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Canadian Population Health Initiative Identifies Obesity as Research Priority

Childhood obesity is not a new problem but a growing one—a serious population health issue that requires attention and action. And it's not simply a problem during childhood: obese children are more likely to become obese adults, and obese adults are more vulnerable to an assortment of serious health problems and represent a burden on the health system. Researchers have estimated that up to $3.5 billion of Canada's health spending in 1997 was attributable to obesity.

Obesity is linked to heart disease, Type 2 diabetes, and other health problems. This largely preventable condition is a major determinant of many non-communicable diseases, increasing the risk of several types of cancer, gallbladder disease, musculoskeletal disorders and respiratory problems. Consequently, obesity-related chronic conditions will have an impact on the future health status of the population and the economic burden of illness.

Among Canadians and around the world, rates of obesity and overweight are growing rapidly, especially among children. Data from 79 developing countries and a number of industrialized countries suggest that about 22 million children under the age of five are overweight.

By current estimates, one in 10 Canadian children is obese, with even higher rates in the Atlantic provinces. Canadian Population Health Initiative (CPHI) funded researchers Doug Willms (University of New Brunswick) and Mark Tremblay (University of Saskatchewan) continue to research this important area and have reported that Canada's children are considerably more overweight than English, Scottish and Spanish children, among others. According to their findings, over the past 20 years, levels of obesity among Canadian children aged seven to 13 nearly tripled.

Almost from its inception, CPHI has identified obesity as a priority. The research on obesity by Willms and Tremblay has attracted considerable public and media attention, raising the profile of obesity as a serious and growing health problem in Canada. CPHI is also funding research to explore the determinants of youth health and will report findings over the next two years that may shed light on overweight and obesity among Canadian youth.

CPHI and others at the Canadian Institute for Health Information (CIHI) are working to communicate these research findings and other relevant evidence to national, provincial and regional decision-makers. Articles, policy forums, workshops, a national round table, meetings with federal and provincial policy-makers, and inclusion of obesity research findings in *Health Care in Canada* (2001 and 2002), are some of the mechanisms used to reach target audiences.

Given the evidence of overall (childhood and adult) obesity impacts on population health, health care and the economy, obesity has become an important priority for the World Health Organization, which has established the International Obesity Task Force. In countries like Australia, the U.K. and the U.S., where obesity is a priority for health policy, action strategies have been developed and integrated approaches to reducing obesity prevalence are unfolding.

CPHI recognizes the challenges that Canada faces in dealing with this problem as a population health issue. Applying a population health lens raises questions about the social, economic and environmental conditions that make healthy food choices and active living less and less feasible in our society and around the world. CPHI seeks answers to these key policy questions: What are the determinants of obesity at the population level? What policy instruments have been tried to prevent obesity, in Canada and elsewhere? What works? What does not work? Why?

Currently, CPHI is cooperating with the Institute for Institute for Nutrition, Metabolism and Diabetes of the Canadian Institutes of Health Research to scope out policy approaches to obesity and related knowledge gaps. In answering the question, "what has been tried?" this work will examine a range of instruments that might (or might not) be found to be effective in reducing population obesity levels.

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Message from the President and CEO

Working Together to Improve Health Information

In recent years, the call for better health information has been getting louder and louder. We have heard from the Clair Commission in Quebec and the Fyke Commission in Saskatchewan. We have read the Mazankowski Report from Alberta. On September 30, the Federal, Provincial and Territorial Governments released their first public reports on health indicators—making good on a commitment made two years ago by the First Ministers. And this fall, two major reports will be handed down: one from the Senate Committee on Social Affairs, Science and Technology, followed by the Commission on the Future of Health Care in Canada, chaired by Roy Romanow.

These reports have emphasized the need for better health information that will support efforts to improve the performance of the health care system. As a result, we are seeing a new era of performance measurement and accountability that will only escalate in the years to come.

It goes without saying that producing better health information is a priority for CIHI but it is a shared responsibility with ministries, hospitals and regional health authorities across Canada—one that carries an obligation by all to ensure data accuracy and data quality.

CIHI has made substantial investments in data quality. Our data quality framework, implemented two years ago, provides a common strategy for assessing data quality across CIHI databases and registries. Additionally, we work closely with data providers to improve data collection practices and processes This includes providing education training sessions and offering different tools and services such as coding guidelines and a coding query service to support the implementation of new classification standards.

