visits and was significantly higher among women compared to men.

Figure 7.12: Causes of intentional injuries resulting in hospital admission for age 20 and above, 2012-2016.



Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

INFECTIOUS DISEASES

Infectious diseases are illnesses that are caused by organisms – these could be bacteria, viruses, fungi, or parasites. Some infectious diseases can be passed from person to person (e.g. influenza) whereas others are passed from insect/animal to human (e.g. Lyme disease). Some infectious diseases are caught by eating contaminated food (e.g. salmonella) and still others can be caught from the environment (e.g. blastomycosis).

Some infectious diseases can be prevented by vaccines. Infectious diseases that are caused by bacteria can be treated with antibiotics.

Infectious diseases that are caused by viruses can be treated with anti-viral medications (e.g. influenza).

It is challenging to capture the true burden of infectious diseases. For example, pneumonia can be caused by different organisms but is included in statistics for respiratory diseases. This section of the report includes information on emergency department visits and hospital admissions for infectious diseases not included in other areas of the report. It also includes statistics on reportable diseases.

Emergency Department Visits

In 2016, there were 184 visits to the emergency department for infectious and parasitic diseases. This made up 2% of emergency department visits. The rate of visits to the emergency department for infectious diseases was highest among people aged 60 and above (Figure 8.0).

Emergency department visits for infectious diseases increased between 2012 and 2016. Women had a higher rate than men for emergency department visits for respiratory disease.

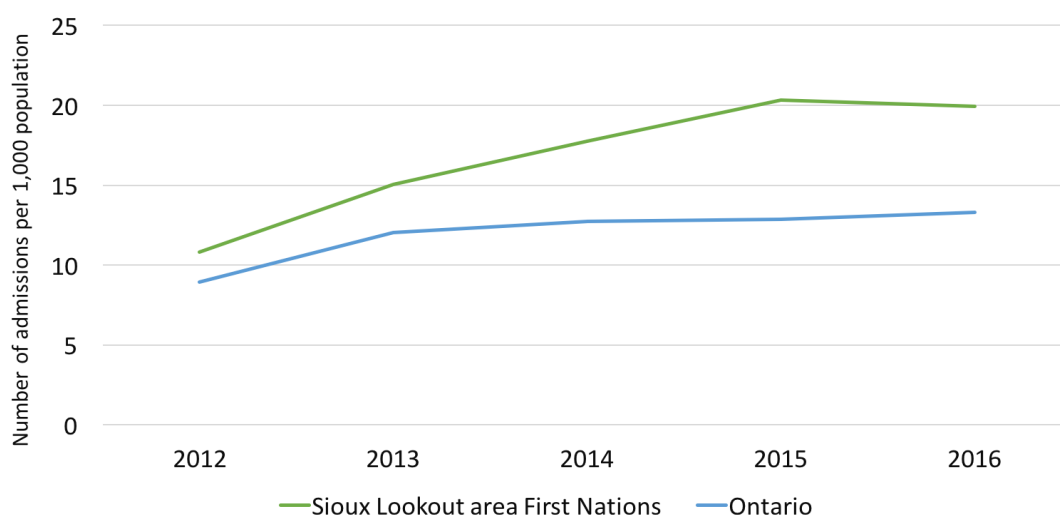
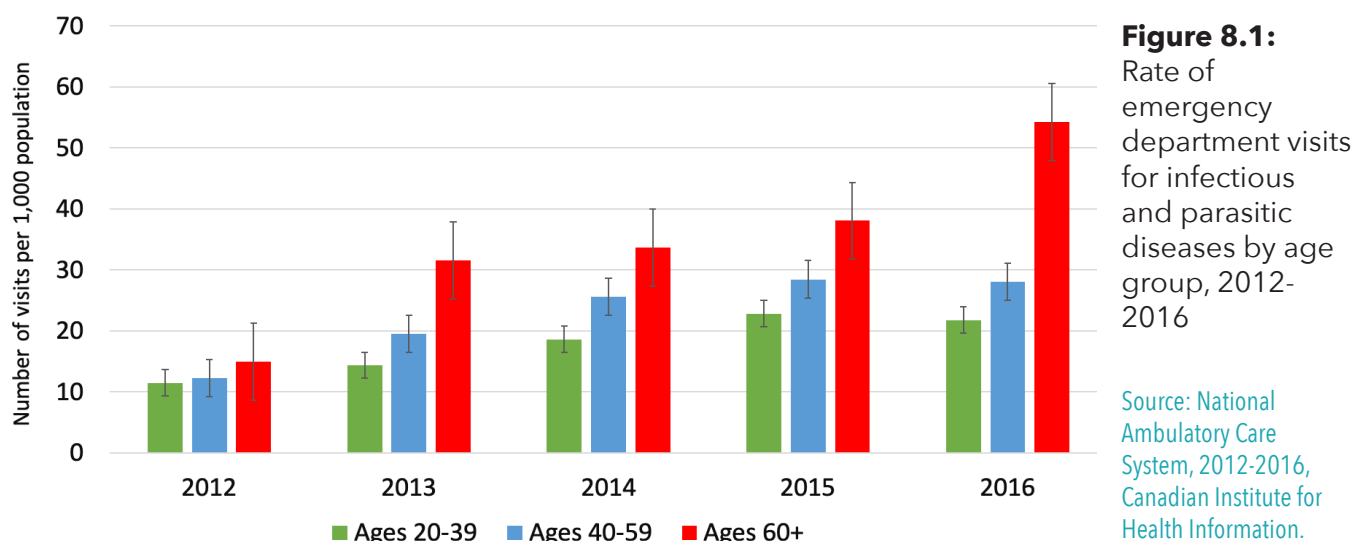


