Community Needs **ASSESSMENT** Summary Report

2019

DETAILED REPORT OF FINDINGS:
Chronic Disease and Injury

Health and Social Services
Haldimand and Norfolk

Report prepared by Quality, Planning, Accountability and Performance (QPAP)

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The following reports outlines results of the Haldimand Norfolk Health and Social Services (HNHSS) Community Needs Assessment (CNA) 2019. This section of the report includes detailed results and conclusions about income, employment, education, and poverty.

Community Profile

Chronic Disease

- Hospitalization rates for chronic disease in Haldimand and Norfolk were significantly higher than in Ontario for 2017 for cardiovascular disease, ischemic heart disease, and diabetes.

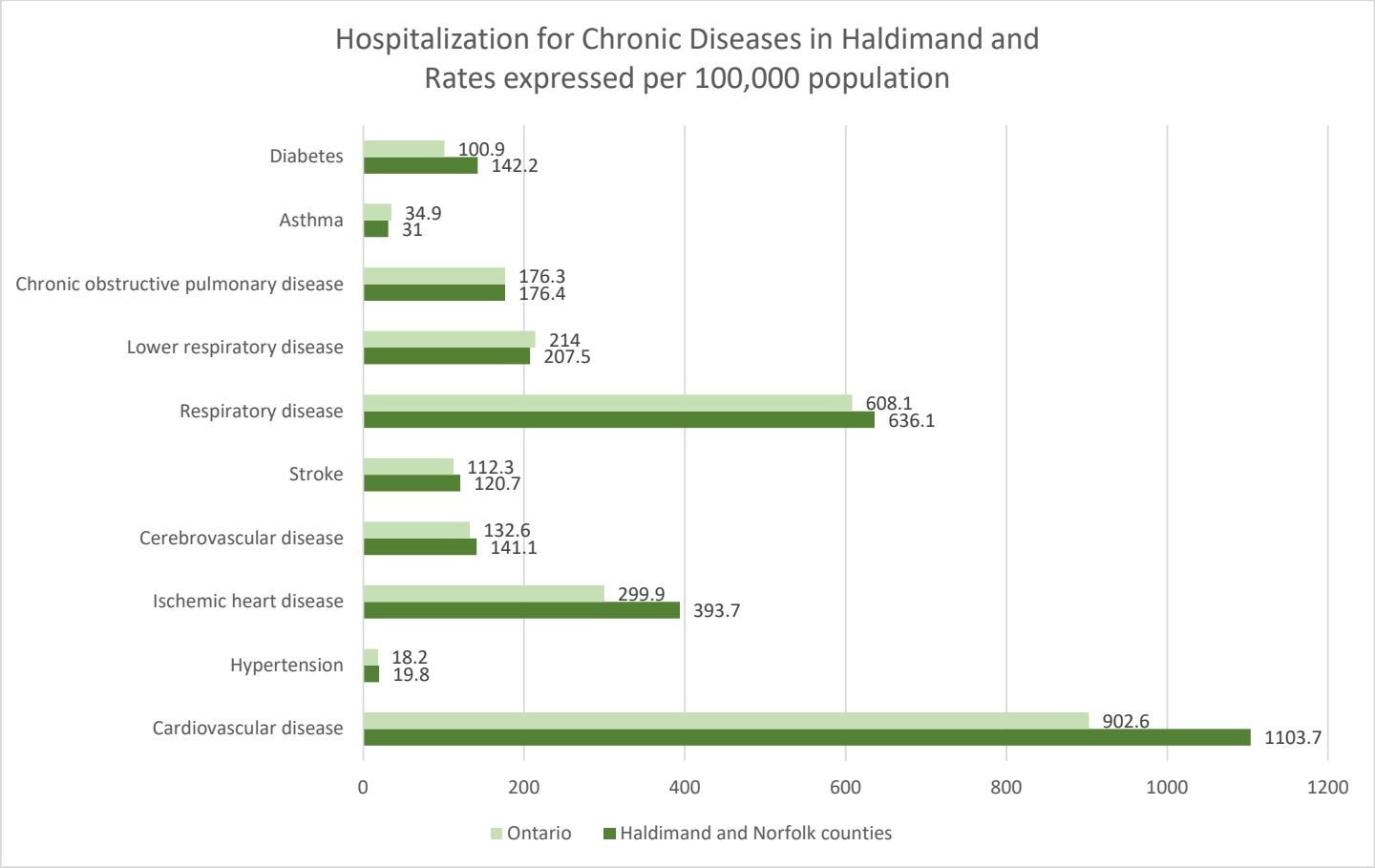

Figure 1. Hospitalization rates for chronic diseases per 100,000 people in Haldimand and Norfolk counties and Ontario in 2017.[1]