At the end of the day, we all agree that we must provide data and analyses of the best possible quality to support evidence-based decision-making in health care. As our information is being used more and more, the demand will only grow. While tremendous progress is being made in improving both the range and quality of data we are producing, we need to continue to work together to answer key questions on the performance of our health care system. To this end, we look forward to continued collaboration with the health care community as we continue our journey towards *better health information for better health*.

Richard C. Alvarez, President and CEO

CIHI Director Awarded Prestigious Harkness Fellowship

Jennifer Zelmer

Jennifer Zelmer, Director of Health Reports and Analysis at CIHI, has been selected as one of two 2002 Canadian Harkness Associates.

The prestigious Harkness Fellowships in Health Care Policy Program are coordinated by the Commonwealth Fund of New York. The fellowship entails attending a series of joint meetings held primarily in the U.S., and conducting a research project on topics of concern to the Fund.

Ms. Zelmer recently completed a significant portion of her PhD thesis which is part of her graduate studies program in economics at McMaster University in Hamilton Ontario.

CORR Data Shows Dialysis Patients Older and Sicker

New statistics released in September by CIHI revealed that there were 14,567 dialysis patients with end-stage kidney disease in Canada on December 31, 2000, a number that continues to climb and which has more than doubled from 6,811 patients in 1991. CIHI's data also show that 4,386 new patients started treatment during 2000, 60% higher than the number who began treament in 1991.

Of the new patients on dialysis, 38.5% were 70 years or older, from 25.8% 10 years ago. Over two-thirds (69.4%) of these patients had diabetes and/or cardiovascular disease. Among all the dialysis patients being treated as of December 31, 2000, over one-third (37.8%) were 70 years or older and slightly less than two-thirds (64%) had diabetes and/or cardiovascular disease as either the cause of the kidney disease or a complicating condition.

For patients with end-stage kidney disease, a condition in which the kidneys are permanently impaired and can no longer function normally to maintain life, dialysis is a life-prolonging process. Dialysis removes toxic materials from a patient's bloodstream, maintaining the fluid and electrolyte balance.

"Kidney disease may be either a cause or consequence of cardiovascular disease," explains Dr. Joanne Kappel, advisor to the Canadian Organ Replacement Register (CORR). "While diabetic nephropathy (diabetes) is generally the main cause of end-stage renal disease, cardiovascular disease has typically been the second major cause of renal failure. Early management of patients with chronic kidney disease requires reducing both the cardiovascular risk factors as well as the risk factors related specifically to renal failure."

The figures are from the Canadian Organ Replacement Register (CORR), a national database managed by CIHI that records, analyzes and reports the level of activity, outcomes and long-term trends in dialysis use and end-stage renal disease, organ donation, organ transplantation and transplant waiting lists.

The statistics also show provincial variations in new patient rates, from a high of 17.6 per 100,000 in Manitoba to a low of 7.0 per 100,000 in Prince Edward Island. Diabetes among new patients was highest in Manitoba while Newfoundland, New Brunswick and Ontario had the highest rates of new patients who were aged 70 years and over.

PATIENT SURVIVAL A DECADE LATER

"While the 10-year patient survival rate is rather bleak for dialysis patients, it is important to realize that improved drug therapy, more flexible dialysis treatment regimens, better nutritional counselling and other general treatment enhancements have occurred since 1991," says Dr. Kappel. "These have helped to extend the length and improve the quality of dialysis patients' lives. On the downside, the cadaveric organ shortage has meant that kidney transplant candidates must stay on dialysis longer."

Of the patients who initiated treatment for end-stage kidney disease in 1991, 70% had died by December 31, 2000. The median treatment duration for these patients was 2.8 years. Patients who died tended to be older at the start of treatment. In fact, 50% were 65 or older, compared with a median age of 42 for the patients who did not die.

While more men (58.6%) than women started treatment for end-stage kidney disease in 1991, proportionately slightly more women had died prior to December 31, 2000. Of the women starting treatment in 1991, 72.6% had died; among the men, 68.1% had died.

Patients who died were twice as likely to have diabetes and/or cardiovascular disease at the start of their treatments than the patients who were still living after 10 years. In fact, 15.1% of the patients who died had both diabetes and cardiovascular disease as either a cause of their kidney disease or a complicating condition, compared with 6.0% for the patients who were still alive.

Treatment and age at initiation of treatment were the defining factors in survival. Of the patients who died, 10.5% died with a functioning kidney transplant. Most died while on haemodialysis (58.1%) or peritoneal dialysis (31.3%). Of those patients who survived the decade, most (64.4%) had received a transplant.