Figure 8.0:
Rate of
emergency
department visits
for infectious
and parasitic
diseases
compared to
Ontario, 2012-
2016

Source: National Ambulatory Care System, 2012-2016, Canadian Institute for Health Information.



Infections of the gastrointestinal system accounted for the highest number of visits to the emergency department. This was followed by other viral infections and sepsis.

Hospitalization

In 2016, there were 49 admissions to hospital for infectious and parasitic diseases. This made up 3% of hospital admissions. The rates of hospitalization for infectious diseases were highest among people aged 60 and above (Figure 8.2). There was no significant difference in the rate between women and men.

People age 20 and above from Sioux Lookout area First Nations were admitted to hospital for infectious and parasitic diseases 6-7 times the Ontario rate. Approximately half of admissions for infectious and parasitic diseases were for sepsis.

Figure 8.2:
Rate of hospitalizations for infectious and parasitic diseases compared to Ontario, 2012-2016

Source: Discharge Abstract Database, 2012-2016, Canadian Institute for Health Information

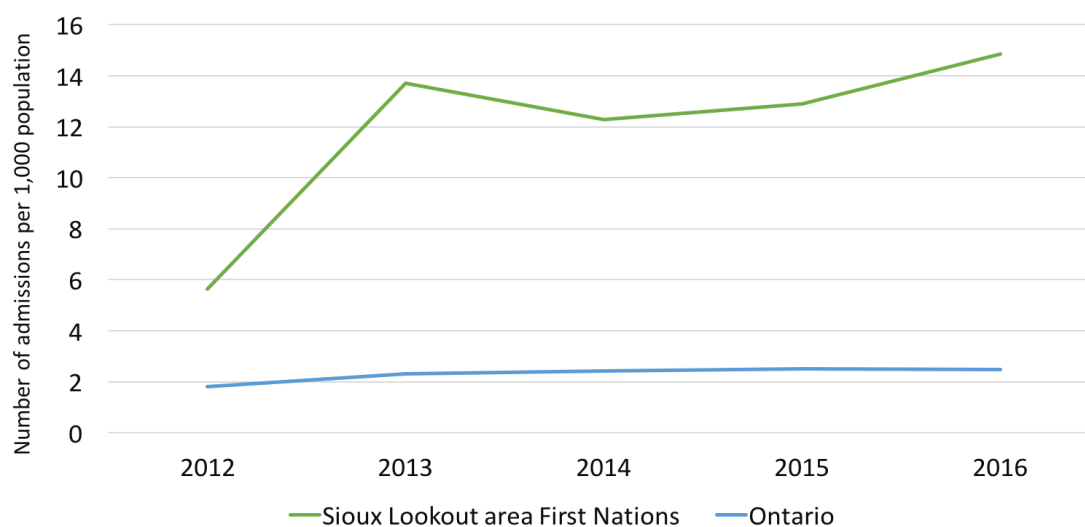
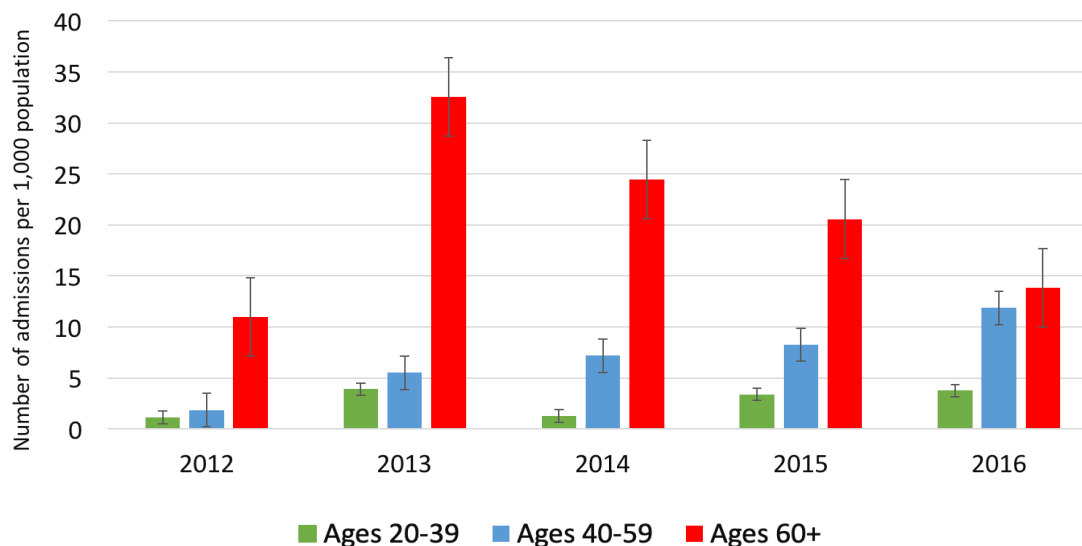