- The self-reported prevalence of diabetes in Haldimand and Norfolk counties was 6.7%, which was similar to prevalence in Ontario (7.4%).[2]
- The self-reported prevalence of asthma in Haldimand and Norfolk counties was 9.2%, which was similar to prevalence in Ontario (8.8%).[2]
- The incidence of all cancers was significantly higher in Haldimand and Norfolk than Ontario in 2010, 2011, and 2012, but not in 2013 or 2014. In the same period, incidence of lung cancer Haldimand and Norfolk was significantly higher than in Ontario in 2012 and 2013, incidence of malignant melanoma was significantly higher in 2010 and 2011, and incidence of colorectal cancer was significantly higher in 2011. Incidence of female breast cancer and male prostate cancer were similar in Haldimand and Norfolk and in Ontario.[3]

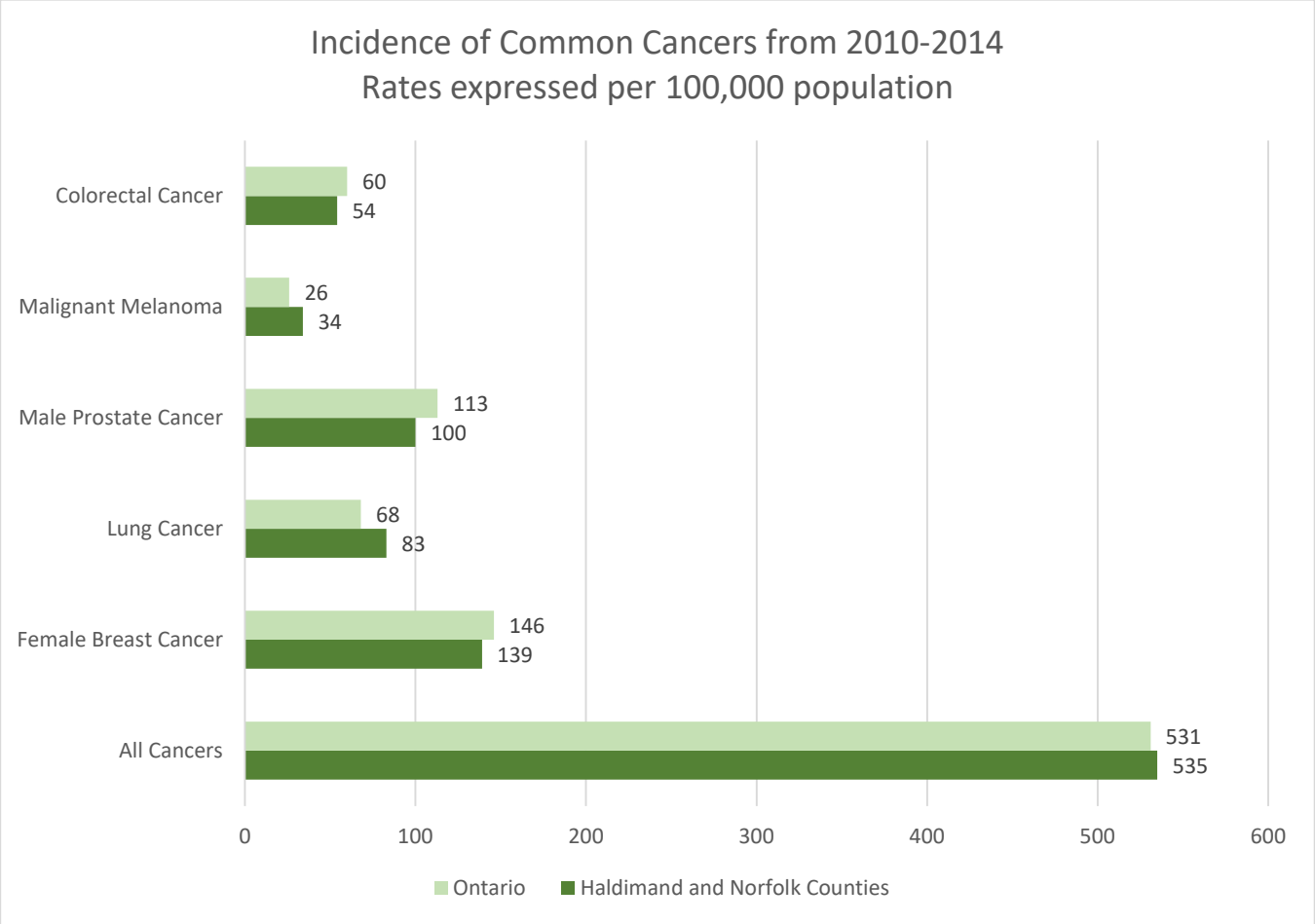

Figure 2. Incidence of common cancers in Haldimand and Norfolk counties and in Ontario from 2010 to 2014.[3]

