

PERSPECTIVES ON POPULATION HEALTH THEORY AND PRACTICE
AMONG HEALTH WORKERS IN A HEALTH REGION

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ABSTRACT

How do health workers understand population health as a concept and as it relates to their practice? How does an accreditation of a health region lead to an understanding of a population health approach?

The purpose of this study was to explore the extent to which health region staff understands population health and to determine how the Canadian Council on Health Services Accreditation (CCHSA) accreditation process addresses population health perspectives. The goal was to ascertain the knowledge, practices, and attitudes of the staff with respect to population health in general and with respect to an accreditation process in order to see how a health region integrates a population health component into its services.

A case study of the Saskatoon Health Region (SHR) was used to determine how a health region can integrate a population health component into the design and delivery of its services. The case study was comprised of a literature review, secondary data review from the 2001 Accreditation Survey Report, and primary data collection from people involved in the 2004 accreditation self-assessment which took place in the health region from March through June, 2004, which was facilitated by the Canadian Council on Health Services Accreditation (CCHSA). Primary data was captured through the use of key informant interviews of twenty employees in the health region. The participants were selected from the sponsors and leads of the accreditation teams that are most connected to a population health perspective; other participants were invited from those teams. These teams were selected by the author after reviewing the results of the CCHSA 2001 Accreditation Report that highlighted areas for improvement. This variety of input from

across the teams triangulated the responses. In addition, key informants representing senior management, (i.e. the medical health officer(s) and the Chief Executive Officer for SHR), were also interviewed. These people were included in order to capture the knowledge practices and attitudes of the visionaries and leaders of the region and their ideas with respect to the direction for population health.

The thesis closes with a discussion on implications for the policy arena and opportunities for the CCHSA to improve the population health content in their accreditation documents.

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DEDICATION

Beatrice

TABLE OF CONTENTS

THESIS QUESTION.....	1
1. INTRODUCTION	1
1.1 Statement of the Situation.....	1
1.2 Purpose of the Study	2
1.3 Conceptual Framework.....	2
1.4 Role of the Researcher.....	3
2. LITERATURE REVIEW	6
2.1 The History of Population Health.....	6
2.2 Early Population Health.....	7
2.3 The Lalonde Report	8
2.4 The Epp Report.....	9
2.5 The Ottawa Charter for Health Promotion.....	10
2.6 Economics and Population Health.....	12
2.7 The Canadian Institute for Advanced Research (CIAR).....	15
2.8 Conceptual Issue: The Tensions between the Different Views of Population Health: Is Population Health a field of study, a concept of health, or is it both?.....	16
2.8.1 Key Elements of the Population Health Template	21
2.9 The Population Health Template:	22
2.10 Summary of Different Views of Population Health.....	26
2.11 Policy Considerations and Population Health.....	27
3. THE CANADIAN COUNCIL ON HEALTH SERVICES ACCREDITATION (CCHSA).....	34
3.1 History of the CCHSA.....	34
3.2 Accreditation Program.....	36
3.3 An Overview of 2001 Accreditation.....	37
3.4 2001 Survey Results of the Accreditation of Saskatoon District Health	37
3.4.1 Comments on Recommendations and Quality Dimensions	38
3.5 Summary of Accreditation.....	39
3.6 Relevance to Research.....	39
3.7 2001 Accreditation Team Results.....	42
4. METHODOLOGY	44
4.1 Qualitative Data and Purposeful Sampling Framework.....	44
4.2 Semi-structured interview instrument design	47
4.3 Research Conduct	52
4.3.1 The Setting	52
4.3.2 Participant Selection	52
4.3.3 Pilot Study.....	55

4.3.4 Data Analysis	55
4.3.5 Analysis Software Used	56
4.3.6 Ethics	56
5. RESULTS.....	58
5.1 Analysis A	60
5.1.1 Upper Management View of Population Health as a Concept.....	60
5.1.2 Upper Management View of Population Health as a Practice	67
5.1.3 Upper Management Strengths and Challenges	73
5.1.4 Middle Management View of Population Health as a Concept	77
5.1.5 Middle Management View of Population Health as a Practice.....	80
5.1.6 Middle Management Strengths and Challenges	82
5.1.7 Front Line Worker’s View of Population Health as a Concept.....	84
5.1.8 Front Line Worker’s View of Population Health as a Practice	85
5.1.9 Front Line Worker’s Strengths and Challenges	86
5.1.10 Summary of Analysis A: Concept, Practice, and Strengths and Challenges.....	87
5.2 Analysis B.....	88
5.2.1 Accreditation Responses	88
5.3 Team 1	90
5.3.1 Strengths, Challenges, and Improvements Identified by Team 1	92
5.3.2 Question 11 Team 1	93
5.4 Team 2	94
5.4.2 Question 11 Team 2	96
5.5 Team 3	98
5.5.1 Strengths, Challenges, and Improvements Identified by Team 3.....	99
5.5.2 Question 11 Team 3	100
5.6 Team 4	101
5.6.1 Strengths, Challenges, and Improvements Identified by Team 4.....	103
5.6.2 Question 11 Team 4	103
5.7 Team 5	105
5.7.1 Strengths, Challenges, and Improvements Identified by Team 5.....	107
5.7.2 Question 11 Team 5	108
5.8 Team 6	109
5.8.1 Strengths, Challenges, and Improvements Identified by Team 6.....	111
5.8.2 Question 11 Team 6	111
5.9 Summary of Analysis B	112
5.9.1 Teams’ Responses to Accreditation Questions about Population Health.....	112
6. SUMMARY OF RESULTS AND DISCUSSION	116
6.1 Discussion of Analysis A.....	116
6.1.1 Concept, Practice, and Policy Implications:.....	116
How do senior management, middle management, and front line health staff with a population health mandate understand population health as a concept and as a practice?	116
6.1.2 Concept:	116
6.1.3 Practice:	121
6.2 Discussion of Analysis B.....	123
6.2.1 Teams’ Responses to Accreditation Questions about Population Health.....	123
How well has this concept and practice been put in place by teams with specific mandates for population health?.....	123
6.3 Study Strengths, Limitations, and Future Research Opportunities	128

6.4 Conclusion	129
Reference List	135
Appendix A: History of the CCHSA.....	140
Appendix B: Population Health (Continuum of Services)	143
Appendix C: Interview Guide	145
Appendix D: Interview Information Sheet and Consent Form	154
Appendix E: Transcript Release Form.....	157
Appendix F:University of Saskatchewan Ethics Approval Letter	159
Appendix G:Saskatoon Health Region Ethics Approval Letter	160

FIGURES AND TABLES

Figure 1: Feedback Loop for Human Well-being and Economic Costs	19
Figure 2: Key Elements and Actions that Define Population Health.....	22
Figure 3: Interview Chart	54
Table 1: Summary Table of Population Health Key Elements E.....	23
Table 2: The Relationship between the core criteria and population health:	89
Table 3: Accreditation Knowledge Summary Across Standards	114

THESIS QUESTION

How do health workers understand a population health component within the design and delivery of services?

1. INTRODUCTION

1.1 Statement of the Situation

There are programs in health regions that have a population health component described as being an essential element of the work delivered in that program. The extent to which staff understands the meaning and the breadth of population health issues is not particularly well known. There is also an accreditation process that health authorities regularly conduct to assess their effectiveness in the programs that they deliver.¹

Similarly, the extent to which accreditation addresses population health knowledge, practices, and attitudes is not especially well known. In order to address this gap, I decided to explore these issues further. I am particularly interested as:

- population health arose in Canadian health system policy discourse during the 1990s
- it embodies some of the same principles, if not the same language, as health promotion, which also exerted influence on health systems during the 1970s and 1980s
- health systems in Canada, notably regional health authorities, have reorganized to incorporate population health concepts, and are now being accredited, in part, on their ability to ensure its practice
- at the same time, both the concept and its practice remain somewhat contested, as I will discuss further in my literature review

I considered it important to examine how the concept of population health and its practice are understood by health systems, particularly in light of accreditation standards for population health. Further, I thought it was important to examine whether the accreditation standards are adequate, when comparing them to what the literature suggests are important criteria for population health.

1.2 Purpose of the Study

The purpose of this study was to explore the extent to which health region staff understands population health and to determine how the accreditation process of the Canadian Council on Health Services Accreditation (CCHSA) addresses population health perspectives.¹ The goal was to ascertain the knowledge, practices, and attitudes of the staff with respect to population health and its accreditation process in order to see how a health region integrates a population health component into its services. Throughout this thesis the term “health systems workers” will be used to describe people who are employed in the health system. The term health system will mean the organized provision of health services ranging from health (medical) care to public health to interventions affecting the determinants of health.

1.3 Conceptual Framework

A case study of the Saskatoon Health Region (SHR) was used to determine how a health region can integrate a population health component into the design and delivery of its services. The case study was comprised of a literature review, secondary data review from the 2001 Accreditation Survey Report, and primary data collection from people involved in the 2004 accreditation self-assessment which took place in the health region

from March through June, 2004, facilitated by the Canadian Council on Health Services Accreditation (CCHSA).¹ Primary data was captured through the use of key informant interviews of twenty employees in the health region. The participants were selected from the accreditation teams most connected to a population health perspective. This selection of teams was by no means exclusive as many other teams in the health region consider themselves to have some population health perspective in their programs. Not all programs with an identified population health component were surveyed, but there was a deliberate attempt to capture those with the most population health relevance. Thus, there was a total of six teams, with three participants per team: a Team Sponsor, a Team Lead, and a Front Line Worker. Team Sponsors were people who worked in upper management levels in the health region. Team Leads were usually middle managers, and front line workers were workers who were involved in delivering the program that was being accredited. Seeking input from three levels in the Saskatoon Health Region triangulated the responses. In addition, key informants representing senior management, such as the medical health officer(s) and the Chief Executive Officer for SHR were also interviewed. These people were included in order to capture the knowledge, practices, and attitudes of the visionaries and leaders of the region and their ideas with respect to the direction for population health. In total there were twenty key informant interviews conducted. The process and rationale are described in the methodology section of this thesis.

1.4 Role of the Researcher

I have been involved in public health since 1981, but I have been interested in it for most of my life. When I was a young boy, my father worked in the same building and became friends with a public health inspector. This naturally led me to wonder what

exactly it was that he did to have an effect on his community. My father also had a strong commitment to his community and so the seeds were planted.

Prior to becoming involved formally in Public Health, I had started an undergraduate degree in sociology at the University of Saskatchewan in 1977. At the time, I also was working in the restaurant industry as a waiter, bartender, and table side chef. The idea occurred to me, and was further encouraged by my Uncle Barry, that a career as a public health inspector could be both a good fit with my background and make a worthwhile contribution to my community, so I left Saskatchewan and obtained a Diploma in Environmental Studies at Ryerson Polytechnic University in Toronto in 1981. While at Ryerson I also wrestled on the college team, travelling around Ontario and Quebec. After graduation, I came back to work in rural Saskatchewan as a Public Health Inspector. I found the work challenging and rewarding. I also stayed involved in my community by coaching high school students in wrestling and football and by belonging to various boards and committees in the communities in which I lived.

Having had this breadth of exposure to all levels of the society in which I lived, and with my earlier study of sociology, I wondered why some people are healthy and enjoy their life while others do not. I decided to go to the University of California at Los Angeles to take some extension classes in Epidemiology and Preventive Medicine in Public Health. Upon return to Canada I continued to work in Public Health, coach, and do Board work, and began to think about finishing my undergraduate degree. Mr. Bryce Graham, my manager at Public Health Services, encouraged me to pursue a master's degree in community health and epidemiology, which I decided to do. I finished the final two years of my sociology degree in 12 months, and then enrolled in the master's

program full-time. I was subsequently asked by the Saskatoon Health Region to help coordinate the accreditation process for the Region. While exploring the literature of the Canadian Council on Health Services Accreditation, I noticed that they stated that a “population health component is woven throughout the accreditation process.”¹ This led me to wonder how well people in a health region understand population health, and how well the accreditation process addresses population health. I subsequently turned these thoughts into my thesis question. I was able to conduct this investigation while coordinating the accreditation process.

On a personal basis, pursuing this Master of Science degree in Community Health and Epidemiology has led me to a supervisory position in the Health Region that addresses the non-medical determinants of health. Moreover, I sit on many boards and committees that also have population health at the heart of their mandates. I have also been serving on the National Committee of the Canadian Council on Health Services Accreditation to rewrite the Community Health Standards for the accreditation document. I plan to stay involved at various levels in the delivery of population health initiatives. This has been a very exciting journey for me; one I will cherish always.

2. LITERATURE REVIEW

This chapter examines the literature around population health. The definition of what constitutes population health is explored, as is the history of population health. Various tensions that exist within population health theory and practice, both historically and currently are also identified and explained.

2.1 The History of Population Health

The following section explores the history of population health and ties the historical issues associated with the concept to the concerns of today. The review explores the writing around population health, works through the arguments, and draws out the implications and lessons to show their applicability to today. Population health, while new as a distinct term, has a longer history embedded within 19th century public health. The review begins by examining these 19th century British and European writings on population health. It then moves to the more recent Canadian policy era, with a brief discussion of the Lalonde paper, *A New Perspective on the Health of Canadians* (1974)², the Epp report *Achieving health for all: A framework for health promotion* (1986),³ and the Ottawa Charter for Health Promotion (1986).⁴ The review finishes with the theoretical and conceptual writings on the more recent, post 1990 adoption of a “population health discourse” in Canada, the U.S., and other countries.

2.2 Early Population Health

In 1854, British physician John Snow convinced the Board of Guardians of St. James Parish in London, England to remove the handle of a pump on a particular well from which contaminated water was making parish residents sick with cholera. Snow used epidemiological analysis of the illness to show that cholera was spread through contaminated water from the Broad Street pump,⁵ and in so doing pioneered the epidemiological method. This public health intervention had a marked health impact on the people in that area of London, reducing their risk of contracting cholera. This was a simple act but it had great implications on the whole population.

Another 19th century British social reformer, Sir Edwin Chadwick, similarly used statistical data to argue for a public response to improve the living conditions of the city's working class in his report *The Sanitary Condition of the Labouring Population* (1842)⁵

It is of note that the evidence from data was not considered sufficient to bring about change; it took a number of years for programs to be accepted by the public. A board of health was established in the United Kingdom in 1848, but it was not until 1850 that any real change in policy was made, with the establishment of the Sanitarian movement.⁵ The purpose of this movement was to develop and implement strategies that would improve health. Edwin Chadwick was effective in mobilizing the opinion of the British middle class so as to have an effect on social and political change, as Hayes and Glouberman describe:

Local governments were established with a strong mandate to protect the health of citizens, improve the water supply, establish sewage/waste removal and treatment, create housing standards and authorize inspectorates to enforce standards. Public health nursing traces its origins to this movement, as do many health protection activities, such as the tracking of communicable diseases and mass inoculation programs (p. 3)⁶

These policies are still considered valuable in today's society. However, there is some discussion as to whether the results expected from these mandates were achieved.^{5,7} Although Chadwick's initiatives were well-intentioned, the results were quite different than he expected. This is described more fully later in this paper.