Figure 8.3:
Rate of
hospitalization
for infectious
and parasitic
diseases by age
group, 2012-
2016

Source: Discharge
Abstract Database,
2012-2016, Canadian
Institute for Health
Information



REPORTABLE DISEASES

In Ontario, health care providers and laboratories are required to report certain infectious diseases to public health. These are called “reportable diseases”. For First Nations on reserve, public health units forward these reports to First Nations and Inuit Health Branch for public health management. The statistics for reportable diseases are followed over time – this helps to see whether an outbreak is starting or where to focus prevention efforts.

The following section of the report includes information on the top reportable diseases for First Nations in the Sioux Lookout area. These include:

- Chlamydia
- Gonorrhea
- Hepatitis C virus
- Invasive group A streptococcus

Chlamydia and Gonorrhea

Chlamydia and gonorrhea are sexually transmitted infections that are caused by two different bacteria. Many people that have chlamydia and/or gonorrhea have no symptoms and may not know that they have the infections. If the infections are not treated with antibiotics, they may lead to infertility.

Between 2012 and 2016, there were 1,256

infections with chlamydia that were reported to public health. **The rate of infection was approximately ten times higher than the Ontario rate** (Figure 8.4). It was also significantly higher among women compared to men – although this may be related to more testing done among women (Figure 8.5).

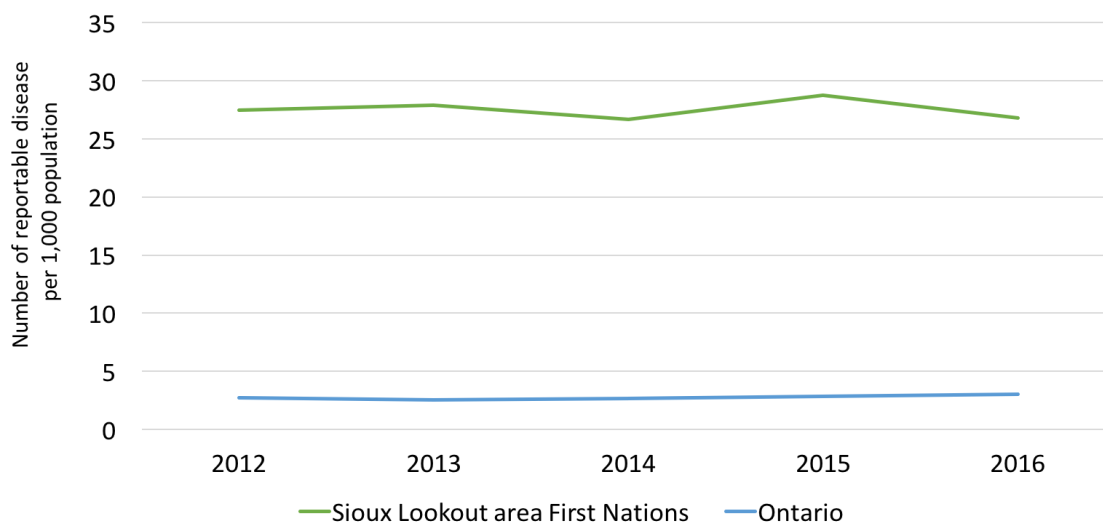


Figure 8.4:
Rate of reported cases of chlamydia compared to Ontario, 2012-2016

Source: Reportable diseases, 2012-2016, First Nations and Inuit Health Branch, Ontario Region.