- The mortality rate for all cancers from 2003-2015 was significantly higher in Haldimand and Norfolk counties (225 deaths per 100,000 population (201, 250)) than in Ontario (190 deaths per 100,000 population (187, 192)) in 2009, 2010, 2013, 2014, and 2015.[4]

- The hospitalization rate for cardiovascular disease in Haldimand and Norfolk counties was 1,104 admissions per 100,000 population (1,048, 1,159), which was significantly higher than in Ontario (903 admissions per 100,000 population (898, 907)).[3]
- The mortality rate for cardiovascular disease from 2003-2015 was higher in Haldimand and Norfolk counties (236 deaths per 100,000 population (211, 261)) to Ontario (170 deaths per 100,000 population (168, 172)). However, the mortality rate for cardiovascular disease in Haldimand and Norfolk counties was significantly higher among adults aged ≥75 years than in Ontario.[3]
- The mortality rate for ischemic heart disease from 2003-2015 was significantly higher in Haldimand and Norfolk counties (141 deaths per 100,000 population (121, 160)) than in Ontario (88 deaths per 100,000 population (86, 89)) for all years. [2]
- The hospitalization rate for chronic obstructive pulmonary disease in Haldimand and Norfolk counties was 176 admissions per 100,000 population (155, 198), which was similar to Ontario (176 admissions per 100,000 population (174, 178)).[2]
- The mortality rate for chronic obstructive pulmonary disease from 2003-2015 was similar in Haldimand and Norfolk counties (30 deaths per 100,000 population (21, 38)) to Ontario (27 deaths per 100,000 population (26, 28)). How ever, the mortality rate for chronic obstructive pulmonary disease in Haldimand and Norfolk was higher in 2012 than in Ontario.[2]
- The mortality rate for all respiratory diseases from 2003-2015 was similar in Haldimand and Norfolk counties (67 deaths per 100,000 population (54, 80)) to Ontario (57 deaths per 100,000 population (56, 58)).[2]

Injury

- The rate of emergency department visits for all injuries was significantly higher in Haldimand and Norfolk counties (16,234 visits per 100,000 population (15,987, 16,481)) than in Ontario (10,175 visits per 100,000 population (10,159, 10,192)).[5]
- The rate of hospitalization for all injuries was higher in Haldimand and Norfolk counties (927 visits per 100,000 population (871, 983)) than in Ontario (552 visits per 100,000 population (549, 557)).[5]
- The mortality rate for all injuries was similar in Haldimand and Norfolk counties (53 deaths per 100,000 population (40, 67)) to Ontario (44 deaths per 100,000 population (43, 45)).[5]
- The rates of emergency department visits for injuries related to motor vehicle accidents was significantly higher in Haldimand and Norfolk counties (1,139 visits per 100,000 population (1,073, 1,206)) than in Ontario (608 visits per 100,000 population (604, 612)).[5]
- The rate of hospitalization for injuries related to motor vehicle accidents was higher in Haldimand and Norfolk counties (155 visits per 100,000 population (130, 179)) than in Ontario (49 visits per 100,000 population (48, 50)).[5]
- The rates of emergency department visits for injuries related to falls was significantly higher in Haldimand and Norfolk counties (4,101 visits per 100,000 population 3,981, 4,221)) than in Ontario (3,150 visits per 100,000 population (3,141, 3,159)).[6]
- The rates of emergency department visits for injuries related to neuro-trauma (i.e. brain injuries) was significantly higher in Haldimand and Norfolk counties (425 visits per 100,000 population (385, 465)) than in Ontario (333 visits per 100,000 population (330, 336)).[5]
- The rate of emergency department visits for injuries related to concussions was significantly higher in Haldimand and Norfolk counties (311 visits per 100,000 population (276, 345)) than in Ontario (246 visits per 100,000 population (243, 248)).[5]

Community Survey Results

Chronic Disease

- When listing the top three health supports or services needed to make their family healthy, cancer screening was listed 26% of the time, making it the third most commonly listed support or service needed for healthy families in Haldimand and Norfolk.
- When listing the top three health education topics of interest for their family, cancer prevention was listed 20% (n=61) of the time, making it also the third most commonly listed education topic of interest to families in Haldimand and Norfolk.