2.3 The Lalonde Report

This review now leaves nineteenth century England and jumps forward to explore how population health came to be understood in the latter third of the twentieth century and the beginning of the twenty-first century. This jump may be excused by the comparative lack of much emphasis on population health during the early 20th century, when biomedical advances and interventions dominated the health sector.^{6,7}

The literature with respect to population health in Canada suggests that the 1974 Lalonde paper *A New Perspective on the Health of Canadians* marked a watershed moment.⁸ Three statements in the Lalonde report have had an impact on the way in which "health" is viewed. First, it "recognized that health was a complex concept that went beyond medical care" (p.11), secondly it "launched health promotion and prophesied a change in attitudes to health," (p.12) and thirdly, it showed that "ideas were linked through a framework to policy recommendations." (p. 12)⁹ That report defined a new way of viewing health that was not tantamount to medical care alone.⁶ This idea led to the introduction of the "health field concept," which is comprised of four main features: lifestyle, environment, human biology, and health care.⁹ Despite the environment being recognized as a determinant, most of the emphasis went to the politically less risky area of lifestyles and behaviour.⁸ As important as these are in determining health, caution

needs to be used lest all responsibility comes to rest on the people who are presumed to fall ill due to their behaviour alone. Hayes and Glouberman write that an over-exaggeration on lifestyle has “plagued the health promotion movement ever since because of the implicit tendency to blame the victim.”⁶ Therefore when doing population health work it is imperative to examine the societal conditions that contribute to lifestyle choices and not just blame individuals as being weak-willed.

Notwithstanding these limitations, the Lalonde report has contributed greatly to the area of population health. When it was introduced it met a cool reception, yet interest grew, contrary to most reports of this type (p.2).⁸ By 1978 Hubert Laframboise, who had been the Director General of the Long Range Health Planning Branch from 1971 to 1975, considered the report an integral component to health policy planning in Canada and elsewhere in the world.⁸ He was involved in the development of the program at the time so he was bound to be biased; still the report has come to be known as an important work in the discussion around population health. In 1984 it was considered to be a “world class document”¹⁰ and was called “one of the great achievements of the modern public health movement.”³

2.4 The Epp Report

The Epp Report, *Achieving Health for All: a Framework for Health Promotion* (1986),³ named after Jake Epp who was Minister of Health and Welfare at the time, expanded upon the Lalonde report in several ways, recognizing the importance of the environment within a community, who controls the society, the importance of being able to cope, social justice, housing, education, and other considerations in promoting health.

It was also specific in that it identified the need for health systems workers to both act upon and advocate for improved health. Its spirit also had the effect of informing provinces of the need to change their policies in order to affect health promotion. The report illustrates the interrelationship of these elements, the challenges and strategies aimed at overcoming them, and what Epp refers to as health promotion:

...health promotion implies a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances. It means fostering public participation, strengthening community health services and coordinating healthy public policy. Moreover, it means creating environments conducive to health, in which people are better able to take care of themselves, and to offer each other support in solving and managing collective health problems. (p. 11)³

This is a significant milestone—public policy acknowledges the need to create healthier environments, or settings, in relation to health.³ The Epp Report shed light on the importance of factors beyond lifestyle and the other recommendations of the Lalonde report to include a more comprehensive view of health and the way in which society influences health.³

2.5 The Ottawa Charter for Health Promotion

In 1986, when the federal government released *Achieving Health for All: A Framework for Health Promotion*,³ it had expanded the previous report from Lalonde to discuss determinants of health. Besides the four main features mentioned earlier, (lifestyle, environment, human biology, and health care), things such as social, economic, cultural and physical circumstances and interactions of these with individuals' biology and behaviour were introduced to the discussion and how they were all important influences on the health of the population.¹¹

As a result of this type of initiative and new ways of viewing health other reports and frameworks were developed. One of these was the *Ottawa Charter for Health Promotion*. The Ottawa Charter (1986) is the touchstone for health promotion as it is practiced around the world. It identified five priority areas for action:

- i) building healthy public policy,
- ii) creating supportive environments,
- iii) strengthening community action,
- iv) developing personal skills, and
- v) reorienting health services away from curative and salvage activities toward health promotion and disease prevention.” (p. 2 and 3)⁴

Individual behaviour change was the target of some of these strategies, while others were more concerned with societal affects on health, and focused on changing social structures through institutional change, such as healthy cities/communities initiatives, recycling programs, and healthy schools programs. Health promotion proponents recognized that influences in health may interact in many ways. The Ottawa Charter describes these “prerequisites for health” thus:

The fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites. (p. 1)⁴

The progression from basic public health measures such as immunizations, through lifestyle and environment concerns, on to a more comprehensive societal component shows that the discourse around population health is moving toward a more broadly defined notion of health.

Population health and the influence that it hopes to generate have a significant role to perform in informing public opinion about long term health outcomes; these changes are important even though they may take a long time to show up in the population.⁷ Clinical

epidemiology tends to pay attention to a person's life choices, their bodies and attendant risks; it is not as concerned or perhaps unable to understand or assign responsibility as to the causes of the change in the living conditions that are present over time in the world:

The recent resurgence of the population health approach has developed from dissatisfaction with some of the limitations of a strongly individual-oriented methodology, which has characterized recent clinical epidemiology. This is a paradigm that has scored notable successes in identifying risk factors such as smoking and hypertension but, it is argued, has become too rigid and all-pervasive, partly because of its convenience for the administrative and accounting approach of the managerial regime politically imposed on the health service sector during the 1980s. However, from a longer-term perspective, the claims of each of these methodologies can perhaps be helpfully located within a much wider-ranging debate over the relationship between economic growth and human well-being, which provides the historical context for the emergence of a concept of population health. (p.421)⁷

2.6 Economics and Population Health

The debate over the health of the various sectors of a population is not new; it goes back centuries. While Edwin Chadwick, who some consider to be the father of public health, had an effect on raising the awareness of the citizens of that time around issues of the public health, he also had some ideas which were not very helpful. He tried to provide for a minimum employment for citizens of the city through the establishment of “poor houses”. The Poor Law Commissioner's Report of 1834 describes these houses:

Our paupers are allowed to leave the workhouse for one day in each week. It is a very common occurrence for both men and women, on the days that they are let out, to return in a state of intoxication. They are let out on the weekly days, about one o'clock, after dinner, and on festival days early in the morning: on these latter days, it not unfrequently happens that paupers, especially women, are brought into the house by constables or policemen, before twelve o'clock, in a beastly state of intoxication; they are received as a matter of course, and the care of the governor and matron is applied, not to their punishment, but to keeping them quiet and peaceable: if they can be rendered so, they are put to bed, and no further notice is taken of the case; if they cannot, and they are very violent and riotous, the heads of

the house are obliged to have recourse to assistance to hold them or tie them down in their beds. (p.1)¹²

The result of these workhouses was pandemics, lower overall wages, and stigmatization of the poor. The diseases that resulted from the use of this policy were due largely to a change in the diet and the unsanitary conditions. This policy was supported by an earlier piece of legislation called “enclosure laws” where it became illegal for residents to hunt or farm on common land. There was an English ditty spoken at that time that sums up this notion up quite well. It goes, “The law locks up the man or woman who steals a goose from off the common, but leaves the greater villain loose who steals the common from the goose.”⁵ This piece of folklore illustrates a very basic concern around the distribution of wealth. Passing laws to make the common land inaccessible to the average citizen and available to those with the power to control it, is tantamount to what is going on currently (and has been for quite some time) with respect to intellectual property rights. Ringen writes, “A late 20th century analogue of these enclosure laws may well be the transnational corporate rush to patent medicinal genetic information from the cells of plants and people in poorer countries.”⁵

The people in charge of passing laws were the same people who controlled the means of production -- industrialists. They were eager to believe the theory of miasma since it was different from the contagion theory which invariably led to quarantines, and thus threatened trade and commerce. They believed that diseases were passed through the air, and thus, they did not feel responsible for them since this theory was not linked to the conditions present at the time.⁵

Similarly, decades earlier, there was a cholera outbreak in Canada. The merchants there had been eager not to subscribe to the contagion theory since it meant they would not be allowed to offload products from the ships waiting in the port. The result was that, in spite of the public calling for a quarantine on the products, the governor sided with the merchants and did not embargo the products.⁵ Knut Ringen, in his paper on the nature of the 19th century public health, states that there is an interesting analogy to the above situation today, where boards, governments, and policy decision-making bodies are frequently populated and at times funded by the powerful, who ask for smaller governments and regulatory agencies with respect to the monitoring of natural resources, food, and safety concerns.

Another point of Ringen's article is that sanitary reform imposed by Chadwick and others was not brought about by the benevolence of kind businessmen, but rather it became necessary due to economic conditions in the marketplace at that time.⁵ Public health and therefore the health of populations have long been at odds with the business community. This is consistent with what other writers have written about the issues between the health of the populace and the interests of business:

Concern over the social and environmental determinants of health has long been a defining characteristic of public health practice. Simply stated, public health operates on different principles than commercial trade policy. First, it is explicitly concerned with the health of populations rather than with the health of individuals. It reflects the utilitarian precept of 'the greatest good for the greatest number.' Second, its interventions emphasize, in hierarchic order, health promotion (creating living and environmental conditions conducive to health), health protection (ensuring people are not exposed to preventable hazards in their external environment) and disease prevention (acting on vectors or behaviours associated with specific disease) (p.7)⁵

Some argue that changes in the economy are the reason for improvements in overall health since it allows for better conditions to exist. Writers such as Thomas McKeown suggested that the greatest changes to the health of the population lay in better nutrition and sanitation. This is to a great extent true, but it is important to note that the improvement in these two conditions did not happen by accident. To say that it was just a matter of economic growth greatly discounts the important work of the medical officers of health, the sanitarians, school nurses, midwives, and home visitors. These people were greatly responsible for the education and encouragement of people to be healthier.⁵ Moreover, the relationship between health and society is also discounted if the efforts of population health initiatives are not embraced. Szreter writes:

In putting such exclusive emphasis as he did on the "invisible hand" of the rising standard of living and the presumed ability of economic growth to put more and better food in the mouths of the majority of the people as the principal source of the modern decline in mortality, McKeown allowed himself the luxury of arguing for the relative unimportance of all forms of socially organized intervention in relation to the history of public health. This is a dangerous untruth. Public health is an intrinsically political subject, and it cannot be divorced from intentional, organized human agency. (p.722)¹³

Szreter is saying that while economic improvements were important, so were the works of health systems workers in raising the overall health of the population. Improvements do not happen in isolation from each contributing factor; the synergistic effect of people working together to achieve a common outcome must also be acknowledged.

2.7 The Canadian Institute for Advanced Research (CIAR)

A portion of the policy discussed from this point forward in this thesis will, to some

extent, involve the Canadian Institute for Advanced Research's work. To help the reader understand the CIAR, some background may prove helpful. The CIAR, founded in 1982, is headquartered in Toronto, but it is not strictly contained within any one building or location. Its role is to bring together Canada's best researchers to work in collaboration with an international set of peers:

CIAR does not attempt to be geographically representative. We select only the most highly regarded researchers from wherever they may be in Canada or around the world. Together, these groups of researchers tackle complex problems in the sciences and social sciences – problems that challenge our understanding of the world, or that are of crucial importance to our future well-being, as individuals and as a society.(online)¹⁴

The CIAR has been prominent in the population health discourse. In the 1990s there was a great deal of literature produced by researchers working through the Institute that was used to inform policy decision making and to further direct research focus. Published works such as Evans et al's *Why Are Some People Healthy and Others Not?* provided sufficient input to suggest that a paradigm shift may be warranted when discussing health research and policy.¹⁵ Many more works have been published by the CIAR that have had an impact in the way in which population health is understood as a term and as a practice.¹¹ Some of these are addressed in the next section of this work.

2.8 Conceptual Issue: The Tensions between the Different Views of Population Health: Is Population Health a field of study, a concept of health, or is it both?

Many differing opinions as to what population health is continue to exist throughout the literature. Hayes and Dunn, in their systematic review of population health in Canada, write that there is 'considerable confusion about what 'population health' is.'¹¹ Authors of the key informant survey on population health undertaken by CPRN found:

[T]here are contrary points of view, and different emphases, which suggest that population health has barely begun to be understood, even among its advocates. The participants for this survey were chosen specifically because of a special expertise with health promotion and/or population health. Yet despite a core of common thought and a belief that it was important to have a common understanding, there were divergent views [about what population health is] (p. 2).¹¹

Although the above description is nearly ten years old, some of the points are still relevant; there is still confusion around what it is and is not. Many authors write that population health is a field of study (research) that measures the health of given populations. Others write that it is interventions in the non-medical or social determinants of health delivered to and with populations. The differences between the two can be difficult to grasp. For example, Hayes and Dunn suggest that, due to the evolutionary nature of population health, it can be difficult to understand. This is due to many contributing factors such as the ability of key leaders to understand what it means to their communities and how the leaders can affect local policy and other leaders having influence in how programs are delivered. For these reasons the very understanding of what population health changes over time and differing interests. Therefore, some writers say that it may be necessary to distinguish between population health research and a population health framework.

Others suggest population health is more broadly defined as the non medical determinants of health. Still others want to merge the ideas. In their article “What is Population Health?” Kindig and Stoddart write,

Population health is a relatively new term that has not yet been precisely defined. Is it a concept of health or a field of study of health determinants? We propose that the definition be "the health outcomes of a group of individuals, including the distribution of such outcomes within the group," and we argue that the field of population health includes health outcomes,

patterns of health determinants, and policies and interventions that link these two. (p. 380)¹⁶

One of the most important pieces of literature with respect to the population health approach is contained in the work of Evans, Barer and Marmor's *Why Are Some People Healthy and Others Not? The Determinants of Health of Populations*.¹⁵ Even though this is considered one of the top works in this field, the term population health is never precisely defined. Rather, they speak to population health's "linking thread [to be] the common focus on trying to understand the determinants of health of populations. (p 29)¹⁵ The following chart, taken from Evans et al. ¹⁵, shows how different determinants of health interact with people to affect the way they live and are able to access services.