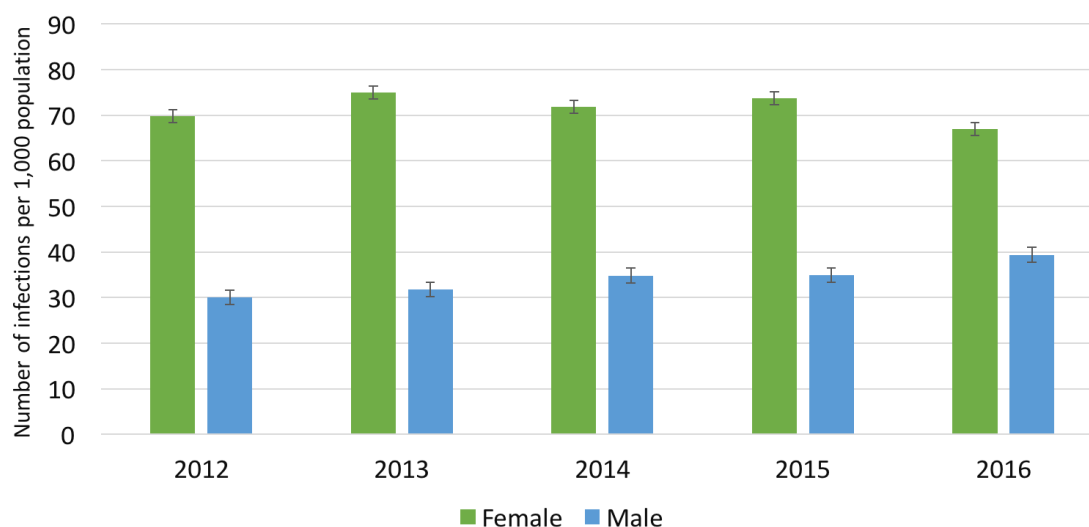


Figure 8.5:
Rate of reported cases of chlamydia, by gender, 2012-2016

Source: Reportable diseases, 2012-2016, First Nations and Inuit Health Branch, Ontario Region.

Between 2012 and 2016, there were 233 individuals diagnosed with gonorrhea. The rate of gonorrhea was significantly higher among women than men (Figure 8.7). This is likely because more women are tested.

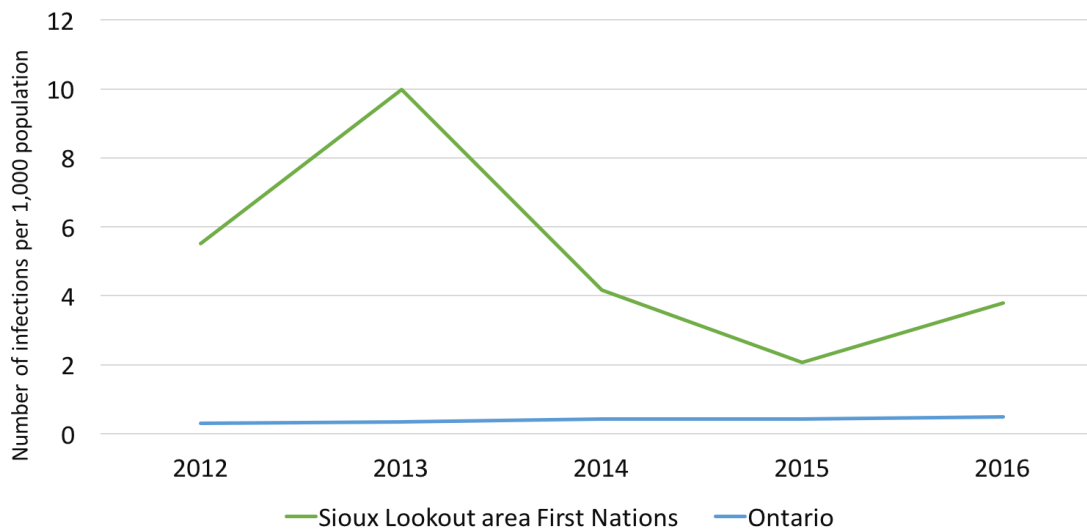


Figure 8.6:
Rate of reported cases of gonorrhea, compared to Ontario 2012-2016

Source: Reportable diseases, 2012-2016, First Nations and Inuit Health Branch, Ontario Region.