Injury

- 24% of survey respondents identified as a person with a disability, of whom, some may have been diagnosed with a disability related to a chronic disease or previous injury.
- When listing the top three health supports or services needed to make their family healthy, falls prevention for older adults was listed 7% (n=22) of the time, and falls prevention for children was listed 2% (n=6) of the time.
- When listing the top three health education topics of interest for their family, injury prevention was listed 6% (n=20) of the time, falls prevention for older adults was listed 6% (n=20) of the time, and falls prevention for children was listed 1% of the time.
- In the past 12 months, 1% of survey respondents reported an animal bite or strange animal behaviour.

Focus Groups and Interviews

Seven major themes emerged from the qualitative data collected via focus group discussions and interviews: (i) Mental Health and Addictions; (ii) Physical Health; (iii) Poverty; (iv) Housing; (v) Rurality; (vi) Availability of Products and Services; and (vii) Organizational Structures.

This chapter on Chronic Disease and Injury discusses the key themes associated with this topic.

Physical Health

Chronic diseases were a commonly mentioned physical health concern among participants in both focus group discussions and interviews. When discussing physical health, many discussions highlighted the high prevalence of chronic diseases in the community. For example, one participant (KI36) shared, "We have a lot of individuals in the community who live with chronic diseases and, you know, more than one chronic disease."

While chronic diseases were discussed occasionally in the context of all life stages, the majority of conversations about chronic diseases focused on older adults. One participant (KI38) said, "Also an increase in the ageing population, lack of long term care beds, more failures to cope in the senior community. Everyone, all the patients seem to be much more complicated. A lot more comorbidities, more complex, not just straight forward patients."

Further, specific to the high prevalence of mental health and addictions issues in the community, one participant (KI32) described how an individual who currently or previously experienced difficulties with addiction may not be provided medication to cope with pain,

"If they any have any history of drug abuse or anything and they break their arm or leg. That hospital is not going to issue them a prescription at all for any type of pain medication during that time, which usually results in people moving towards illegal activity to help themselves during that time."

Another participant (KI20) reiterated the idea that individuals facing addictions issues may not be provided medication for their pain,

"Sometimes I think for the people at the clinic who are addicts, when they go to the hospital, I sometimes feel like people are more hesitant to give them pain medication. They just get tested at the hospital. I don't know what the policies are at the hospital, but if you and I went to the hospital do you think you will be randomly drug tested at the hospital? No. But you will see these results come through at the hospital where they have been drug tested. Maybe it's just their policies, I am not too sure, but I kind of feel like it is profiling. Like 'why did you drug test them?', if you wouldn't do that to me, why do that to them? I don't know if it is just their policy or if they don't want to give them pain meds because they think that someone is just in there to get them."

Cancer and Other Chronic Diseases

The most commonly discussed chronic disease in the focus group discussions and interviews was cancer. Many of the conversations about cancer focused on higher than average rates of cancer in Haldimand and Norfolk counties. One participant (KI47) shared,

"There are others as well in terms of health. I was a little disheartened, but not surprised that when we found out about the cancer statistics that you're 20 percent more likely to get cancer if you were born and raised in Haldimand-Norfolk, Norfolk County, specifically, you're far more likely to contract cancer. And even in council, not much. Not many people batted an eye. We've heard this statistic before and we're quite used to it. I've known this my entire adult life."

Similarly, another participant (KI63) stated, "I know some of our rates that were sent to the health unit at the rural community were subpar with cancers and a number of things that go wrong." Further, some participants began to describe things they had learned or heard about that might be possible reasons for the higher rates of cancer in this region. A participant (KI36) described,

"We have, you know, some, in some areas higher cancer rates. Could that be due to some of this outdoor work, some of the outdoor chemicals that are sprayed? It's from the tobacco that we've grown in, smoked and sold here for a long time. That's what makes this unique, we are like one of the tobacco growing counties. It creates a lot of barriers and challenges up to more recently with all the transitions."

Other chronic diseases, such as diabetes, cardiovascular disease, and respiratory diseases were rarely mentioned and no major or minor themes emerged from the data.

Injury

Injury was rarely discussed, but often when it was discussed in conversation, it was in context of the uniqueness of rural communities. One participant (KI36) shared about Haldimand and Norfolk being unique for injuries by saying, "And so we have waterfront. So that makes us unique. And it brings in different public health challenges with water testing, water safety, boating safety. You don't drink and drive, wear your personal flotation devices." Later this participant (KI36) added,

"So there's that whole aspect of what makes it unique in that it's a great place to live and grow. But there are also more dangers. ATV rates for injury are like four times [higher than] the province here. Its great where we're all we've got lots of trails, but we've got a lot more deaths and injuries when it comes to ATVs."