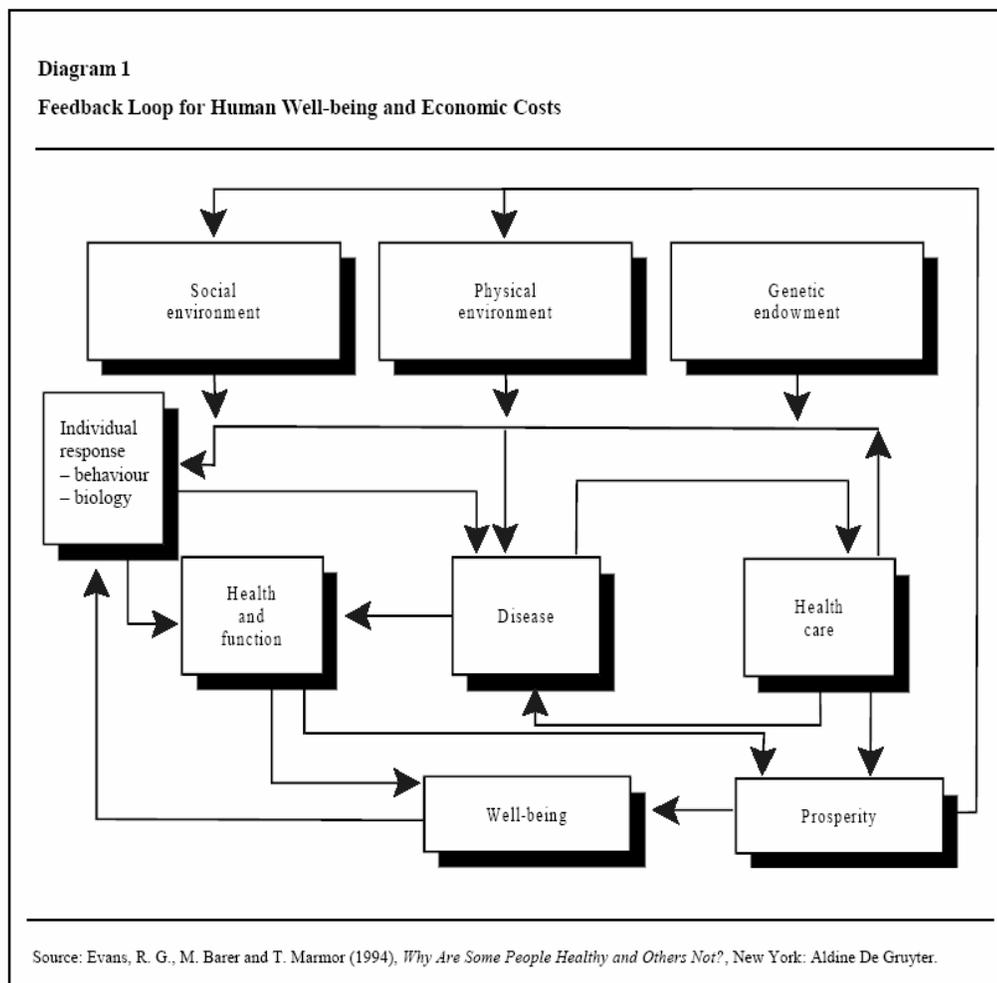


Figure 1: Feedback Loop for Human Well-being and Economic Costs

They view population health as those conditions or determinants that have an effect on health outcomes. This work has led to more discussion that population health is a field of study or a research approach focused on health determinants:

Early discussions at the Canadian Institute for Advanced Research also considered the definition and measurement of health and the processes of health policymaking, but the dominant emphasis evolved to the determinants themselves, particularly the nonmedical determinants. John Frank, the scientific director of the recently created Canadian Institute of Population and Public Health, has similarly called population health "a newer research strategy for understanding the health of populations." T. K. Young's recent book *Population Health* also tends in this direction; he states that in Canada and the United Kingdom in the 1990s, the term has taken on the connotation of a "conceptual framework for thinking about why some populations are healthier than others as well as the policy

development, research agenda, and resource allocation that flow from this framework."(p. 4)¹⁵

However, Young also suggests that the term has been used previously to describe the health of populations, which is the actual literal meaning of the term. In still other work, Evans and Stoddart supported an emphasis on "understanding of the determinants of population health," however, they have also written that "different concepts [of health] are neither right or wrong, they simply have different purposes and applications..." (p. 28)¹⁵

Other writers, like Friedman and Starfield, argue:

Models of population health differ not only in their implicit or explicit definitions of population health, but in other key ways as well. They:

- include different categories of factors affecting population health, and vary in their relative emphases on certain categories.
- depict different causal relationships among factors, and between those factors and population health.
- represent interactions among factors differently.
- vary in their presentation of factors as actually determining population health rather than influencing it.
- differ in their distinction between population health and individual health, and the relative influence of various factors on each. (p. 366)¹⁷

Hayes and Dunn write:

Population health is a framework for thinking about the social and economic forces that shape the health of citizens. Population health builds on a long tradition of public health and health promotion, and goes beyond the more traditional focus on the individual as the medical, biological or lifestyle problem. (p. v)¹¹

The Public Health Agency of Canada website describes a population health approach as one where the focus is directed toward populations or groups within a population rather than the individual. This therefore directs focus toward the reduction of

inequalities between subgroups. Further, it follows, that investing in upstream activities within those subgroups will lead to overall better health among populations.¹⁸

The literature suggests that when all of the discussion that eventually defines population health is incorporated, there are essential key elements that emerge. There are many population health templates that are identified in the literature. The author has chosen to highlight the following one from Health Canada, Population and Public Health Branch, Strategic Policy Directorate,¹⁹ since it is very thorough and addresses measurement of population health status, the decision making process, policy implications, and has many other features.

2.8.1 Key Elements of the Population Health Template

The *Population Health Template* consists of eight *key elements*.¹⁹ They are:

- (1) focus on the health of populations,
- (2) address the determinants of health and their interactions,
- (3) base decisions on evidence,
- (4) increase upstream investments,
- (5) apply multiple strategies,
- (6) collaborate across sectors and levels,
- (7) employ mechanisms for public involvement, and
- (8) demonstrate accountability for health outcomes.

While *all eight elements are necessary* for implementing a population health approach, key elements one and two are unique to the definition of a population health approach and key elements three to eight reflect implications of a population health approach and factors associated with good management practices.

The eight key elements are presented in the figures below.

2.9 The Population Health Template:

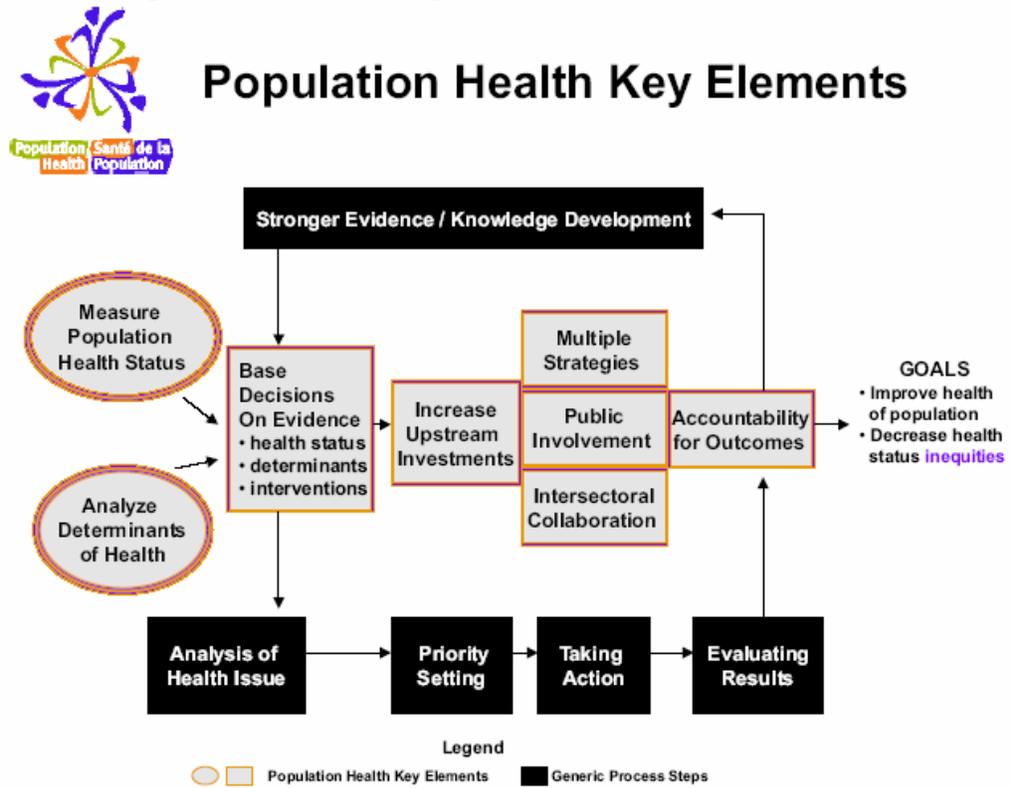


Figure 2: Key Elements and Actions that Define Population Health

Table 1: Summary Table of Population Health Key Elements

Summary Table of Population Health Key Elements

The goals of a population health approach are to maintain and improve the health status of the entire population and to reduce inequities in health status between population groups.

Key Element	Actions
1. Focus on the Health of Populations	1.1 Determine indicators for measuring health status 1.2 Measure and analyze population health status and health status inequities to identify health issues 1.3 Assess contextual conditions, characteristics and trends
2. Address the Determinants of Health and Their Interactions	2.1 Determine indicators for measuring the determinants of health 2.2 Measure and analyze the determinants of health, and their interactions, to link health issues to their determinants
3. Base Decisions on Evidence	3.1 Use best evidence available at all stages of policy and program development 3.2 Explain criteria for including or excluding evidence 3.3 Draw on a variety of data 3.4 Generate data through mixed research methods 3.5 Identify and assess effective interventions 3.6 Disseminate research findings and facilitate policy uptake
4. Increase Upstream Investments	4.1 Apply criteria to select priorities for investment 4.2 Balance short and long term investments 4.3 Influence investments in other sectors
5. Apply Multiple Strategies	5.1 Identify scope of action for interventions 5.2 Take action on the determinants of health and their interactions 5.3 Implement strategies to reduce inequities in health status between population groups 5.4 Apply a comprehensive mix of interventions and strategies 5.5 Apply interventions that address health issues in an integrated way 5.6 Apply methods to improve health over the life span 5.7 Act in multiple settings 5.8 Establish a coordinating mechanism to guide interventions
6. Collaborate Across Sectors and Levels	6.1 Engage partners early on to establish shared values and alignment of purpose 6.2 Establish concrete objectives and focus on visible results 6.3 Identify and support a champion 6.4 Invest in the alliance building process 6.5 Generate political support and build on positive factors in the policy environment 6.6 Share leadership, accountability and rewards among partners
7. Employ Mechanisms for Public Involvement	7.1 Capture the public's interest 7.2 Contribute to health literacy 7.3 Apply public involvement strategies that link to overarching purpose
8. Demonstrate Accountability for Health Outcomes	8.1 Construct a results-based accountability framework 8.2 Ascertain baseline measures and set targets for health improvement 8.3 Institutionalize effective evaluation systems 8.4 Promote the use of health impact assessment tools 8.5 Publicly report results

Although different organizations have their own way of describing population health; there are common threads throughout the various definitions. The website of the Calgary Health Region, (based on a model developed by Hamilton and Bhatti), describes Population Health as follows:

The Population Health Framework is an over-arching or core framework that focuses on the entire range of individual and collective factors and the interactions among them that determine health and well being. These factors are referred to as determinants of health. By focusing on determinants of health, the Population Health Framework acknowledges the combination of factors that influence health. These include: the health care system; individual factors (e.g. healthy behavior); and the conditions of risk known to affect health status, over which individuals have limited control (e.g. poverty, unemployment, unhealthy physical environments, poor housing). The need for coordinated action by all sectors of society, not only health, in order to address these risk factors is also recognized.(online)²⁰

Health Canada describes population health as “an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.” (online)²¹ An underlying assumption of a population health approach is that reductions in health inequities require reductions in material and social inequities. Health inequities refer to the broad determinants of health that are different at different social strata.¹⁶ This is stated further by the Health Promotions and Programs Branch of Health Canada thus: “the overall goal of a population health approach is to maintain and improve the health of the entire population and to reduce inequities between population groups.” (online)²¹

Bringing the concept a little closer to the author’s research interests, Saskatchewan Health describes population health promotion as “creating the conditions that support the

best possible health for everyone. Promoting health is a shared responsibility that requires the coordinated action of many sectors working together to improve well-being.” (p. 28)²²

Its *Action Plan for Saskatchewan Health Care* notes that the health of a population or community depends on a great many influences that go beyond the notion of traditional health care or the behaviour of the individual. The support of a family, meaningful employment, and a healthy place to live and work all affect our health. “People are much more likely to be healthy if they live in communities where it is ‘easy’ to be healthy.” (p. 16)²³

The Saskatoon Health Region (SHR) addresses a broad population health perspective in a variety of programs. It also focuses on population health throughout its programming and through the use of two programs: Public Health Services and the newly formed Primary Health Services. There is considerable and desirable networking between the two groups. Public Health Services “strives to enhance health and well being through population-based programs that: promote healthy communities, groups, families and individuals; prevent disease and disabilities; (and) protect the public from environmental hazards.” (online)²⁴ SHR also provides population health services through Primary Health Services. The SHR website describes primary care as the first level of contact with a health care system and attends to a specific problem or health concern. Primary Health Services expands upon this to include, “a holistic approach to health, a continuum of services, a range of health providers, involvement of the public, (and) a recognition that health is influenced by many factors outside of the traditional health system.” (online)²⁴

The Canadian Council on Health Services Accreditation describes population health by

asking organizations such as health regions, to look beyond the clients using their services to the whole population that they may serve. They write that population health is:

A way of looking at health and services, and an approach to managing them, that focuses on the needs of a given group as a whole, and the factors that contribute and determine health status. A population health approach facilitates the integration of services across the continuum and is an underlying philosophy of the AIM [Achieving Improved Measurement] standards. p.16¹

(This is described more fully in chapter three, the following chapter of this thesis.)

To summarize the above definitions: Promoting health, partly through services and programs delivered by health systems, involves much more than what is typically thought of when considering health care. Previously, hospitals and doctors' offices were thought to be the "place" for health care and to many they still are. But, we also know now that it is far more than that; it is the social, environmental, and economic conditions that contribute to the health of a population, and that create inequities in health between different groups.

2.10 Summary of Different Views of Population Health

In this portion of the literature review, the differing view points with respect to population health have been highlighted. A great deal has been written about the definition of population health as well as the inability to concisely define what it is. Even though population health can not be precisely defined, due to its changing nature, the literature suggests that it is never-the-less very important and the need to conduct research in this area has been demonstrated.^{6,11,25} As Hayes and Dunn write there has been a good deal of importance to furthering these initiatives:

Population health has emerged as a major theme of health research and social policy reform in Canada. At the national level, the Federal/Provincial/Territorial Advisory Committee on Population Health (FPTACPH) *Report on the Health of Canadians* (September 1996) and *Strategies for Population Health* (September 1994), recommendations of the National Forum on Health (February 1997), the National Population Health Survey (1994-95), and the National Health Research and Development Program's *Toward the Year 2001* (1995) plan for research funding illustrate its impact.(p.1) ¹¹

2.11 Policy Considerations and Population Health

Within the field of population health and epidemiological research there exist differing points of view with respect to what to measure, how to measure it, and whether this is all that matters. This next section of the chapter will look at population health from a broader perspective: identifying points from other writers that address the issue of population health as more than simply measuring the health outcomes of a population or defining the non-medical determinants of health. It will look at the way in which policy affects those determinants, and the things that must be considered at a societal level in order to have an effect on improving the determinants of health for all members of the community. It is not enough simply to identify these policies and know that there are different health outcomes as a result. It is also important to utilize them as a means to creating a more egalitarian society.

Now, with the advent of different social theorists becoming involved in the field and the recognition of the importance of the non-medical determinants of health, the whole 'practice' takes on a different tone. It becomes much more than just assigning resources to study a problem: you need to view the world from different political and economic analytical assumptions. ²⁵ Frohlich et al write that:

Just as social theory may help develop a more robust social epidemiological practice, so too may it contribute to the development of population health research and practice. The phenomena of interest to population health—population-level patterns of health—are not naturally occurring or “random” events, but are inexorably tied to how societies are organized. Gender, income, ethnicity, and other “determinants” of health both reflect and at their core, constitute complex social processes. To better research and address population health problems, we require social theories that help frame questions, interpret data, and explain social phenomena. (p. 392)²⁵

They go on to discuss how many writers have different theories to explain why there are inequities in health outcomes associated with inequities in social or economic status. Some authors offer that the health outcomes related to income inequality is a result of disinvestment in social capital (a term that refers to the assets and attributes of social networks). This reason for differences in health outcomes associated with income inequality^a may be valid; indeed it has its supporters and they all make valuable points. The way in which writers discuss issues depends on how those writers become informed about the topics. If one places too much stock in any particular school of thought to the exclusion of other ways of thinking about things, then only some of the story gets told and subsequent policies designed to mitigate population health inequities may lack important elements. For example, if a person looks only at obesity rates and the accompanying coronary diseases, you develop a good understanding of obesity and the attendant illnesses, but you may not become any better at understanding why people become obese, do not exercise, eat or drink destructively, or are unable to change their

^a The concept of **inequity** has been considered synonymous with the concept of **inequality**; however, it is fundamental to differentiate between the two. While inequality implies differences between individuals or population groups, inequity refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. Not all inequalities are unjust, but all inequities are the product of unjust inequalities. The definitions of *just* and *unjust* are subject to various interpretations. In the context of health, one of the more accepted definitions of "just" refers to equal opportunities for individuals and social groups, in terms of granting access to and using the health services, in accordance with the needs of the various groups of a population, regardless of their ability to pay.²⁶

behaviour. Some knowledge of the makeup of that person's character and social surroundings may lead to a better understanding about the type of interventions that could have a positive effect on that situation. It is therefore necessary to look at population health and policy concerns from a broad perspective.