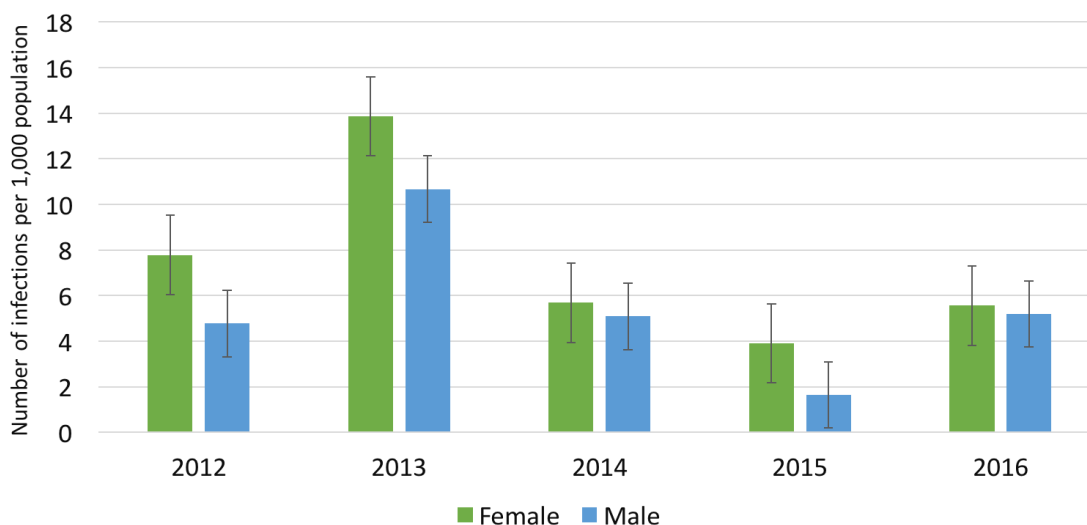


Figure 8.7:
Rate of reported cases of gonorrhea, by gender, 2012-2016

Source: Reportable diseases, 2012-2016, First Nations and Inuit Health Branch, Ontario Region.

Hepatitis C

Hepatitis C is caused by a virus that is passed between people. The blood from someone with the virus must directly enter the blood from someone else for the virus to be passed on.

Many people with hepatitis C do not have any signs and symptoms and may not know that they have the infection. The only way to find out is to have a blood test done.

For some people, their body is able to fight off

the infection and get rid of the virus without taking medication. Many people, however, develop chronic hepatitis C infection. There are medications that can treat and cure hepatitis C infection.

Between 2012 and 2016, there were 287 newly reported cases of hepatitis C. The rate of new infections is significantly higher than the Ontario rate. (Figure 8.8).

Figure 8.8:
Rate of newly reported cases of hepatitis c, compared to Ontario, 2012-2016

Source: Reportable diseases, 2012-2016, First Nations and Inuit Health Branch, Ontario Region.