An analysis of reported causes of death revealed that over one-third (38.1%) died of cardiac failure, and 15.0% died because they ceased or refused treatment, or committed suicide. The latter causes of death were proportionately higher among women (18.1%) than men (12.7%). An additional 10.1% died from infections, 7.1% died from strokes, 5.6% from cancers and the remaining 24.1% from various other or unknown causes.

"Faced with an aging population, the rise in kidney disease is cause for concern," suggests Dr. Kappel. "The best measure that people can take to both prevent the onset of kidney disease and slow its progression is to adopt a healthy lifestyle—engage in daily physical activity, maintain a healthy weight by eating nutritional foods and refrain from smoking."

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CIHI Launches Innovative Home Care Pilot Project

Provincial spending on home care services increased by 350% between 1989 and 1999. Drivers of this growth include pressures in the acute care system, new technologies allowing for more health conditions to be managed in the home, and an aging population.

Policy-makers and service providers require high quality information to ensure the quality and sustainability of this important segment of the health care system. The Home Care Project, spearheaded by CIHI, addresses this urgent need with a proposed national reporting standard.

In September 2002, a pilot project was launched to test the feasibility of collecting a small number of standardized data elements required to generate a balanced set of health and health system indicators. These indicators were based on the CIHI Health Indicator Framework and extensive consultation across the country.

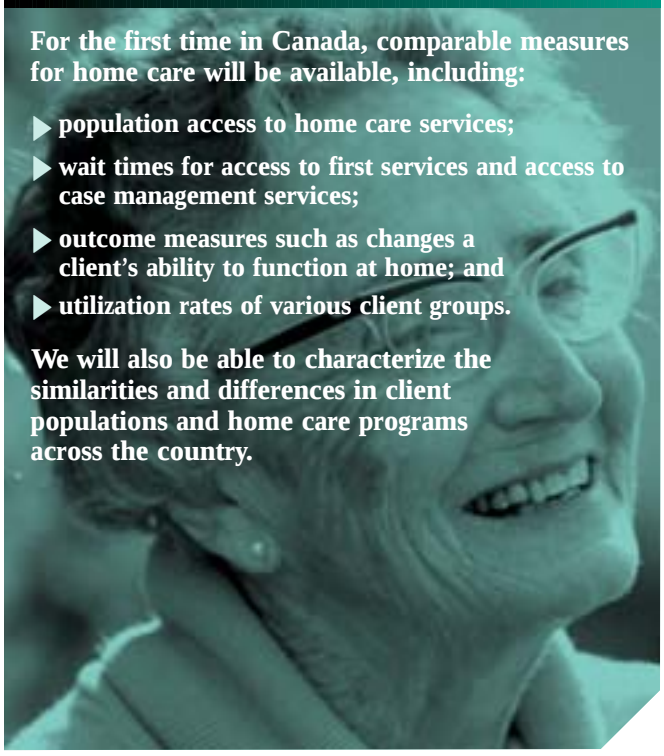
The Home Care Project incorporates a number of innovative approaches to promote consistency of analysis and reporting across the health care continuum and across jurisdictions.

FIRSTS FOR HOME CARE

For the first time in Canada, comparable measures for home care will be available, including:

- **population access to home care services;**
- **wait times for access to first services and access to case management services;**
- **outcome measures such as changes a client's ability to function at home; and**
- **utilization rates of various client groups.**

We will also be able to characterize the similarities and differences in client populations and home care programs across the country.



Firstly, it draws upon a variety of international clinical standards to describe the diverse populations served through home care programs. For example, clients receiving rehabilitation services in the home will be described by Rehabilitation Client Group (RCG)©, an international standard used in the National Rehabilitation Reporting System (NRS) for in-patients. And, for the first time, CIHI is piloting the use of the new World Health Organization International Classification of Function (ICF) to describe clients who are receiving maintenance and long-term supportive care.

Secondly, the data set is designed to be compatible with a variety of clinical assessment tools currently in use across the country. Should the CIHI minimum data set be adopted as the pan-Canadian standard, all jurisdictions could submit a subset of their clinical data, mapped to the national reporting data set, with minimal adjustment to their current systems. This was deemed to be a priority as there is little consensus to date on adoption of a common clinical tool.

Six health regions from across the country have volunteered to participate in the pilot. They will submit data to CIHI for a period of six months, under strict privacy conditions, using a CIHI data collection software tool designed to promote optimal data quality.