In the CPRN Study No. H|01, Labonte addresses this issue by speaking to two important concerns with respect to population health as it has been described throughout the literature. He identifies that it is important to recognize that epidemiology is not capable of being the exclusive way of conducting research into determinants of health, as it becomes too individually focused such that it cannot take into account the discrepancies between social classes. For example, it is known that people in lower socioeconomic status (SES) groups smoke more. Epidemiology can identify that but it does not explain why, nor more importantly, how different SES groups, or social classes, come to exist. Further, epidemiology, because it embodies a positivist methodology, and positivism remains privileged in our society as the "real" science, dominates population health research. Yet, epidemiology fails to address the importance of human agency, and social theoretical critiques of capitalism, gender, and environmentalism. However, it is worth noting that this epidemiological dominance is now changing.¹¹

The other point Labonte makes is with respect to economic growth. As mentioned earlier in this paper, there is a great deal of importance placed upon economic growth and the result being a rising standard of living. Dunn and Hayes write that Labonte argues that placing too much emphasis on the effect of this model of economic growth is of concern for the following reasons:

First, it fails to value the contribution of caring to overall levels of population health. Second, presenting health care as a consumer of wealth,

while at the same time arguing that health care has little impact upon overall levels of population health, feeds into the neoconservative/liberal obsession with deficit reduction and the related agenda of downsizing the state (i.e., population health as right wing political discourse). Third, in presenting economic growth as de facto good, and in the absence of a critical analysis of capitalism, there seems to be a blindness as to the root causes of income inequality, which figures so prominently in the CIAR's analysis of major health "determinants." Finally, Labonte questions the ecological limits of economic growth. Japan's economic growth, for example, which also figures prominently in the CIAR analysis, was attained at great environmental expense by the rest of the world (particularly in Southeast Asia). Just as Marmor, Barer and Evans criticise health promotion for healthism – i.e., defining all aspects of life and public policy as having a health component – Labonte charges that the CIAR's focus on economic growth breeds "economism" – the belief that all public policy should be subordinate to sustained economic growth and increased prosperity. (p.32)¹¹

Labonte writes similarly in the *Journal of Critical Public Health* (1997) that some of CIAR's economic models regarding population health reflect a status quo view of the world, and that these models have a deficit–reduction bent rather than any genuine health reform agenda as their goal. At the basis of the use of these models in the way in which the CIAR themselves defines "'society as 'population' and 'economy' as a set of forces independent of peoples' values, beliefs or ideologies." (p.18)²⁷ Articles published by population health branches of health jurisdictions can be found throughout the literature, proudly displaying savings in health care expenditures.²⁸

The importance of including input from all levels of society in order to pay attention to those beliefs is echoed by Coburn and Denny:

How might we expand on, or reframe, currently dominant versions of population health? How might we push beyond the conceptual and methodological limits of population health models? We need to develop analyses that not only demonstrate the relationships between variables but tackle the social processes that produce them. That is, we must incorporate the broader context of politics and economics into our analytical models. We also need to commit to research that involves real people and groups in such areas as policy, implementation, and action. (p. 394)²⁹

By including grassroots stakeholders and people from across the population to provide input onto the policy development and direction of programs, policy writers will be better able to write policy that will help develop more relevant and meaningful programs to address the broad spectrum of issues that dictate health outcomes.

This inclusion of all aspects of a population, including community as a determinant, is considered vital to identifying and implementing interventions to address issues in a community. This is important because if these links can be identified there is hope for a healthier community. Edwards writes:

However, a more expansive understanding of what protects against disease or illness might emerge from examining causal links between determinants and health rather than determinants and disease. This “reverse” causal thinking would identify additional variables to measure and new statistical models to test. Theoretical models (e.g. models of resilience, capacity development, meaningful participation in society, and social cohesion) are required to guide this type of thinking. (p. 10)³⁰

It is also important not to consider determinants as some forces that have an impact on health, yet exist in isolation. The determinants are very much a part of society and it is the society upon which the analysis of population health is based.³¹

However, it must also be noted that greater forces than those that just exist within the immediate community have an impact on that community. Political forces such as globalization and class structure are very important in this whole discussion and must be addressed.³⁰

This type of thinking about community and populations is not new. In the nineteenth century Rudolf Virchow said that diseases were caused by defects in society.³² He argued that government should address disease through economic and social policies that would

reduce illness throughout the population. Public health advocates and now population health policy workers and policy writers have always faced opposition to their ideas because the people in positions of authority maintain their positions by maintaining the status quo. It is often not in the interest of a politician or a government or health care worker to further social policy that would challenge the current way that things are done or that cost more money. There is optimism that the advent of the new Public Health Agency of Canada will have an effect on mobilizing attitudes and resources to further a population health goal, but it will take vigilance to ensure that this happens.³²

The way in which population health concepts are discovered and taken forward is important, of course. However, centuries of demonstrated health outcomes, across economic and social strata, is quite compelling. This story has been told for generations. Our society and the people whom we elect to direct our society have to make a decision to invest in the health of the citizens and the community in which those citizens live. That decision is not always easy; but it is ultimately necessary if broader health outcomes are to be realized.

As described above, there is much conflicting discussion with respect to what population health is. Some writers have identified it as a way to measure the health status of a population, others understand it to mean the non medical determinants of health and the impact those societal influences have on the health of a population. Still others write about the differences in the philosophical basis between the ways to consider a population health approach. Some argue that it is important to address the non medical determinants of health while maintaining the current systems. Others suggest that it is time to change the systems and consider a population health approach from a point of view that considers

society in a more egalitarian perspective, thus having the greatest effect on the greatest number of people across the breadth of the population. I will therefore look for the things that the participants identify as important to population health and which of the varied perspectives they consider best addresses a population health approach. I contend that the understanding of community involvement and the structural social inequalities are the two least understood pieces around population health.

This previous section of my thesis described the ways in which the notion of population health came into existence, and the many ways in which it is viewed. The remaining sections describe my qualitative interviews, their results and discussion of how workers in a health region view population health. I intend to demonstrate the way population health impacts their practice, and the sorts of tensions and issues this raises for health systems. Their responses will reveal whether they view it as a measurement tool, an instrument which will save health regions money by keeping people healthy, and whether they see it as bigger than these ideas and integral to a more robust and egalitarian society. This will be discussed more fully in the methodology chapter.

3. THE CANADIAN COUNCIL ON HEALTH SERVICES ACCREDITATION (CCHSA)

The CCHSA Accreditation process is integral to the research topic. Below the author briefly discusses the history of the CCHSA, and its recent adoption of standards for population health.

3.1 History of the CCHSA

The roots of the CCHSA go back to when a group of the American College of Surgeons (ACS) developed basic hospital standards (see Appendix A). The first standards' inspections began in 1918; only 89 out of 692 hospitals met the minimum standards. In 1952 many more organizations joined the accreditation process, such as The American College of Physicians, the American Hospital Association, the American Medical Association; the Canadian Medical Association also joined with the ACS to create the Joint Commission on Accreditation of Hospitals (JCAH)^{1,33}

In 1953 “the Canadian Hospital Association (now the Canadian Health Care Association), the Canadian Medical Association, the Royal College of Physicians and Surgeons, and l'Association des médecins de langue française du Canada established the Canadian Commission on Hospital Accreditation (CCHA). The CCHA's purpose was to create a Canadian program for hospital accreditation.” (online)³⁴ The Commission realized its goal with the incorporation of the Canadian Council on Hospital Accreditation.

The Canadian Council on Hospital Accreditation (CCHA) was incorporated in 1958. The Council's purpose is to set standards for Canadian hospitals and evaluate their compliance. “The accreditation program is voluntary, free from government intervention, national, bilingual, and not-for-profit.” (online)³⁴

Since 1958 its accreditation programs have focused on assessing structures and processes of health organizations and the ability to deliver care and services set against a set of national standards.³⁵ The health care facility accreditation function continued until about 1990, when the Council started to focus on structure and process. A survey conducted in 1992 with member organizations led to the development of client-centred standards that advanced a quality improvement component. By 1995 the Council started to focus on a client-centred accreditation program in which community health services are also accredited.¹ At this time the Council began to consider population health as a requisite of function of health systems: “A population health focus has been built into the standards to indicate that all health services organizations bear some responsibility for the health of the populations they serve.” (online)³³

The 2003 Edition of the CCHSA Achieving Improved Measurement (AIM) standards addresses population health in a more complete fashion than previous iterations of the AIM document had. (This is the text of accreditation standards.) This edition spells out what CCHSA considers important to a population health approach. They write:

What about population health?

Another concept in the AIM Program is that of population health. When CCHSA asked its clients and stakeholders about the trends in health services, *population health* was a theme that made a frequent appearance. The time was right to emphasize its importance within the accreditation program.

Throughout the AIM Accreditation Program, we ask organizations to look

beyond the individual clients using their services, to the whole population that they may serve. This is population health. The following points highlight the key elements of the population health approach in the AIM Program:

- placing more importance on “health and wellness”
- being aware of the factors that affect health (determinants of health), of the health status and health needs of the population when planning and allocating resources
- empowering and involving the broader community in planning and decision making
- integrating services across the continuum of health services
- using evidence-based information about health outcomes to make decisions. (p. 10)¹

For a listing of the CCHSA Population Health Indicators and Determinants see Appendix B.

The CCHSA writes in their literature that when considering a population health perspective two key elements need exploring. One is the “continuum of health services” and the other is the “determinants of health” The CCHSA does address some of the key aspects of a population health focus such as determinants of health and the need to involve the broader community in planning and decision making. The literature review in the previous chapter identified some larger societal considerations that the CCHSA literature does not ask health regions to consider, i.e. the notion of population health as the driving force for communities to develop a more inclusive and equal society in which to live, thereby paving the way for better health and life outcomes.

3.2 Accreditation Program

The CCHSA writes in its literature that the accreditation process has a strong population health component woven throughout the Achieving Improved Measurement

Program.¹ Initial follow up of the previous 2001 recommendations to the Saskatoon Health Region (the health organization that provides the sample for this case study) has provided an excellent opportunity to conduct an environmental scan to determine what conditions and attitudes exist with respect to population health. For example, one of the recommendations from the 2001 accreditation was to have the health region conduct a mock emergency disaster. The health region conducted an emergency measures operation in concert with other agencies in Saskatoon such as police, fire and ambulance. The operation was a success and showed cooperation between the various agencies. It should be noted that the success of the operation was not contingent on everyone involved performing perfectly; rather, it was a learning exercise with the object of the task to identify areas of improvement and implement those discoveries. This has been accomplished.³⁶

3.3 An Overview of 2001 Accreditation

The 2001 Accreditation of Saskatoon District Health identified many strengths, opportunities for improvement, and some recommendations. Recommendations are those issues that required a more deliberate focus and were expected to be in place prior to the next accreditation survey. Information gathered from the 2001 report has helped to shape the specific research questions in the case study (see Methodology chapter).

3.4 2001 Survey Results of the Accreditation of Saskatoon District Health

The following is a verbatim transcript of portions of the SDH 2001 survey results. It is presented here to inform the reader of what some of the issues were in the previous

accreditation process. The survey instrument of this research asks participants if they think there have been improvements around some of these issues since that time:

The summary of the 2001 report speaks specifically to the importance of Community Integration. In the summary, council highlights the collaboration of the health region and many community organizations. Council also highlights the fact that the health district “has endorsed a population health approach. This recognizes the need to integrate service across the continuum and collaborate across health and community sectors.”

Examples of this integration include:

- Saskatoon Regional Intersectoral Committee chaired by SDH with membership from education, social services, and justice
- Co-ordinated access unit
- Central intake system for mental health
- Mental health and rehab populations are attending a camp sponsored by business, CMHA crisis service, church, and SDH
- White Buffalo Lodge, venture of the Saskatoon Aboriginal Tribal Council and SDH for aboriginal children and adolescents with social, health, and educational needs
- The excellent relationship between SDH and the affiliate long term care facilities is commended.³⁷

The CCHSA also mentioned that the teams worked well together and had identified areas of strength and improvement opportunities.

3.4.1 Comments on Recommendations and Quality Dimensions

There are four main components to the accreditation of an organization as outlined by the CCHSA. They are Client/Community Focus, Responsiveness, System Competency, and Worklife. The surveyors from the 2001 accreditation identified 22 recommendations for Saskatoon District Health. The following lists the ones that have a population health focus:

Client/Community Focus

The recommendation for this component is with respect to information that is sensitive to a culturally-diverse population.

Responsiveness

Here two population health recommendations were noted. They are: ‘integrating services in the community, strengthening feedback from Home Care.

System Competency

“There are several population health recommendations under System Competency relating to creating safe and efficient work space, a mock disaster exercise, incorporating best practices, integrating Public Health with Family Health, integrating community services, enhancing health promotion and prevention in Rehabilitation.

Worklife

There were no population health recommendations associated with this dimension.³⁷

3.5 Summary of Accreditation

Several of the recommendations listed are directly associated with population health, specifically, a mock disaster exercise, incorporating best practices, integrating Public Health with Family Health, integrating community services, and enhancing health promotion and prevention in Rehabilitation. While many of these recommendations do have a population health aspect to them, there is still a need to address broader community determinants in a more meaningful way as suggested by many of the writers as described in the literature review.

3.6 Relevance to Research

All of the above findings from the 2001 Accreditation are important. Some are more connected to population health than others. The research has focused attention to those areas that are more directly involved with population health.

The accreditation of a health region is accomplished by a series of meetings involving staff from the various work places in the region. The people who meet are known as team members. There were a total of 18 teams involved in the 2001 accreditation. The four teams with the greatest population health responsibility were Community Health Services, Home Care Services, Mental Health, and Rehabilitation. The 2004 Survey had a slightly different collection of teams, which assessed themselves according to the accreditation standards. The teams are Addictions, Home Care, Mental Health, Public Health, and Rehabilitation and the newly formed Primary Health team. During the 2004 Accreditation there were a total of 21 teams involved in the accreditation of the Health Region. These teams were selected by program based on criteria prescribed by the CCHSA and as decided by SHR. The CCHSA does allow for some latitude with respect to team creation. These teams were from all programs within SHR. Everything from acute care to surgical to rehabilitation had accreditation teams. For the purpose of this study the six teams with the greatest population health relevance have been chosen to participate.

In the previous accreditation, both Home Care and Addictions were represented by the Family Health Services team; they each had teams of their own for the 2004 Accreditation and were given the previous results entitled: "*Team Summary Home Care Services Standards Family Health Team*"³⁷ Also, of particular note, due to its specific relationship across many teams and disciplines, is the new program Primary Health Care Services.