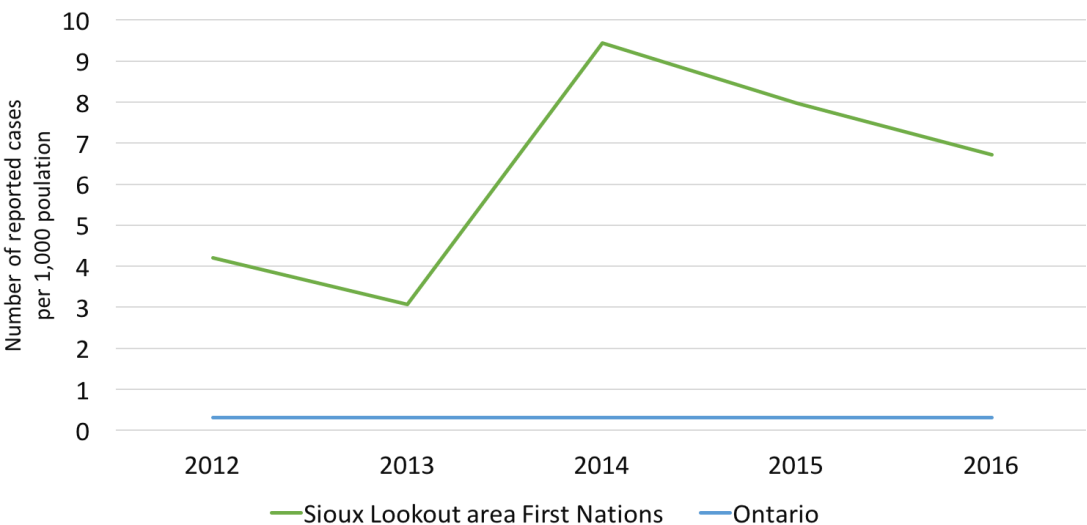
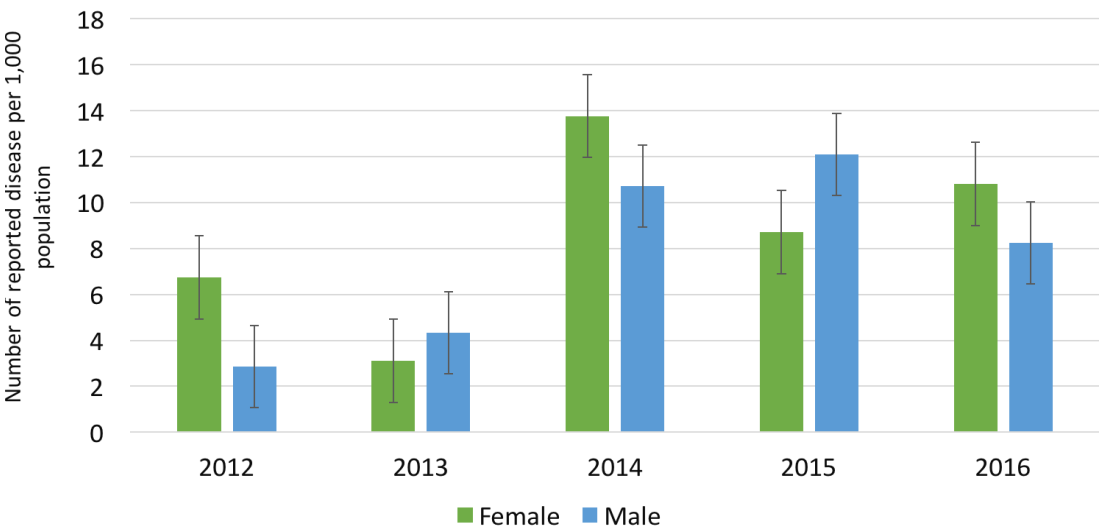


Figure 8.9:
Rate of newly reported cases of hepatitis C, by gender, 2012-2016

Source: Reportable diseases, 2012-2016, First Nations and Inuit Health Branch, Ontario Region.



Invasive Group A Streptococcus

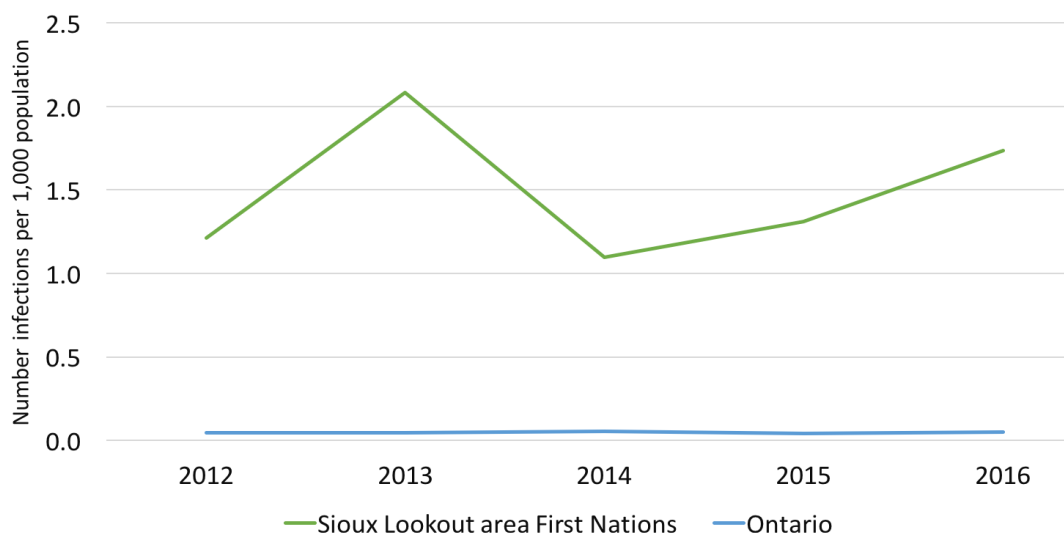
Group A streptococcus is a bacterium that can cause a range of infections from strep throat to skin infections. When the bacteria infects places in the body that are normally considered sterile (such as the blood or fluid in the brain), it is considered “invasive”. Only invasive

infections are reported to public health.