CIHI wishes to recognize the tremendous efforts of the following health regions in preparing for the launch of the pilot project and supporting this important home care initiative:

- Health and Community Services-St. John's Region, Newfoundland;
- Burntwood Regional Health Authority, Manitoba;
- Regina Health District, Saskatchewan;
- Capital Health Authority, Alberta;
- Fraser Health Authority, British Columbia; and
- Department of Health and Social Services, Yukon.

A special thank you to the management and staff of the Ottawa Community Care Access Centre for their valuable feedback in the pre-test phase of the project.

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National Hospital Financial Performance Indicator Project Breaks New Ground

CIHI will break new ground in early 2003 when it releases its first public report of comparative hospital financial indicators. The report will include 12 key hospital financial performance measures, reported at the regional board level, using 2000/2001 data.

"This marks an important step in the public reporting of hospital financial performance indicators," says Terry Campbell, CIHI's Manager, Health Expenditures. "While there are several localized financial performance projects underway across Canada, until now there has been no coordinated activity at the national level."

Financial performance indicators provide information about the current financial health of the health care system, and they shed light on issues related to the future sustainability of the system. Financial indicators can be used either alone, or in conjunction with other measures, such as health status and clinical outcomes, to make informed decisions at the system level, or within individual organizations.

The indicators to be contained in the report measure the following concepts: financial viability; liquidity; corporate efficiency; deployment of human resources; capital asset management; and cost of hospital outputs. Examples are: administrative expenses as a percentage of total expenses (corporate efficiency); percentage of total hours spent on patient care activities (human resources); and cost per weighted case (hospital output).

These indicators are calculated from CIHI's Canadian MIS Database (CMDB). The CMDB is the national source for financial and statistical information for hospitals and regional health boards. The data collected under the CMDB is structured according to the national data standard, *Guidelines for Management Information Systems in Canadian Health Service Organizations* (MIS Guidelines), which have been implemented in provinces and territories across Canada (with the exception of Saskatchewan and Quebec). CMDB data is post-audit information supplied by hospitals and health boards to their respective provincial ministries of health.

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CIHI and CIHR Fund Study on Adverse Events in Canada

U.S. studies estimate that between 48,000 and 98,000 deaths and more than one million injuries each year are related to health system adverse events. Many of these are preventable. British and Australian studies have come up with similar findings.

"Until we have Canadian data nobody will line up to the idea that this is a Canadian issue," said Dr. Ross Baker, Associate Professor, Health Policy, Management and Evaluation at the University of Toronto.

Dr. Baker says there is an urgent need to develop indicators, data definitions, standards and systems to collect data on these events (which should also include "near misses", hospital-acquired infections and the adverse effects of drugs).

The CIHI, along with the Canadian Institutes for Health Research (CIHR), are jointly funding research to determine the extent of adverse events (avoidable and otherwise) in Canadian hospitals and the availability of data that could serve to monitor and reduce health system adverse events.

Dr. Baker will lead the study and work in collaboration with Dr. Peter Norton, Professor and Head of the Department of Family Medicine, Faculty of Medicine, at the University of Calgary.

Through a systematic review of Canadian hospital charts, Drs. Baker and Norton and their colleagues from across Canada will determine the extent and nature of adverse events in Canadian hospitals. British Columbia, Ontario, Alberta, Quebec and Nova Scotia are the provinces where the study will take place. One teaching hospital, one community hospital and two rural hospitals will be randomly selected from each province for a total of 20 facilities. The research teams will look at approximately 3,700 randomly selected patient charts. The results of the study will be reported on a national level and the individual hospitals will not be identified in order to protect patient confidentiality.

They will also determine the availability of routinely collected data that, if appropriately monitored, could serve to reduce the occurrence of preventable adverse events. The study should be completed and released to the public in 2004.

This study has been designed as a first step to help improve Canada's health care system and to make it more efficient and safe. It is hoped that the study's results will provide the impetus for action to seriously address the issue quality of care.

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NEWS BRIEFS

Trauma Bulletin Analyzes Emergency Visits in Ontario

Earlier this year, CIHI released an analytical bulletin, *Emergency Department Visits due to Trauma in Ontario*, drawn from the Ontario Trauma Registry and the National Ambulatory Care Reporting System. This bulletin provides a descriptive analysis of trauma-related emergency department (ED) visits in Ontario, including a comparison of hospital admissions due to trauma. Results of the study were presented at the Sixth World Conference on Injury Prevention and Control in Montreal.