Poverty

The topic of chronic diseases co-occurred with poverty frequently. Conversations primarily reflected how years of living in poverty may cause or exacerbate chronic disease. A participant (KI1) clearly linked chronic disease to living in poverty by saying, "In terms of vulnerabilities, we are seeing increased prevalence… [of] I would say chronic disease that I would link to years of living in poverty and the stress that comes with that."

Further, some participants also discussed how poverty might be an outcome of chronic diseases as well. For example,

one participant (KI16) described how chronic disease(s) might lead to unemployment, especially when coupled with pain, and how this may further prevent the individual from seeking new employment by stating, "With the physical health needs, same thing can prevent them from going to seek employment."

Availability of Products and Services: Family Doctors

Related to the issues of chronic disease and pain, many participants described the lack of available family doctors in the communities. When ranking the local issues in the community, one participant (KI27) said, "But those are the biggest barriers. We have had a little one off of things that happen, but it is typically mental health, addiction and family doctors that are still a big concern here. And the counselling piece of course."

Participants frequently explained how there were simply too few doctors available to take patients in Haldimand and Norfolk counties. For example, participants said:

(KI4) "I know that a lot of people having a hard time processing family doctors so they end up going to emergency."

(KI63) "I know we just got the ER here. Having doctors available on the road, which is something we discussed, trying to get doctors, to recruit doctors. Why can't we? Why can't we get doctors?"

(KI27) "We get some people that are lacking a family doctor. It has gotten a little bit better over the past year or so. But there are still a great percentage of people that still lack a family doctor or are unhappy with their family doctor but don't want to change because it is almost impossible to find one in this area."

Participants also described how this was putting a lot of weight on the emergency departments at hospitals in the region. In context of chronic diseases, one participant (KI4) explained, "And fair enough to the emergency department, they get inundated and people, like, feel like they are not welcome there. This is fair enough because it is for emergencies and they have non-emergency situations, but then again, these people have nowhere to go." Another participant (KI63) explained that the doctors here seem so overwhelmed by the caseloads that patients feel they are being sent to the emergency department because they can't be seen by their doctor, saying "And by the way, you just show up at their office so you don't get turned away and say go to [emergency room] they deal with it."

With regards to individual patients, one common concern of too few family doctors was the implications for applying to the Ontario Disability Support Program (ODSP). One participant (KI18) explained how a lack of available family doctors may decrease the chances that a client is successful with an ODSP application, stating,

"However, ODSP application has to be filled out by a doctor and a doctor needs to know the medical history. So if we are connecting somebody with a doctor and right on that medical form, they're saying, how many times have you met with this client within an X number of months? And they're saying 'once' the documentation that may be needed there isn't going to be as concrete. It's kind of another thing. We've also got a lot of doctors that have retired locally, I've noticed, a lot of people have new doctors, so that can be a bit of a hindrance."

With regards to chronic disease and disability, multiple participants described how nurse practitioners could be part of

the solution for a lack of doctors locally. One participant (KI18) explained, "… maybe we have people who are trying to do ODSP applications and they are only seeing their doctor once every three years and any other time they go in they are meeting with a nurse practitioner. And you know that it's the doctor that needs to fill it out and things like this." Further, another participant (KI4) described,

"I'm not too sure about what [a nurse practitioner] can do, I think they can do almost the same thing as a doctor. I would like to see more of those health clinics like that. Where people can go in like a 24 hour emergency clinic. Like kind of go in and 'O my gosh, I have a tooth ache'. You have a lot of people going to emergency for doctor care."

In relation to the other themes, one participant linked the lack of family physicians in Haldimand and Norfolk counties to a problem with returning to employment. This participant (KI17), explained that not having access to a doctor could delay the process of seeking accommodation or treatment for pain and chronic diseases that might lead to unemployment, saying "…if somebody has just been employed and they can't stand up for work, for foot pain, if they could get orthotics quicker, that would be great. If there was something to help them maybe fast track it, because sometimes you can fast track things, but that's hard to navigate if you don't know the system."

Conclusions

Chronic diseases were an important concern for participants, however, not as immediately dire as the needs for mental health provisions. Participants particularly described how the rates of some chronic diseases seemed to be higher than normal or expected here and felt that this was linked to the agricultural and tobacco industries in the region. Participants also described clear links between chronic disease and pain and poverty experiences.

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