Between 2012 and 2016, there were 68 cases of invasive group A streptococcus. The rate of infections was significantly higher than the Ontario rate (Figure 8.9)

Figure 8.9:
Rate of reported cases of invasive Group A streptococcus, compared to Ontario, 2012-2016

Source: Reportable diseases, 2012-2016, First Nations and Inuit Health Branch, Ontario Region.



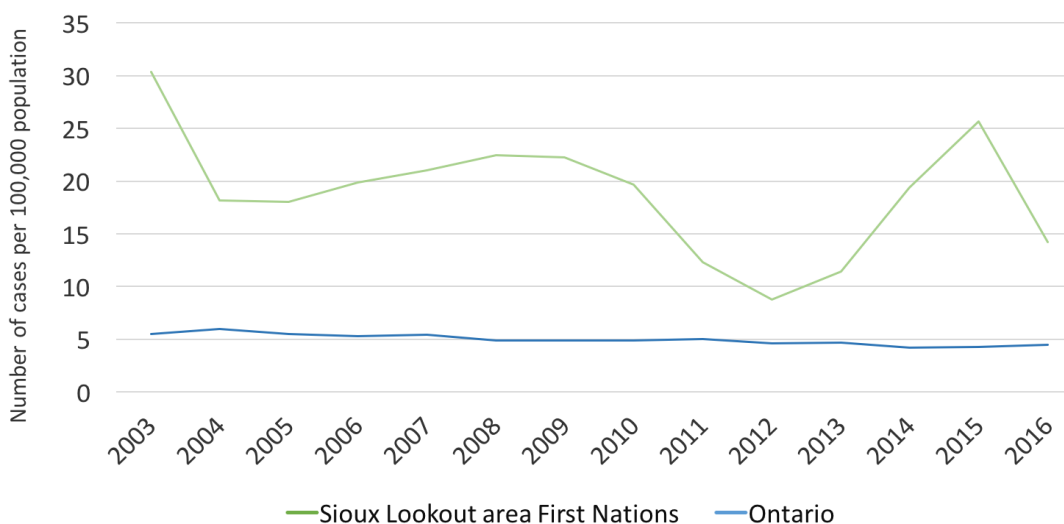
Tuberculosis

Tuberculosis is caused by a bacteria that can be passed through the air between someone who is sick with the disease to someone else. Although rates of tuberculosis among Sioux

Lookout area First Nations have decreased significantly over the last two decades, the rate of infection is still higher than the Ontario rate (Figure 8.10).

Figure 8.10:
Three year rolling average of active tuberculosis cases compared to Ontario, 2003-2016

Source: Tuberculosis surveillance system, 2003-2016. Sioux Lookout First Nations Health Authority



FINAL THOUGHTS

The Truth and Reconciliation Commission Call to Action number 19 called for measurable goals to identify and close the gaps in health outcomes between indigenous and non-indigenous people (7). This report is a small step toward defining measurable health outcomes for Sioux Lookout area First Nations.

The information presented in this report helps to tell the story of health and wellness for adults in Sioux Lookout area First Nations. While numbers are an important part of the story, they are not the only part of the story. We would like

to acknowledge the lived experience of the region and the unique burdens that illness can cause.

We hope that this report can serve as a tool in the continued struggle for Sioux Lookout area First Nations in achieving equity in access to quality health services and other underlying determinants of health. Follow-up measurement of these same indicators in the future will help us to understand if we are moving in the right direction.



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APPENDIX A: DATA SOURCES

Below outlines the different data sources used within this report. Brief limitations of the data sources are described. A more detailed summary of the analyses undertaken for this report is available on request.