According to CIHI data, the age distribution of ED cases differed from trauma hospitalizations. The mean age of ED cases was 33 years, compared with 53 years among hospital admissions. Forty-four per cent (44%) of trauma hospitalizations were for people over the age of 65 years, whereas this age group accounted for only 11% of ED visits. More than one-third of trauma ED visits were among cases under the age of 20 years.

There were peaks among male cases in their late teens and late 30s in both databases, and among female ED cases. For females hospitalized due to trauma, the most marked peak was among cases around the age of 80 years, but this peak was noticeably smaller among female ED cases and absent among their male counterparts.

The bulletin also summarizes trauma ED visits by triage level, according to the five-level Canadian Triage and Acuity Scale (CTAS). The scale, which is a mandatory data element in the National Ambulatory Care Reporting System, is used by hospital emergency departments to prioritize patients' care according to the type and severity of presenting symptoms. Over half of all trauma ED visits were less urgent in nature, with another one-quarter being non-urgent. Less than 3% of all ED visits due to trauma were severe enough to require immediate medical intervention.

To download a PDF copy of this bulletin, please visit CIHI's Web site:
http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=bl_otrmay2002_e

CIHI and CPHI Make Submissions to the Romanow Commission

Earlier this year, Richard Alvarez, CIHI's President and CEO and Dr. John Millar, Vice-President, Research and Population Health, appeared before the Commission on the Future of Health Care in Canada (chaired by Roy Romanow) to present CIHI's vision for the future of health care in Canada. Mr. Alvarez discussed the organization's mission and activities that help shape Canada's health policies and support informed decision-making. He also reviewed how CIHI has helped to improve the health of Canadians and strengthen the health care system.

From the development of databases to assist administrators in evaluating their programs and services to publishing reports that identify trends or issues in health care—Mr. Alvarez emphasized how integral these activities are as all Canadians move forward to help develop a new course of treatment for Canada's health care system. He also provided an update on CIHI's work, including the Health Indicators Framework and the impact of these projects and reports on the health care system.

Dr. Millar also submitted a brief on behalf of the Canadian Population Health Initiative (CPHI) to the Commission this spring. The brief noted that in the past Canada has been a leader in prevention and health promotion but in recent years has fallen behind countries such as the U.K. and Sweden. The brief also emphasized the need for intersectoral cooperation at the national, provincial, territorial and regional levels to address some of the major population health issues such as child and family poverty, aboriginal health, obesity and early childhood development.

Dr. Millar urged the Commission to consider the policy implications emerging from these key issues related to population health. He said that Canada has, once again, the potential to become a leader in population health and health promotion resulting in improved overall health and productivity of citizens and a reduction in the present inequities in health.

To view a copy of the CPHI submission to the Romanow Commission, visit CIHI's Web site at:
www.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_new_e#romanow

New pan-Canadian Specification: *A Building Block to EHRs*

As Canada moves forward with developing electronic health records (EHRs), the need for a standard to transmit patient information between facilities or provinces and territories will be critical, especially when it comes to ensuring the accuracy of information.

In response to this need, CIHI has developed an electronic messaging specification that allows different client registry applications to use a standard set of messages for accessing, maintaining and distributing client (or patient) identification information across and within jurisdictions across Canada.

"This messaging specification is a key building block in the development of pan-Canadian electronic health records," explains Caroline Heick, CIHI's Director of Health Information Standards. "The specification was created through a collaborative process that included participation from federal, provincial and territorial governments, health regions, hospitals and key health information stakeholders. This resulted in a specification that recognizes needs specific to the Canadian health care system."

The pan-Canadian Client Registry HL7 Messaging Specification facilitates the exchange of key patient demographic information across provinces, regions, and facilities. The specification fosters communication between client registries and/or other applications such as pharmacy, lab or eligibility systems. Through cross-referencing patient identifiers, messages can be sent that alert health information stakeholders of deaths, births, name changes, and new addresses. The specification has successfully undergone the HL7 Canada approval process and is being housed and distributed by HL7 Canada.

In developing this specification, the importance of ensuring the protection and privacy of personal health information was paramount. Requirements outlined in provincial and territorial privacy and confidentiality legislation should be adopted when implementing the Client Registry HL7 Messaging Specification.

"We anticipate that the implementation of this specification will result in increased patient care through accurate and timely patient identification that will improve efficiencies," adds Ms. Heick.

For example, Manitoba Health, a leader in the development of the Client Registry Specification, has expressed interest in implementing the messages as a means of sharing information with provincial health authorities. Other organizations that have expressed interest in using the messages include the University Health Network in Toronto and Health Infostructure Atlantic, a collaboration of the four Atlantic provinces.