The new Primary Health Team²⁴ received special attention and was a part of a pilot project, launched by the CCHSA and with participation of SHR to study what the

accreditation needs of a primary health team will be.^b The Health Canada website describes how Primary Health Care came into being as follows, “As part of the Action Plan for Health System Renewal adopted by First Ministers in September 2000, First Ministers identified primary health care reform as a priority for the renewal of Canada's health care system. To support this goal, the Government of Canada created the \$800 million Primary Health Care Transition Fund to help bring about systemic, long-term reform. The Fund will support provinces and territories in their efforts, over the next four years, to improve the delivery of primary health care.” Health Canada continues to describe Primary Health Care:

Primary health care is the first level of care and is usually the initial point of contact individuals and families have with the health system. Examples include: regular checkups with family physicians, phone calls to health information lines, visits from public health nurses, or advice given by pharmacists. Primary health care is the most common experience Canadians have with the health care system and it often takes place in physicians' offices or community health centres.(online)²¹

Since primary health care has been identified by Health Canada as being an important initiative in Canada today and since there currently are no specific standards available to address this team, CCHSA and SHR worked together to make the 2004 accreditation an avenue that has helped to define what constitutes the standards for CCHSA with respect to primary health care. Therefore the Primary Health team was represented in the accreditation process.

^b As a part of the coordination process of the SHR 2004 Accreditation, the General Manager, Manager, and Primary Health Team staff were consulted and asked to review the Community Health Standards to identify what part of those standards would be useful for Primary Health. They then worked with CCHSA to construct standards that would be useful to accredit a Primary Health program.

3.7 2001 Accreditation Team Results

The results of the 2001 Accreditation Survey for the teams listed above as being most relevant to population health formed part of the background knowledge to help inform the researcher with respect to creating the survey instrument for the key informant interviews.

As part of an accreditation of a health region there are four core teams that are considered to be the basis of support for the way in which all other teams within a health region function. The four core teams are stand alone teams that participate in the accreditation process. These core teams were *not* a part of the case study conducted by the researcher. However, all of the recommendations written during the 2001 accreditation process rest on what has been written with respect to these four core teams' standards that CCHSA identifies in their literature. In the survey instrument the criteria that are most relevant to a population health approach are written out for each of those four core teams. The core teams of Leadership and Partnership, Human Resources, Information Management and Environment are considered to be the basis of a continuum of care, which is required to support population health initiatives. These four core teams are the backbone of the organization. All other teams rest fundamentally upon these core teams. Each of these core teams has specific standards that are considered integral to a population health initiative. They all have elements of population health woven throughout the criteria in each of the standards of these core teams. The standards for these teams were provided to the author by the Canadian Council on Health Services Accreditation.³⁵ They were thought to be a good way of capturing the knowledge around population health from a broad perspective. This idea was discussed among the author, the thesis supervisor, and a member of the thesis committee.

In this chapter I have outlined the history of the CCHSA and brought to light the recommendations from the 2001 accreditation. I also described what teams would be involved in the accreditation interview portion of the case study.

4. METHODOLOGY

In this chapter the author will describe the way in which the data was collected and analyzed. The setting, participant selection, pilot study, the instrument, and other items particular to the methods used in this study will be addressed.

4.1 Qualitative Data and Purposeful Sampling Framework

The data collection method used in this research was qualitative. Qualitative methods of inquiry delve into the way in which people view the world around them; how they see things; in this case, population health. Qualitative methods can reveal the knowledge, make known the attitudes and highlight the practices that exist in a health region.³⁸

Qualitative methods have a variety of philosophical and theoretical perspectives. Patton writes that there is no one way to categorize the many methods that are used.³⁹ Patton continues, “Creswell (1998) distinguishes “five qualitative traditions of inquiry”: biography, phenomenology, grounded theory, ethnography, and case study.” (p.79)⁴⁰

The author has chosen to use the case study method of research inquiry because it offers the researcher the opportunity to appreciate the worker’s role and experiences in a program. McNamara writes that a case study, “fully depicts client's experience in program input, process and results and is a powerful means to portray program to outsiders.”(online)⁴¹

McNamara also writes,

Case studies are particularly useful in depicting a holistic portrayal of a client's experiences and results regarding a program. For example, to evaluate the effectiveness of a program's processes, including its strengths and weaknesses, evaluators might develop case studies on the program's successes and failures. Case studies are used to organize a wide range of information about a case and then analyze the contents by seeking patterns and themes in the data. A case can be individuals, programs, or any unit, depending on what the program evaluators want to examine through in-depth analysis and comparison. (online)⁴²

The researcher thought that the opportunity for examining the way in which health workers considered population health as a concept and a practice would be afforded best through the use of the case study method. As Robert Stake writes:

Case study is not a methodological choice but a choice of what is to be studied... We could study it analytically, entirely by repeated measures or hermeneutically, organically or culturally, and by mixed methods-but we concentrate, at least for the time being on the case. (p. 435)⁴³

Therefore, I have chosen to examine the Saskatoon Health Region workers' knowledge, practice and attitudes regarding population health by discussing it with them. This comprised the case study I was conducting. It was the idea of trying to capture their knowledge which helped form the construction of the interview instrument.³⁹ "The case study approach to qualitative analysis constitutes a specific way of collecting, organizing, and analyzing data; in that sense it represents an analysis process."(p. 588)⁴⁰

Another reason for using case study method is that it allows for the ability to triangulate the results of different groups of people based on their understanding of a phenomenon. It is useful to help control or recognize where there might be different things going on in an organization that may have an influence on how that employee views a particular subject. "*Triangulation* tests the consistency of findings obtained through different instruments. In the case study, triangulation will increase chances to

control, or at least assess, some of the threats or multiple causes influencing our results.”
(online)⁴⁴

I chose to use this stratified purposeful sampling technique because purposeful samples allow the researcher to stratify various levels within the case study. This helps to capture the differences across the strata rather than identifying a common core.

Patton describes this method:

One might combine typical case sampling with maximum heterogeneity sampling by taking a stratified purposeful sample of above average, average, and below average cases. This represents less than a full maximum variation sample, but more than a simple typical case sampling. The purpose of a stratified purposeful sample is to capture major variations rather than to identify a common core, although the latter may emerge in the analysis. Each of the strata would constitute a fairly homogenous sample. This strategy differs from stratified random sampling in that the sample sizes are likely to be too small for generalization or statistical representativeness.(p.240)⁴⁰

By using this method I was able to stratify the various levels of workers in the Health Region and identify differences in their understanding of population health based on their level in the organization. Similarly, I did this with the accreditation teams to see if there were differences in population health understanding between and among programs. This was the main way in which I triangulated the results. The other was to compare policies and literature to the participants’ responses to the interviews.

The total number of participants involved in this work was twenty. There were eight upper management interviews, six middle management interviews, and six front line worker interviews. The researcher had one hundred per cent participation rate; all the people invited were willing participants.

Analyzing the data gathered through the semi-structured interview process provided me with the insights of the staff as to how they regarded SHR policies with respect to

population health and how it affected their practices and to the bigger picture of population health as described in the literature. These responses to the policies and literature can be found in the results and discussion chapters of this work.

4.2 Semi-structured interview instrument design

The research data was gathered through an in depth interview process. The interview schedule was comprised of open-ended questions to allow participants to expand on their answers. The literature review, the author's experience with the accreditation process, and advice from the author's thesis supervisor were instrumental in the development of the interview questionnaire.

Results from the 2001 Accreditation survey reveal some recurring themes in the five teams selected as the most population health relevant. There appears to be some good networking across various teams within the health region and local community groups. However, the opportunities for improvement suggest that these relationships need to become broader, stronger, and greater in number. The results from the 2001 accreditation helped to formulate some of the interview questions.

The instrument was designed to answer the initial thesis question. The key research question of this study reads: How do health regions integrate a population health component in the design and delivery of services?

The key research question, the purpose of this study, the literature review of population health, and the analyses of the 2001 accreditation, lead to the following set of sub-questions:

- (1) How do senior management, middle management and front line health staff with a population health mandate understand population health as a concept and as a practice?
- (2) How well has this concept and practice been put in place by the region as a whole?
- (3) How well has this concept and practice been put in place by teams with specific mandates for population health?
- (4) What evidence is there of change in integrating population health within the region and the mandated teams over the past 3 years?
- (5) What expectations of change do employees have (i.e. Where do they see an avenue for population health improvements in the region?)

The Saskatoon Health Region comprised the case. The SHR conducted a formal accreditation of services in December 2004. In preparation for that accreditation, the health region needed to conduct a self-assessment of the services that were surveyed by the Canadian Council on Health Services Accreditation (CCHSA). A nationally recognized assessment program that has been developed by the CCHSA guided the region. The program is entitled Achieving Improved Measurement (AIM). The CCHSA has a population health concept woven throughout the AIM program. The accreditation process that the researcher was involved in happened between August 2003 and December 2004.

Questions 1 through 5 of the semi structured interview asked participants some general questions about how long they had been a health worker and some questions with

respect to their knowledge of what population health is and how it impacted their practice. (To view a copy of the interview schedule please see Appendix C)

Questions 6 through 10 of the semi structured interview instrument were concerned with the accreditation process. In particular question 6 spoke to the population health standards as they are presented in the AIM tool. Questions 7 through 10 were about the core teams of Leadership and Partnership, Human Resources, Information Management and Environment that are considered the basis of a continuum of care required to support population health initiatives. One of the ways a health region can provide for a population health component to be included in its services is through the use of the self-assessment portion of the accreditation process. The AIM document has many indicators for population health from morbidity and mortality rates, to levels of self rated well being, to living and working conditions, and other medical and non medical determinants of health. The author constructed the survey instrument around AIM criteria relevant to population health, especially those that comprise the make up of the four core team standards.

The researcher's role with the Saskatoon Health Region was that of Accreditation Coordinator. This role has provided the researcher with an excellent opportunity to gather in-depth information from colleagues and other staff. This role was not in conflict with the research work as it is this type of fact finding that is the essence of accreditation; this research takes that thinking a step further. This combined role of graduate student/researcher and SHR Accreditation coordinator was discussed with, and approved by, both my thesis committee and my employer, Saskatoon Health Region.

It is important to mention that care and sensitivity was used in order to bracket the health region worker from the researcher. By this the author means two things. First, the research (interview process) was conducted in a manner that allowed complete freedom of the participants to withdraw at anytime and to not answer any question the participant did not want to. Participants were given a consent form (Appendix D) to read and sign which outlined the nature of their involvement and they were also be given opportunity to review their transcripts before signing a transcript release form. (Appendix E)

Second, the researcher recognized the importance of not confusing his roles as researcher and worker. Fortunately, all of the interviews conducted were of peers or superiors, therefore coercion of staff was not an issue. There was little or no risk to participants. The author was a liaison or facilitator, responsible to get the teams what they needed in order to conduct their accreditation self-assessment. The researcher did not carry influence or authority over any team member. This non threatening relationship between the researcher and the worker afforded the participants the opportunity to express their thoughts and feelings freely.

4.2.1 Limitations

One of the limitations in doing this work was the amount of time that it took to complete the project. Time was a factor when interviewing participants, who were all very busy people with demanding schedules; I was grateful for their generosity. Due to the fact that I knew I would only have one opportunity to interview the participants, I needed to gain as much information as possible; thus, the very lengthy interview instrument. I felt it was important to respect the participants' time, therefore I made the

instrument quite comprehensive. The average time for an interview was between sixty and ninety minutes.

Another limitation associated with case studies is that as one develops an understanding of what one is studying one may tend to observe or focus only on those things that support the theoretical conclusions one seeks.⁴⁵ This was accounted for by using a very in-depth interview questionnaire and straying very little from it from one participant to another. If a point was forwarded by a participant then that point was included for the rest of the participants to comment on. While I state that it was a semi-structured interview questionnaire, I think it is important to mention that in order to capture broadly representative answers, I needed to ask the same initial questions of all participants to begin with, otherwise I ran the risk of only asking the questions that would provide me with the answers I wanted to hear. By staying true to the strict questions first and then letting the probes flesh out the rest of the answer I was able to overcome the potential for bias.

Something else that deserves comment is sample size. This case study, having twenty participants, is considered large for a Masters level study of this type, but it still did not cover many potential program areas where population health could or should have a component. I thought it was important to include three levels of employee across the six most population health relevant programs. To some extent, the sample size was predetermined in order to get the “correct” representation to answer the research questions I needed to ask. Moreover, the sample size is not as important as the accuracy of the questions. By this I mean that if the correct questions are asked of the participants, then fewer participants are necessary. However, it is important to develop a very good

instrument. Patton writes: “The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size.” (p.245)⁴⁰ By using a sufficient number of participants from each program represented and by developing a meaningful interview schedule I have addressed both concerns.

4.3 Research Conduct

4.3.1 The Setting

In the formal participant interview invitation participants were asked to contact the researcher to arrange a suitable time and location for the face-to-face interview. At that time the researcher asked each participant where they would like to meet and the author offered his office to participants if that made things easier for them. Most of the participants chose their own office for the interview but three participants did use the researcher’s office.

4.3.2 Participant Selection

Individuals with hands on knowledge of the services available in the health region and what attitudes drive the policy decision making policy process were selected, giving the researcher a good opportunity to assess the integration of population health perspectives by the health region. This portion of information gathering consisted of key informant interviews, using a purposive sampling frame and semi-structured interview guide.

Caution was exercised with the selection of informants to ensure that all aspects of the health region were reflected and not just public health attitudes. This is important because many programs besides those in public health have an impact on population health. The

reasons for selecting these teams have been identified above. Besides Public Health (Community Health Services), Mental Health Services, Rehabilitation, Addictions and Home Care were chosen on the researcher's informed basis that they all play a role in population health. Primary Health, due to its unique situation, was also selected. The following table shows the make up of the teams.

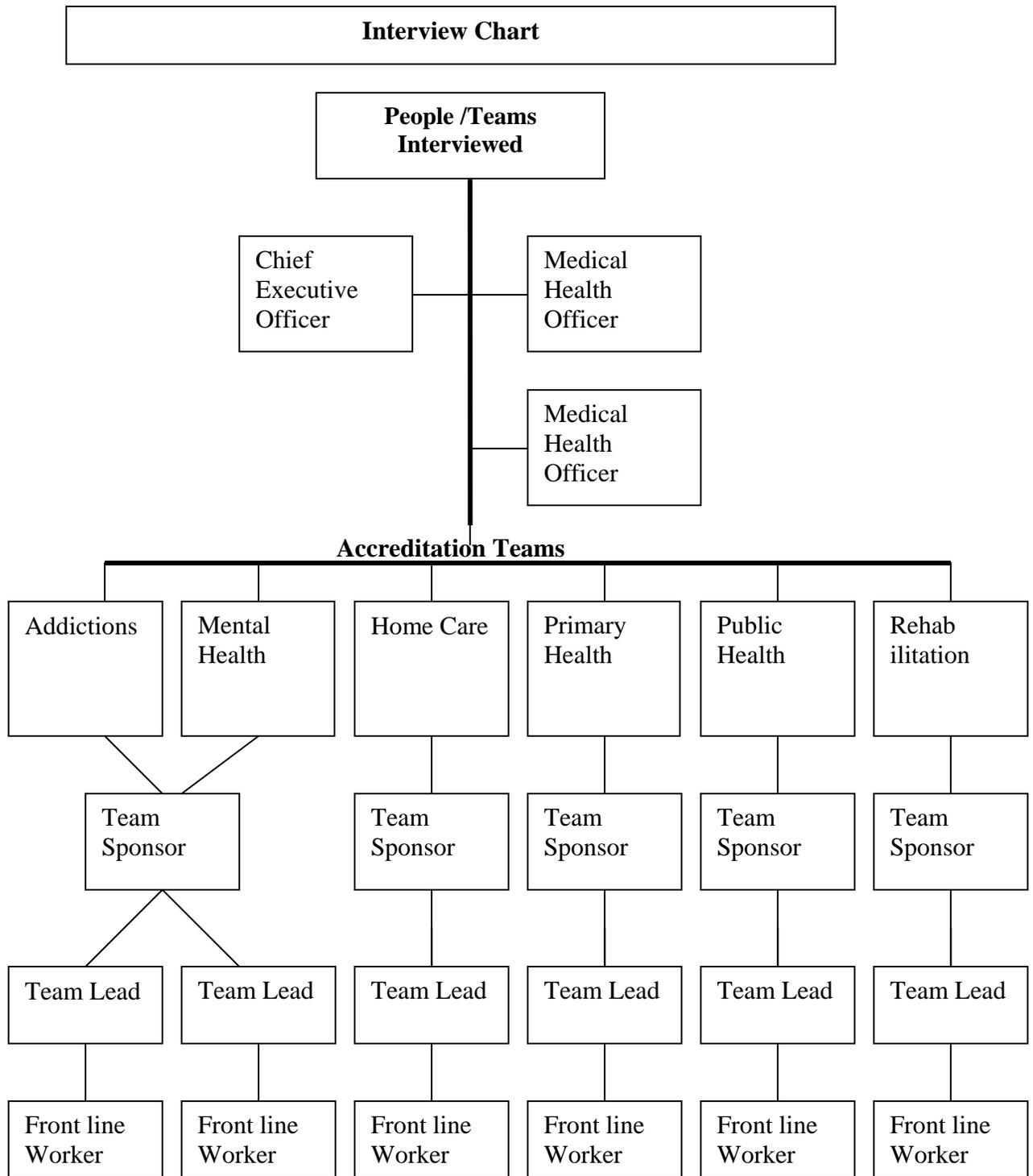


Figure 3: Interview Chart

4.3.3 Pilot Study

Interviews were conducted during the summer of 2004. It was anticipated that the participants would be involved in the interview for approximately one hour. The researcher had engaged two colleagues at his workplace to help define the length of time an interview would require. These colleagues were involved in the administration of the accreditation process and had an understanding of population health perspectives, but they were not a part of the research proper. Therefore, they were good choices for field testing the instrument. It was discovered through this process that an hour to an hour and a half was approximately the correct amount of time for an interview.