Measure	Data Source	Access	Notes
Emergency Department Visits	National Ambulatory Care System	Canadian Institute for Health Information	<ul style="list-style-type: none"> • 31 communities in dataset • Data extracted using Ontario residence codes • Rate includes Ontario and Manitoba • Leading reasons include Ontario only • ICD-10 Chapters 15 and 21 excluded from analysis
Hospitalizations	Discharge Abstract Database	Canadian Institute for Health Information	<ul style="list-style-type: none"> • 31 communities in dataset • Data extracted for Ontario using residence codes • Data extracted for Manitoba using Census Subdivision • Includes Manitoba and Ontario data • ICD-10 Chapters 15 and 21 excluded from analysis
Nursing Station Visits	Service Administration Log	First Nations and Inuit Health Branch – Ontario Region	<ul style="list-style-type: none"> • 19 communities in dataset • Well visit category and “other” category excluded from analysis
Diabetes Prevalence	Oscar Electronic Medical Record	Sioux Lookout Regional Physician Services, Inc.	<ul style="list-style-type: none"> • 24 communities in dataset • Case definition for diabetes from the Canadian Primary Care Sentinel Surveillance Network
Ontario Comparators	Discharge Abstract Database, National Ambulatory Care System	Public Health Ontario	N/A
Reportable Diseases	Communicable Disease Line List	First Nations and Inuit Health Branch – Ontario Region	31 communities in dataset

APPENDIX B: DATA CATEGORIES

The table below compares the different classification systems used by hospital administrative data (International Classification of Diseases [ICD]-10), and nursing station data (Service Administration Log [SAL]). Hospital administrative data includes both emergency department visits and hospital admissions. The table only includes the categories used in this report.

How it is named in this report	ICD-10 Chapter Name (Block) <i>Examples</i>	SAL Chapter Name <i>Examples</i>
Mental health	Mental and behavioural disorders (F00-F99) <i>Mood disorders (anxiety, depression), mental and behavioural disorders due to substance use, schizophrenia</i> * Excludes self-injury	Mental health conditions <i>Mood disorders (anxiety, depression), self-injury, substance use, violence or aggressive behaviour</i>
Respiratory system	Diseases of respiratory system (J00-J99) <i>Upper respiratory tract infections, pneumonia, influenza, asthma, bronchitis</i>	Respiratory system <i>Asthma, bronchitis, pneumonia, upper respiratory tract infection</i>
Digestive system	Diseases of the digestive system (K00-K93) <i>Diseases of the mouth, stomach, intestines, appendix, liver, gallbladder</i>	Gastrointestinal system <i>Bowel obstruction, dehydration, diarrhea, constipation, peptic ulcer disease</i>
Skin/subcutaneous tissue	Diseases of the skin and subcutaneous tissue (L00-L99) <i>Skin infections, dermatitis, eczema, nail disorders</i>	Skin conditions <i>Acne, cellulitis, diaper rash, scabies, skin wounds, warts</i>
Endocrine (i.e. diabetes)	Endocrine, nutritional and metabolic diseases (E00-E90) <i>Diabetes, nutrition disorders, thyroid problems, other metabolic problems, etc.</i>	Hematology, Metabolism and Endocrine <i>Diabetes, thyroid problems, other metabolic problems, etc.</i>
Signs, Symptoms, and Abnormal Lab Findings	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99) <i>This category is assigned when no clear diagnosis has been made.</i>	N/A

How it is named in this report	ICD-10 Chapter Name (Block) <i>Examples</i>	SAL Chapter Name <i>Examples</i>
Injuries	<i>External causes of morbidity and mortality (X01-Y09, Y85-Y871)</i> <i>Accidents, intentional self-harm, assaults, etc.</i>	N/A
Infectious and Parasitic Diseases	Certain infectious and parasitic diseases (A00-B99) <i>Intestinal infectious diseases, tuberculosis, sepsis, viral hepatitis, mycoses, etc.</i>	N/A
Ear, Nose, Throat, and Mouth	N/A	Ear, Nose, Throat, and Mouth <i>Toothache, foreign body in the nose, ear infections, gingivitis</i>
Musculoskeletal system	Diseases of the musculoskeletal system and connective tissue (M00-M99) <i>Joint problems (i.e. arthritis), muscle injuries, connective tissue disorders (i.e. lupus), etc.</i>	Musculoskeletal system <i>Chronic pain, dislocations, sprain/strain, arthritis, lower back pain</i>
Genitourinary system	Diseases of the genitourinary system (N00-N99) <i>Kidney problems (kidney failure), diseases of the urinary tract, diseases of the penis/testicles, diseases of the breast, etc.</i>	Genitourinary system <i>* excludes disorders of the breast</i>

NOTES

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