The pan-Canadian Client Registry HL7 Messaging Specification is currently available to HL7 Canada members only.

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(see Infostructure Standards under the Standards section)

Working Together to Build the Future of Nursing in Canada

Canada's nursing sector is facing some major challenges. High attrition rates, reduction in nursing schools' seating capacities, stress, work overload, and lack of human resource planning are contributing to an increasing shortage of nursing personnel. Now nursing is embarking on a process to address these challenges.

Building the Future: An Integrated Strategy for Nursing Human Resources in Canada is a milestone project, the first national nursing study that is both endorsed and led by all of Canada's nursing sector stakeholder groups, including CIHI as well as Human Resources Development Canada, provincial and territorial governments, and Health Canada.

According to Dr. Mary Ellen Jeans, one of the Study's Co-chairs, "The overall goal of this two-year project is to produce an integrated labour market strategy for Canada's three regulated nursing groups, Licensed Practical Nurses, Registered Nurses, and Registered Psychiatric Nurses."

This project consists of two phases. Phase I involves key informant interviews; nurse, student, and employer surveys; focus groups; and a comprehensive literature and Internet site review and assessment. These activities will be used to assess the current and future state of the nursing labour market in Canada.

In Phase II, broad-based consultations with nursing sector stakeholders across Canada will help build consensus on the human resources challenges and the recommendations to address them.

For more information on how to participate, visit:
www.buildingthefuture.ca or contact the Nursing Sector Study Secretariat at (613) 233-1950 or by e-mail at info@buildingthefuture.ca.

UPCOMING EVENTS

November 19–20, 2002: HL7 Canada Conference

This fall, HL7 Canada will hold its fall conference at the Delta Victoria Ocean Pointe Resort in British Columbia from November 19–20, 2002. HL7 Canada (housed by the Canadian Institute for Health Information) is the forum for Canadian health information stakeholders to decide how HL7 is adopted and adapted for use in Canada. HL7 Canada is a recognized international affiliate and a voting member of the HL7 International Committee.

The conference will feature two concurrent tutorials on November 19:

- **Tutorial 1:** *Everything you ever wanted to know about HL7 but were afraid to ask* is geared for people who are unfamiliar with HL7; and
- **Tutorial 2:** *Turning the standard into the solution* will focus on the knowledge required to implement HL7 and solve common problems in health care.

The tutorials will be followed by the HL7 Canada Meeting on November 20 with a keynote presentation by Bert Kabbes, Chair of HL7 Netherlands. He will discuss the approach being used by the Netherlands to adapt HL7 for their electronic health record (EHR) initiatives. The day will also feature break-out discussions to address common HL7 implementation and design issues, workshops on Canadian HL7 development projects, as well as HL7 advice, tools, and requirements in Canada.

For more information, please visit:
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=event_hl7_nov02_e

November 21–23: Join us for The Partnership Symposium

The Partnership for Health Information Standards, a program under CIHI, brings together key players from both the public and private sectors to address issues facing health information standards today. From November 21–23, The Partnership will hold its Fall 2002 Symposium, *Time for Action: Implementing Standards in Canada*, at the Delta Ocean Pointe Resort in Victoria, British Columbia.

The event is designed to encourage dialogue and debate on how to influence the development and uptake of Canadian and international standards. Participants will learn about how electronic health record projects are implementing international and Canadian standards; experience how to conduct a Privacy Impact Assessment; engage in grassroots discussions on emerging standards issues. A one-day InfoFair will be featured at this year's event, as well as a welcome reception on November 21, and the ever popular "Night on the Town". A new addition to this year is a meeting for Provincial Standards Councils to discuss common standards activities and opportunities for linkages and collaboration.

This Symposium is open to both Partnership members and non-members interested in learning about and getting involved in discussions related to pan-Canadian health information standards.

For more information, please visit:
http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=event_partner_nov02_e

CIHI directions ICIS

CIHI directions ICIS is published three times a year (January, June, October) by the Canadian Institute for Health Information (CIHI). Since 1994, this pan-Canadian, independent, not-for-profit organization has been working to improve the health of Canadians and the health care system by providing quality health information.

The Institute's mandate is to coordinate a common approach to Canada's health information system. To this end, CIHI provides accurate and timely information that is needed to establish sound health policies, manage the Canadian health system effectively and create public awareness of factors affecting good health.

Cette publication est également disponible en français.

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