4.3.4 Data Analysis

Once all of the information had been collected the author needed to bring some sense to it. This consisted of the analysis of the key informant interviews. I examined the data and assigned codes to the responses. I also highlighted relevant quotes that had messages germane to the interview questions. The interviews reveal recurring themes from the participants. They are highlighted and presented in the next chapter of this paper.

Some commentary about their understanding of what their job is around population health and how that is reflected in their job description was also examined. Does their program description actually indicate population health components or program areas? Here, the researcher is not just looking at how much the person does but how much they understand, trying to find out some of the reasons why people might or might not understand the concept, might or might not be implementing it. The author is trying to

find out how the health authority has actually defined the responsibilities for population health for the people being interviewed.

4.3.5 Analysis Software Used

The author used the qualitative data analysis computer program ATLAS.ti to organize the responses from the participants. I had taken the University of Saskatchewan's basic and advanced ATLAS.ti training. This software program allows you to analyze interview data more easily, creating codes assigning sections of text to codes in order to find themes and meaning in the data.⁴⁶ I assigned 598 codes and 1045 quotes to the 20 key informant interviews to help with identifying recurring themes, which allowed for a synthesis of each stratum or team to develop.

I still had to bring sense to the answers gathered during the interviews. Some codes arose naturally from the questions themselves, and others were revealed through the responses to the more open-ended probes to which people responded.

4.3.6 Ethics

When conducting any research it is necessary to protect the participants as much as possible. To that end a proposal of this study was submitted to and accepted by the University of Saskatchewan Advisory Committee Behavioural Research Ethics Board (Beh-REB). An Application for Approval to Conduct a Research Project was submitted to the Saskatoon health Region to their Research Services Unit for their ethics approval process. The approval letters are included. (see Appendix F and Appendix G)

Also, the researcher provided each participant with an Interview Information Sheet and Consent Form which outlined the scope and purpose of the study and described any

risk that might be involved and assured their confidentiality. (see Appendix D) After the interview had been transcribed each participant was given a typed copy of their responses and asked to read it and make any changes that they thought were important to what they had to say. No names were assigned to any of the participants and care was taken when writing the results so as not to identify any of the participants. The tape recordings of the interviews will be stored in the office of the Community Health and Epidemiology department, University of Saskatchewan for five years, after which they will be destroyed.

In this chapter I have explained the methodology used in the writing of this paper. I have highlighted qualitative data analysis, the setting, the participants, the qualitative data software program used to help analyze the responses, and outlined the ethics process.

5. RESULTS

This chapter will examine the data gathered in the semi structured interview process in order to answer the primary question with respect to how a health region integrates a population health component into the design and delivery of services. The key research question of this study reads: How do health regions integrate a population health component in the design and delivery of services?

To accomplish this task the research sub questions will be addressed. They are:

- (1) How do senior management, middle management and front line health staff with a population health mandate understand population health as a concept and as a practice?
- (2) How well has this concept and practice been put in place by the region as a whole?
- (3) How well has this concept and practice been put in place by teams with specific mandates for population health?
- (4) What evidence is there of change in integrating population health within the region and the mandated teams over the past 3 years?
- (5) What expectations of change do employees have (i.e. Where do they see an avenue for population health improvements in the region?)

To answer them I will examine the data in the following way. I will first look at how each stratum of employee responded in the key informant interview, irrespective of which

accreditation team they happened to serve on. Some upper management participants did not serve on an accreditation team; they were selected in order to capture the point of view of the visionaries and leaders of the health authority. By assigning various codes to the dialogue provided by the participants using the ATLAS.ti tool (as described in the methods section of this paper), I was able to ascertain the knowledge and view points of the participants. I examined the data and assigned codes based on the responses, such as poverty, education and partnering, especially those types of comments that spoke to non medical determinants of health.

I will examine how upper management responded to the interview questions regarding population health as a concept. I will then write about how they viewed population health as a practice. Finally I will look at the strengths and challenges discovered through the semi structured interview process and highlight those concerns from an upper management perspective. I will then do the same from a middle management perspective and follow with a front line worker's point of view with respect to these issues.

The next step in the process will be to examine the results from an accreditation team specific point of view. I will explore how each team viewed population health as a concept, as a practice and strengths and challenges that the teams identified. I will examine how each accreditation team as a whole responded to the interviews irrespective of each member's position of employment within the health region, i.e. it will not matter whether they are upper management, middle management, or front line worker for this portion of the analysis. The differing strata responses are addressed in part one of the results. It is the accreditation team's responses that are of interest for this part of the

analysis. Finally I will look at the way in which each team responded to the final question of the interview which asked them about their thoughts on how the accreditation tool was written, their ability to implement population health initiatives, and any ideas they have with respect to forwarding a population health approach.

I will end each stratum and each team with a short summary of the discoveries revealed through the data analysis across employee strata and across teams.

The final portion of this chapter will look in a general way at the recommendations to the teams from the 2001 accreditations. I will examine how the teams responded to those recommendations in general and how they responded to them in the delivery of their program.

This will then lead into the next chapter of discussion.

5.1 Analysis A

5.1.1 Upper Management View of Population Health as a Concept

I began by examining the general ideas with respect to the concept of population health as expressed by the participants who were employed in the health region in the upper management stratum. I interviewed and examined the data from a total of eight participants at this level. When asked the direct question with respect to providing a definition of population health or describing a population health approach, two of the participants articulated how population health is about measurement or surveillance: “In terms of the Disease Control bit, [it is] important to identify the defined population- identify the denominator, look for changes in rates.”

Similarly, another participant responded that population health was about measuring the incidence of any particular malady and being able to track that illness.

You could take a look at, for example, the seniors group within your target area and you would say the population health of this population is characterized by the following, and so then you would apply utilization statistics to tell you what the incidence of heart disease is or what the deaths are, the causes of death, the number of hospitalizations etc., so, you would get a picture of the health of that group of people but not on an individual basis, on a big basis. I think you could also get a picture of population health by taking a look at it, coming from a medical diagnosis and working backward, to say what is the incidence of Diabetes Type II in this population? So, you can get a picture from the population, but coming at it from a diagnostic perspective. That's what I think it [population health] is.

Later in the interview, these same participants revealed that they did see the need to address the issues that centre on the non medical determinants of health, and how it is important to be able to provide the appropriate intervention as required. They spoke to the idea that it is not just about identifying morbidity and mortality rates, and that the community is an important determinant of health outcomes.

Well, it is about understanding the needs of the community, it's about providing the most effective services to the community, the most effective interventions.

I know where some of the poor neighbourhoods are for example I know that poverty affects health, I know that education affects health, I know that even one illness can affect overall health as well.

This quote seems to privilege health (medical) services as first priority over non-medical determinants of health, and is not about the broader aspects of health care. It may reveal the tension between medical and non-medical determinants of health that plagues population health.¹⁹ Further, when I examined the interviews of the rest of the participants more was revealed about the participants' notion of some of the broader aspects of health care and how important addressing the needs of the community were.

In my view the most important thing the Health Region does is provide health services and so again getting its own house in order it's got to make sure the health services it provides meet the needs and are effective in the most efficient manner that take into account inequalities in health in the community.

Other participants, however, were quick to mention that the non-medical determinants of health were of paramount importance when speaking about population health. They also suggested that addressing the non-medical determinants of health was a way to realize an improvement in health outcomes.

For me a population approach is [one] that looks at the broad community and that understanding the health status indicators and outcomes related to the population we serve and then gearing programs to address that both from the treatment and the prevention side. That's population health. It's when you are looking at what does your population really need - what are the health issues - and you're gearing your programs to prevent that from happening and to overcome it, treat it, or manage it once it does happen, it's the broad spectrum. With population health you should be working from where the people are.

As the results of the interviews were examined, even more population health relevant points of view were discovered. Some of the comments were very community focused and not just centered on the clinical or acute side of health care.

Population health is very important to the work that I do because it should be important to the population as a whole. We can't focus on treating, if we focus on treating we are going to end up with a weak population that can't care for itself. We are going to basically weaken ourselves to the point of no return and we have to have people focus on improving their health or preventing deterioration of health if we are going to have a strong productive population.

Two interesting inferences come from this quote; it still focuses on individuals taking care of themselves thus, creating the possibility of victim blaming as was discussed when I critiqued the Lalonde report⁹ and there is mention of investing in

population health to create a “productive” population. This notion was examined in the CIAR portion of the literature review.¹¹

Some participants in this stratum spoke to the need for partnerships and networking in the community. They were eager to develop and maintain these liaisons as they thought they were important to furthering the goal and effectiveness of population health initiatives. One participant suggested that all decisions made in the health region should be based on the community’s needs and that it is important to be working in such a way as to always have a current view and understanding of what those needs are and what the health status in the community is in order to be able to make good decisions. The participant went on to describe the importance of partnerships and linkages with other agencies in the community and that no single organization was responsible or could accomplish all that is necessary to improve and maintain the health of a population. The linkages are important to ensure that service delivery gaps are prevented, that duplication or overlap of service is avoided and that the gains that come from synergy can be realized. The participant suggested that the governing body and managers of the Health Region did promote, support and participate in ongoing community development.^c Other participants discuss these community initiatives throughout these results.

The participant went on to talk about the importance of discussing population health initiatives in broad terms and in many arenas in order to help people understand the link between their health and the health of society as a whole.

^c Saskatoon Health Region offers support to groups within our Region for new projects which help to build healthy communities. Three community grants are available: Community Wellness Grant, Health Promotion Grant, Community Grant Program.⁴⁷

They need to know what the problems or issues are so they can make informed decisions, and in terms of using research and best practice we have to always be changing and growing based on the new knowledge and information that is out there; so having a way to keep on top of that is important to the organization.

Others defined population health as a concept by describing in detail how they envisioned it working. One participant spoke to viewing population health from an applied approach such as a population based physician would take, looking at diagnosing the health of the community as a whole and getting a very broad perspective of all of those things that influence health. It involves looking at things like treatment outcomes, quality performance and determinants of health, and examining things by going back as far as possible and looking at the environments that people find themselves in; the influences of income, education, social support, justice, environments as well as their genetics and biology. The participant mentioned that there is a long list of determinants.

The participant then went to look past the above diagnosis side of the community and looked at the action plan for the community. Questions around how things in the community were linked surfaced in the interview.

What are the things that float to the top? Where are they linked? Where can you then intervene, farthest upstream possible, to make the biggest bang for the buck? And have a balance between upstream thinking as far as possible as well as mid-stream and down stream so that you can be making impacts at all levels.

This participant went on to say that population health and public health are very strongly joined, such that the two may combine to form the “New Public Health”

The concepts of population health and public health have been merging more and a new concept or term called the ‘New Public Health’ is emerging. I don’t know whether it is really new or whether it is just putting into different words what we have been trying to do for hundreds of years in terms of the upstream thinking and the thinking about determinants. But, the tendency has been, over time, for Public Health to

be getting more and more involved in individual interventions as well and more primary care type of things, so people are trying to ensure we get back to thinking at a population level.

Many other participants were similar to the above in their responses. There was a recurring theme that pointed to an expansive notion of health interventions across a broad spectrum of programs and at differing times across that horizon. Participants spoke to the need to move away from narrow definitions of health and begin incorporating a more complete definition that includes the non medical determinants of health like poverty, housing, employment, and the health of the community (the capacity of the community to be able to provide for its population). Participants also mentioned the need to work in an integrated approach to have more people invested in the outcomes of health in a population. Two quotes that are worth providing around these points:

I think population health goes beyond sort of the delivery of health care. I think it gets back to the determinants of health and gets back to an integrated approach that health isn't just done by a health region or health care deliverers, that health's integrated into social policy, health is integrated into education, health is health care that will look at prevention and promotion as much as we do intervention and in health we should take a long term view of health and not acute interventional approach.

Population Health is the health of the community. As an organization we are service oriented, especially individually service oriented; we don't look as deeply as we need to at the other determinants of health such as culture, housing, family, neighbourhoods, poverty, etc.; things that look beyond what is typically taken into account.

The following quote from one of the participants identifies some of the important considerations to bear in mind when discussing population health.

The other thing I would say is that it is looking at what are the needs and trends, the morbidity, the mortality, the social issues, income, health determinants, etc. for a whole community and trying to understand the trends and the areas of where to focus when it comes to disease entities. But also social issues and equity when it comes to the population, and it also means having in some cases where you have special needs or special

groups that have more health problems due to lack of literacy and income and social cohesion, that there you might in health care make special attempts to meet those people where they are... I would extend that to changing the staff mix in public health or in health care to include other lay people within the work, or even peer leaders or others that you would provide a meaningful honorarium to provide bridges from our professional world of health to actually the grass roots. So that's a very broad sort of look and a very holistic look of health and that often times population health itself is not only the health sector that has influence on all those aspects that I mentioned earlier but it is really a more intersectoral approach with education and justice and many other community partners including the not for profit sector. So, it is not something that health as a system can own, it's something that collectively it is more of a community look to health.

Similar responses to these were found throughout this stratum. To conclude this discussion it would be fair to say that upper management has a comprehensive view of the concept of population health surveillance (as a tool for measuring the health of the population and a way to inform the direction of health programming), and the non medical determinants of population health. Another recurring idea was that of networking, partnering, and working in an interdisciplinary fashion to affect change at a community level. This is encouraging since it suggests that more and more people, programs, and organizations will become familiar with a population health focus and thus increase the chances for more meaningful interventions and the acceptance of all people in society and their needs. This is where the literature that critiques the CIAR is useful and worth considering since it speaks to a more inclusive society.¹¹ It is also interesting to note that, if during the initial attempt at describing the concept of population health the non medical determinants of health were not included (as was the case for two of the participants), later in the interview those determinants did surface. This is encouraging since eight of eight upper management employees all mentioned the non medical

determinants of health as being important when discussing population health as a concept.

5.1.2 Upper Management View of Population Health as a Practice

Next, I examine the views with respect to population health as a practice as expressed by the participants who were employed in the health region in the upper management stratum. Some of these participants articulated how population health is delivered in terms of how it related to their position in the region and, more broadly, how it was delivered in the region in general.

It is important to note that one participant identified that the need to do population health work is constrained by other budgetary considerations. Yet, the participant was also cognizant of how important upstream population health work is when considering health region policy with respect to health outcomes.

Some of things I would do in an administrative perspective are the budgeting... trying to maintain focus on not just decreasing the wait lists and managing those and treating everything that comes to the door but remembering that we have to get up front and prevent either in the primary prevention or secondary prevention piece so that not everybody ends up having to come to the hospital doors. So that's a big part of what I do is making sure we try to keep some of that balance in the budget... And probably an even bigger part is the continual spreading of the message, wherever I am, and whether it's with the Board or whether it's when I am with the School Boards or at Saskatchewan Health or community members at large. It's to remind people that there is other important things than just treatment and we have to focus on those as well.

Another participant commented that the role of public health staff is to use their wealth of knowledge to train other workers in health care and across other agencies to help further the ways in which population health can be implemented in service delivery. This participant went on to describe some ways in which this could be accomplished:

I'll just give you one brief example with that with Primary Care. The model as the province has put it out involves clinicians who may do individual health education and health promotion working together with public health, very laudable. However, taking a population health approach to this would potentially have some of these staff actually doing some crossover work and sitting down before they even went into a community with a Primary Care Clinic, saying what are the needs in this community both from a literature perspective, our analysis of the health status and from the community needs expressed by the people?

Again, whether as a concept, or when describing population health as a practice, the need to address underlying determinants of health continue to be emphasized. The participant suggested that perhaps it is a good thing to create a clinic in a neighbourhood to address the needs of that community but it needs to go far beyond that. Within the scope of the mandate of Saskatoon Health Region issues such as education and employment need to be considered. Also, as suggested by Coburn et al, people from that community would benefit from being employed in that clinic, in that neighbourhood.²⁹ Further, they write about how it is important for communities to be a place where people can feel fulfilled. Therefore, as one participant offered, people from that community need to be encouraged and supported to get more education to enable them to be employable in the clinic and in other local initiatives within the neighbourhood. This is at least thinking past the CIAR model, past simply financial savings that can be realized from a population health approach and begins to think in terms of society as some of the other writers describe in the literature review.^{29,30}

One participant articulated that information management practices and funding issues were a concern. The challenge has been to take the existing resources and focus them on the highest needs. One of the ways to determine what those needs are is through an efficient information management strategy. The challenge with this is that while the

information system has identified increasing demands and expectations from the public there has not been the accompanying resources to further analyze, clean or make use of the data. Yet, it is widely believed that the data is very important to informing the direction of programs. (More on this in Analysis B)

Another participant spoke about population health practice as being about the services directly provided. The idea was that anything that affects the health outcomes could be considered as affecting the health of the population and therefore services provided are important to those outcomes.

I have limited experience here but certainly in terms of environmental health there is a lot of emphasis there in terms of, for example, housing and water quality. We have to be clear about the areas in which we have direct responsibility (jurisdiction) and work with others to ensure policy that they are responsible for adds to health.

The participant went on to say that it is important, when discussing population health as a practice, to have ways and means to inform the direction of the services provided in this area. Having robust and verifiable data can be a very powerful tool in demonstrating to the funders of programs what an investment in upstream interventions can yield in terms of realizing savings in downstream interventions.

I think one of the things is having a clear view of population health needs and that has been helped through the production of the Health Status Report. Using that report, that analysis to help the health region develop priorities for tackling important health issues, so, rather than being driven by or pulled along by clinical concerns we can use the information to determine our own direction.

Other participants noted similar concerns with respect to being able to properly fund the programs in which their staff was practicing. A need to do more in the community

was identified to have an effect upstream on the health issues in the community and again the notion of linking with other service providers was mentioned.

One participant spoke of a conflicting direction in the practice or service delivery as it relates to a population health approach, the growth in number and medical care concerns of an aging population. There is an increasing need to address the issue of people living longer, there are more of them and their needs are increasing. Yet, there is no more room for them at hospitals as they are full of other patients. The direction in some of the programs has been to focus on the acute care side of things and to be less concerned with helping people maintain their health and stay in their homes. In order to accomplish this latter outcome, some upstream interventions are necessary but quite achievable with a different focus on how the program is delivered. There needs to be more prevention work in order to achieve this end.

For example, take a look at diabetics, you have to take a look at the population that you are serving and all kinds of things like, what is the age of diabetics with foot problems and the big thing is they are primarily elderly but, in addition to that they have other health problems, sometimes secondary to the diabetes, i.e. blindness that makes diabetic foot care even more important. So, initially you just take a look at the big picture of Diabetic Foot and try to arrange your program and operationalize them for the elderly because that is the lion's share of who uses the diabetic foot program. But then you have to go beyond that and take a further look at what are the other demographics or characteristics of this group. So that would be one example.

The programs need to have more of a population health strategy in terms of forward planning. This participant also suggested that more attention needs to be paid to upstream interventions with respect to chronic disease management and went on to mention that:

They had identified a large number of people with many types of chronic disease and had provided a kind of a grass roots way of people coming together to teach one another the best way to manage, whether it is the

pain of chronic disease, attitudes towards chronic disease, whether it is self concept, all of those things, that has been something that we have looked to and responded to with the community in terms of health status.

Again, another participant spoke to the need to involve interdisciplinary teams in delivering the programs. The participant also mentioned that job descriptions be written to support a population health approach so that the people in those positions are able to deliver the programs as required and not become encumbered by a job description that would not allow for that latitude.

One of the participants identified the need for the health region and other organizations to work together with any particular community or neighbourhood in order to approach problems from a community development or partnership building approach. This participant mentioned the need for a core neighbourhood grocery store as necessary because all of the education around proper nutrition is ineffective if people do not have access to nutritious foods.

There are about 22,000 people that could access that grocery store and to me it's more than telling people to eat more fruits and vegetables and drink your milk, it's more about providing access to food...There hasn't been a grocery store in that core neighbourhood for a number of years so this is something very tangible and it's the population approach versus a school curriculum approach about healthy nutrition. So that would be another example.

Another participant identified the need to partner with other agencies and to educate people with respect to prevention especially around issues like stroke mitigating activities such as exercise, blood pressure monitoring, and diet. Trauma reducing activities, like bicycle helmets and seat belts, and partnerships with other agencies regarding the education of the population around these activities were also mentioned. The participant went on to say that these prevention strategies would yield significant savings in

treatment services to the health region. Cardiovascular disease is a very big expenditure of health resources as is acquired brain injury; steps to mitigate these illnesses would help fund other programs within the community. This is another argument that supports the need of the Region to reduce its spending. As mentioned earlier some of the literature suggests that population health is about more than simple fiscal responsibility to the Region but needs to be more focused on the benefit to the society.^{11,29,30}

This participant went on to elaborate further about the need for more interdisciplinary and cross sectoral work, identifying the benefit of such arrangements.

I think we should do more cross sectoral work particularly in disease management and particularly in chronic disease management. I think we do tend to, because of how we work very much in sort of silos and I don't think we get tremendous opportunities to share information around chronic disease management, prevention and promotion; that type of thing. We always think that prevention and promotion are at the primary level and it is primary health and public health that should do that. So, I think we need a more cross sectoral approach to it.

This section dealt with the way upper management viewed and tried to incorporate population health into the work that they do and how they identified how population health works as a practice across the health region and intersectorally across the community. Again, the notion of collaboration and cooperation comes through at the practice level much as it did when they described population health as a concept. Some of the participants identified how population health would yield financial savings to the Health Region while others were able to identify some of the upstream interventions that will have an effect on the health of the community. The need to have all members at this stratum understand that population health is about more than savings to the health care facility is important since this stratum sets the agenda with respect to programming in the community.²⁷ More on this will be discussed in the Discussion Chapter of this work.

5.1.3 Upper Management Strengths and Challenges

The next section of the results for the upper management stratum will look at the strengths and challenges that the participants identified or those which I have gleaned from the data. Sometimes participants would just be talking away, not really knowing that they were identifying a strength or a challenge; yet, when reading the interviews there are times when those strengths and challenges revealed themselves. This was the role of my analysis; I needed to assign codes to their comments and identify what they were articulating.

One of the strengths that a participant discussed was the way in which SHIPS (Strategic Health Information and Planning Services) helped identify the current information and best practice research to help the region stay on top of things, using the information to help inform the direction of programs.^d Another strength identified by this participant was the way in which the region has built partnerships and interdependent relationships to work in collaboration and cooperation with other organizations. Several other participants mentioned that one of the strengths of the health region with respect to population health was that of linkages both within the region and in the community. The stronger linkage between public health and primary health and the two general managers working closer together in developing strategies was mentioned and was felt to be a very important step.

^d Strategic Health Information and Planning Services (SHIPS) is a support area within Saskatoon Health Region: “Our purpose is to turn data into information to be used in planning, evaluation, and policy development to assist and support Saskatoon Health Region to make the best decisions and policies. The Region benefits from a coordinated approach to using health information in planning and policy development. We also participate in the development and implementation of information management strategies and policies.”⁴⁸

As much as all of the networking and partnering is considered a strength, the participants also mentioned that one of the challenges lay in maintaining those relationships.

Probably the most challenging part is keeping those knitted together that all those pieces take place within the organization or within the city and they are all seen as individual entities and it's that continual need to reinforce how all are important and how all have to be integrated and knitted together, and you can't lose sight of one taking precedence over another.

One of the most important strengths identified was that of the Population Health Surveillance Unit. The participant identified how the establishment of this unit and the information that comes from it help to build and strengthen relationships within the region and across sectors.

The creation of an entity like the Population Health Surveillance Unit to service the entire region is something that we have been credited for as a unique thing across Canada. The extent to which we are trying to partner with an entity like the Regional Intersectoral Committee and many many other partnerships at a region level is being viewed enviably across the country. The way we have been able to work with existing managers in all parts of the system to where their understanding of what population health themes are and how community development fits in that, I think speaks for itself. And, I think in terms of research and best practice, the creation of SHIPS as a unit to facilitate, that again has been seen as a very bold move. The challenge in all of these areas, despite all of this, I still think we need to be spending more resource time than we are in order to really make it pervasive in the organization, but I think we are making good strides from a leadership perspective in making those things a priority.(online)⁴⁹

The participant identified another challenge that is worth mentioning, related to consumer centred care and that our consumer is more than the individual. Our "consumer" includes the individual but also groups, the community, and the population as a whole need to be identified as a part of that client base. The participant went on to mention that it is important to remember to work at a population level and a prevention

level and not just as an organization that treats disease only. To that end the participant also said that this thinking affects our ability as an organization to provide education to staff and students as well as the direction the organization takes when conducting research.

This participant also stated that one of the biggest issues that needs to be addressed is the active dissemination of relevant population health information to all parts of the system. Also, the extent to which the employees of the health region could be spearheading an approach to work to partnership in a prioritized way to influence key areas of population health was mentioned; not just some of the staff providing information to other staff but actually advocating for policy change. The participant suggested that while this is a good idea, not many staff would probably see this directly as their role.

A strength mentioned was the creation of the new the Comprehensive Community Information System (CCIS).^e It will provide the public, staff and organizations better access to population health information and the ability to interact with and query the data themselves to get out what they need.

Similarly other participants identified that the health region has a responsibility to be a leader in forging these interdisciplinary and cross sectoral relationships in order to have them achieve meaningful results: “We have got to understand that we have a leadership role in health to encourage other agencies to develop policies which enhance

^e One-step to improve information sharing and inter-sectoral work is to build a Comprehensive Community Health Information System (CCHIS), a project started by Saskatoon District Health (SDH) [and now continued by the Saskatoon Health Region], and supported by the Regional Inter-sectoral Committee (RIC). The project would assemble, analyze, and disseminate information to decision-makers for planning related purposes. CCHIS is more appropriately called a comprehensive community information system (CCIS) because it would include local qualitative and quantitative data from many sectors.⁵⁰

health.” This can be viewed as both a strength and as a challenge. The health region has the capacity to lead the charge in this area; they also have the responsibility to carry it through.

Another participant remarked that one of the biggest challenges was that of the client based services and how those services diverted funds needed for education and research into more urgent or clinical client based needs. Later in the interview the participant revealed that there had been some progress toward developing quality of care activities and outcome indicators but that it was still a challenge because those initiatives tend to get dropped along the way when more pressing or immediate demands need to be met. The participant was identifying that even though there has been some progress toward placing more funding toward research, education and population health initiatives, the pressing needs of the clinical typically received the resources if there was competing demands for the money and manpower.

This participant went on to recognize the need to have the health region participate in improving the health of the community. The participant realized that there were a number of programs attempting to do this work, particularly in Public Health, but questioned if there was really a strong strategy that would see the health region investing to improve the health of the community, what that strategy would look like, and how the region would implement it.

To this end another participant identified a challenge with respect to the way in which consumer expectations were met and the way in which programs are designed to meet those expectations. The idea of having the public involved in the design and delivery of programs was suggested.

I think sometimes we don't engage our public perhaps as much as we could, and I am not sure all the time that we get input from our public as to how our programs should look like and how we should develop them. And I think that has been a more traditional approach to health care; I think we are changing a little bit, but it's a challenge sometime, and I don't think we always think of bringing the public in to look at these things; I don't think we consciously ignore them, I just don't think they are at the forefront of our thoughts sometimes.

The strengths and challenges mentioned by this stratum focused on several things.

One that stood out was research and the inability to conduct the amount of research that participants felt was needed. Consumer expectations regarding service were also cited as being a challenge. Participants suggested that client-centred service was important. There was a real challenge between being able to service the clients as clients expected to be served, and the need to educate both the public and staff about the importance of being able to conduct the research required to design educational program components.

Of the strengths, the partnerships and intersectoral work were highlighted. People in this stratum felt very strongly about the usefulness of networking and believed in the synergy that it could bring to the design and to the delivery of programs.

5.1.4 Middle Management View of Population Health as a Concept

The next step in analyzing the results was to explore the way in which the middle management viewed population health as a concept. There were six participants in this stratum.

In general participants from this stratum identified the concept of population health similarly to the way in which it was identified by the upper management stratum. Many of the same ideas and beliefs were expressed. It is again interesting to note that while some of the participants talked about measurement of populations' health when asked for

a definition of population health they later went on to describe non medical determinants of health as being an important consideration in determining health outcomes.

Two of the six participants immediately replied that population health looked at groups within the community or the health region, and was used to measure the health outcomes associated with those groups.

Population health to me is very broad. There are many populations within a population. So how to define that; it could be young moms, it could be the young children of those young moms, it could be the elderly, it could be the young disabled and within each of those groups you can subcategorize, but to me that is population health in its broadest sense. It could be immigrants, the population of immigrants, it could be just women in general, just men in general, you could define it down to age categories.

However, they later went on to describe the importance of upstream interventions, both in terms of how it would impact on their program and how it was important for society or the population in general: “ The Child Hunger Education Program (CHEP), that’s good. That whole inner city piece and the White Buffalo Youth Lodge, Primary Health Centre to address that as well as the Primary Health Centre in Nutana, that is the elderly population there.”^f

^fAt The Child Hunger and Education Program, CHEP, “our vision is: CHEP exists to work with communities to achieve solutions to child hunger and to improve access to good food for all. CHEP's vision for the community is of a community where good nutritious food is always available for everyone no matter what their circumstances, where there is care for the environment, support for farmers, access to local food production, and knowledge about making healthy food choices. CHEP's philosophy: CHEP believes that food is a basic right and that inadequate nutrition adversely affects a child's development, learning ability, health and participation in community. CHEP believes that a community development approach is necessary to fulfill our mission.”⁵¹

The White Buffalo Youth Lodge is a partnership between Saskatoon Health Region, Saskatoon Tribal Council, City of Saskatoon, and Central Urban Metis Federation Inc. The Lodge was officially opened in December 2000. White Buffalo is a multi-purpose health and recreation facility located in a core area of Saskatoon which has a high aboriginal population. The primary health team at White Buffalo Youth includes a primary health nurse, addictions worker, public health staff, and a physician from the West Side Community Clinic.²⁴

Nutana Collegiate is a community school providing alternate choices for youth within the public secondary education program. A Primary Health Nurse works together with other support staff at Nutana, teachers,

The other four participants were quick to mention the non medical determinants of health in their description. They also went on to describe social issues such as education, poverty, and hunger as being vital to describing population health as a concept. One of the comments that stood out with respect to population health at a fundamental level described the importance of giving people in the communities a voice and responsibility.

I always think of population health as being involvement and assigning of authority and empowerment of a client group so that they have some true control over what initiatives are implemented. So, if we look at population health promotion, in, say, the housing program, it means that we need to have a link with those community groups that represent the renters. It means that we need to develop some kind of strategy in cooperation with them to allow them to deal with some of their own problems and understand what their roles and authority could be, and understand and support them in addressing their concerns.

Similarly another participant replied that population health is looking at the health of a community from an eagle's eye perspective.

If we only deal with this very small percentage of the population in trouble and at high risk it is not very significant in terms of the normal bell curve of the entire population. For example, when looking at healthy communities, you're thinking about the entire community, looking at things like how connected is the whole community to each other? How much do they feel a sense of belonging to that community? What are the kinds of things that happen in that community such as recreational activities, where and how do people get together to support one another and support healthy behaviours?

These kinds of comments that spoke to the needs of the greater community were consistent across most of this spectrum. As in the upper management stratum, those who did not initially mention non medical determinants of health when defining or describing a population health approach did so later in the interview process.

families, and students to address health-related questions and concerns. The aim is to help students make healthier lifestyle choices so they can feel and be healthier in order to achieve their educational goals.²⁴

5.1.5 Middle Management View of Population Health as a Practice

All six of the participants spoke to the need to address the non medical determinants of health and to look at those conditions in place in the community both within the health region and more broadly within the community to see what affect things like poverty, education, and addictions have on the health of a population.

When describing their practice and the tasks they deliver in their programs all of the participants spoke to the need for upstream intervention; whether they saw it as their job, per se, or whether it was something done within their program just not necessarily by them. Even though they were not involved in the hands-on delivering of that part of their program they were still aware of the need for and the delivery of the service.

We provide secondary & tertiary care and do not focus our efforts on primary prevention in the community by focusing on population health. Our education prevention coordinator does that for acquired brain injury, but for my day to day job, not a lot, I'm working with individuals.

Later in the interview the participant revealed more about the need to partner with other organizations to deliver programs that would have an affect on the delivery of the program.

In the last couple of years my general manager and I have done some program reviews for our out-patient services, our programs and we spoke to the community. We spoke to clients; we spoke to staff to look at what they are presently receiving and what they need for services. We connected with partnerships and organizations so I think we have explored this and looked at our program to see what we need to improve.

Other participants were very cognizant of the need for a population health approach to be included their program. They mentioned the importance of incorporating population health into the very nature of the way in which they deliver their program. One of the

participants said that it is important to use the principles of population health to initiate change by better understanding the breadth of situations affecting people's health.

What we have tried to emphasize in that whole program now is some population health promotion principles, where we are dealing with community association leaders or groups. That might be a group of tenants in a building; landlords that we have traditionally used only enforcement strategies to motivate, we have tried to use a process where we educate them on the needs of the clients and how their property needs fit into the neighbourhoods and how we try to promote some type of sense of responsibility for doing just the bare minimum compliance. So housing is an example of how we use population health promotion.

Still others spoke of the need to invest efforts in programs that have a longer term pay off. Some things, especially clinical services can be measured quite easily and immediately. Other interventions need time to develop until those results can be realized.

In research for example, you can be much more quantitative when you are dealing with things like surgical waiting lists and hospital days. It becomes much more difficult when you are looking at working with a group of kids who are disconnected from the community and trying to create that connectedness to avoid addiction problems or crime activity,[by] working with people who are trying to make a difference in these areas and measure what the outcomes might be. You may not see the results of that until maybe three or four years down the road when these kids actually complete high school and go on to become positive contributing members of their community as opposed to kind of falling into areas that do not result in healthy lifestyles. That is just one brief example. I think that is one of our challenges.

It is a challenge, as stated, but it is also an example of how this participant views population health as a practice.

Others saw the need to use the practice of population health surveillance as a way to identify gaps in service within the community to ensure that service is provided appropriately to the people who need it.

So, from a population approach we would like to know what the gaps in services for these individuals are. Who is falling through the cracks? What do you do well? What other information is being monitored by whoever

that will assist you in making decisions for that group of people? ... if you cannot meet the needs because there is a gap in service that's when you need to dialogue with your other partners.

This same line of reasoning was used in other programs to determine the needs that will emerge in the years to come and how to properly plan for the next 'population' that will need those services.

Overall, in this stratum, we see that there is a strong recognition of the need to implement upstream initiatives to have an affect on the non medical determinants of health. This group also considers a portion of a population health perspective as a measurement and program service delivery assessment mechanism for planning future initiatives, strategies, and policies that will have the desired effect on health outcomes.

5.1.6 Middle Management Strengths and Challenges

Participants identified a number of strengths which included planning the strategy that service delivery providers will use to meet the needs of the future. They included the fact that their design focus would look at an aging population and a way to incorporate Aboriginal cultural design into their facilities. They mentioned there was a lot of investigation, collaboration, and partnership used to determine how services would be delivered by health region employees across the region and more globally by using intersectoral teams to deliver the programs throughout the service delivery area.

This stratum recognizes collaboration as a strength. Yet, some of the participants also saw it is a challenge also. They suggested that even more partnering and team work was needed: "I don't find that we work a lot with community partners at this time as much as we probably could, and that was a recommendation that was made a few years ago."^g

^g This was a recommendation made in the 2001 Accreditation, as identified in Chapter 3 of this thesis.

Another challenge identified was that of trying to educate the people who control the resources within the health region and within the province. There is insufficient attention or investment paid to population health initiatives and too much attention given to the emergency or demand type of service like surgeries and waiting lists.

It is too easy to be caught up in the tyranny of the urgent. We try to address the demand for greater and greater medical services or acute care services and the problem is the true gains to improving population health lie in those Population Health strategies. There is the example of the baby floating by in the river and we need to work upstream, we need to find out where they are coming from and solve the source of the problem as opposed to getting better at dealing with the baby baskets.

Another participant mentioned that a challenge is in the inability to identify or measure whether the work being done in the programs is having the desired effect:

The improved health piece. It is the most challenging to produce the evidence that improvement occurs. I think we have the evidence; I think it is there but it is always buried. It is not easily accessible and we don't all talk the same indicators. There is a lot of work that has to be done.

Similarly, another participant identified that a challenge for her team was around the research aspect and how to use the research to demonstrate the effectiveness of the program.

I am involved in research. I know that it is important and I don't think we have the funds available sometimes to do the research that's necessary in terms of effectiveness studies because they're done over a long period of time and a lot of hours are needed to follow up with clients.

This stratum recognized the importance of partnering and collaboration. They also highlighted the need for more partnering and the need to be able to measure what their program is doing to have an affect on the health outcomes of the populations that their programs serve. These strengths and challenges were similar to the ones identified by the Upper Management stratum.

5.1.7 Front Line Worker's View of Population Health as a Concept

The next step in analyzing the results was to explore the way in which the front line workers viewed population health as a concept. There were six participants in this stratum.

Overall there was some good understanding across this spectrum. However, it was not as vast as the upper or middle managements' understanding of population health as a concept. One of the six was unable to articulate what it was or what it meant. Another said it was the health of the population as a whole but did not mention any of the non medical determinants of health and the implications those would have on health outcomes for that population. Four did grasp the concept, however and were able to speak to the health of the community and the determinants that affect those outcomes.

Well, I think that rather than treating the individual you are looking at the community - how the population affects health. What I mean is that, you know, the problems within the community, if there are community problems, like inner-city problems - prostitution and things like that and how that impacts the whole community - the ...population of Saskatoon as a whole.

Others defined the idea more broadly. They spoke to the need to look at broad aspects of society and the things in one's community that would have an influence on their health.

What it does mean is looking at a broader approach to health than just illness, sickness, cures. It goes further upstream looking at disease prevention and health promotion and looking broader than the individual, looking at really the whole determinants of health. So, looking at what things in a person's life and their experience affect their health. So, be it poverty or culture or race or gender, all of those different pieces, all of those things affect what ultimately a person's health is and their ability to be healthy, so, it is lifestyle things that are involved. There are also systemic things that are greater than what you traditionally view as health.

These kinds of comments are consistent with the way the rest of this stratum viewed population health as a concept. However, it is worth noting that two of the six never did mention non medical determinant issues at any time throughout their interview.

5.1.8 Front Line Worker's View of Population Health as a Practice

Two of the six participants did not speak to the community and social issues that would have an impact on the way in which they delivered service, the type of services that would be influenced by population health initiatives, nor the way in which population health would impact on those programs that they currently delivered. However, four of the six participants spoke to these issues quite well. One of the participants replied that it is about interdisciplinary collaboration and investment in community initiatives in order to make a long term difference.

Really, what we are looking to accomplish is looking at that broader based approach and it comes from both the way we work together as service providers and having very much an interdisciplinary team approach looking at broadly some of the client issues and they are not necessarily medical issues or social issues. They are spiritual issues; they are psychological issues, and all hinge on how they interplay. It is hard to make that connection sometimes simply by looking at the immediate and saying we need to cure, we need to treat, we need to pour a bunch of money into the system. We really have to look at putting the money in and looking at longer term goals about health.

Other participants spoke to these issues as well in their interviews. They provided responses such as looking past the initial treatment of the client or patient to what is happening with respect to the health of the population (quality of life issues) that have an impact on the degree and number of people that will need to seek treatment.

5.1.9 Front Line Worker's Strengths and Challenges

Some of the strengths identified by this group hinged on the way in which they have been able to create partnerships across disciplines and sectors. Yet, one of the participants also identified this as problematic. The concern expressed around this was that a lot of different agencies have an effect or can impact on the way in which services are delivered and each may have different ways of defining how or why a program is effective.

When I think of partnership I think outside of health. So, I think of kind of what are the connections that we need to make as a health region and I think one of the challenges is, is that despite what we desire, and I mean even personally what I desire in my job, so much of our work is tied to directly what health does and different provincial departments, say like social services, justice and all of those folks, each operate in a kind of similar silo and it is hard to necessarily establish those partnerships when you are focusing on the day to day work of your job and the organization.

Other challenges included the lack of time and other resources to conduct research.

Education of both staff and the public was expressed as being a challenge.

One of the participants identified that there was a lot of information being gathered by another body [provincial government and other organizations] that they were expected to provide, yet, they had no say into what it would be used for, what it meant or how it would affect their program. This was considered very frustrating.

This stratum identified fewer strengths and more challenges than the upper or middle strata. This is likely because they were not as aware of some of the initiatives that the other strata would have been privy to. Also, they seem to have less population health approach knowledge overall than the other strata which would further restrict their ability to identify strengths.

5.1.10 Summary of Analysis A: Concept, Practice, and Strengths and Challenges

In this section of the results I examined the data gathered in the semi structured interview process in order to examine the original thesis question by looking at several sub questions with respect to population health as a concept, as a practice, and the strengths and challenges with respect to a population health perspective across three strata of employee in a health region.

The analysis revealed that by and large there is a broad understanding of population health as a concept across the upper and middle management strata. That knowledge is not as vast at a front line worker level.

Similarly, the understanding of population health as a practice was well articulated by both the upper and middle management groups. Again, that knowledge was not as great in the front line worker stratum.

Both the upper and middle management strata were able to more effectively describe their strengths and challenges than were the front line workers. The front line worker stratum seemed to be able to describe mostly challenges; they were not as aware of their strengths.

However, there was limited discussion with respect to the policy implications surrounding population health concerns.

5.2 Analysis B

5.2.1 Accreditation Responses

In this next section I looked at the six accreditation teams' responses in order to capture their knowledge around how accreditation works as a process to help with the understanding of population health as a concept, a practice, and some of the strengths and challenges identified in using the Achieving Improved Measurement (AIM) tool. There is some overlap with findings from the first section of these results. However, I also synthesized the team's responses to provide their understanding around how accreditation addresses a population health approach.

In order to preserve anonymity it was necessary to label the teams as Team 1, Team 2, etc. Due to the specific nature of some of the comments identification of the participant might have been possible if this precaution was not taken.

Questions 6 through 10 of the semi structured interview survey that the participants participated in were concerned with the accreditation process. In particular question 6 spoke to the population health standards as they are presented in the AIM tool. Questions 7 through 10 were about the core criteria of the Leadership and Partnership, Human Resources, Information Management and Environment Standards; they are considered to be the basis of a continuum of care, which is required to support population health initiatives. Each of these core set of standards are considered integral to a population health initiative. These standards were provided to the author by the Canadian Council on Health Services Accreditation.³⁵

I analyzed the six accreditation teams' responses to these core criteria to see how well the accreditation process addressed population health. Did the use of these core standards

sufficiently address population health? The following table highlights this relationship.

Table 2: The Relationship between the core criteria and population health:

Core Standards	Core Criteria	Relation to population health (PH)
Leadership and Partnerships Population Health Standards	<p>Criterion 1.0 reads The organization anticipates and responds to the community’s changing needs and health status.”</p> <p>Criterion 2.0 reads The organization has broad and meaningful linkages and partnerships with other organizations and the community.”</p> <p>Criterion 3.0 reads The governing body and managers promote, support, and participate in ongoing community development.</p> <p>Criterion 13.0 reads The organization uses research and best practice information to improve its performance. ^[46]</p>	<p>These criteria are very important to PH since it is through these types of partnerships that PH awareness and a greater informing of health and social policy will be realized.</p>
Human Resources Population Health Standards	<p>Criterion 1.0 reads: The organization’s documented resources plan anticipates and responds to current and future human resources needs.</p> <p>Criterion 9.0 reads: The organization’s work environment is safe, healthy, and positive for staff, independent practitioners, and volunteers.</p> <p>Criterion 10.0 reads: The organization is committed to the occupational health and safety of staff, independent practitioners, volunteers, and students.</p>	<p>Important to PH since it is this area that accounts for the allocation of sufficient staff in the programs that deliver population health focused services</p>
Information Management Population Health Standards	<p>Criterion 1.0 reads: The organization’s information management processes meets current and future information needs and enhance its performance.</p> <p>Criterion 3.0 reads: The organization collects and reports relevant data and information in a way that is timely, efficient, accurate, and complete.</p> <p>Criterion 5.0 reads: Staff, service providers, clients, and families have access to information to support decision making and improve knowledge.</p>	<p>Important to PH since evidence based research is the focus of health programs. The data that is collected informs program design. Therefore it is important to gather PH relevant data and not focus only on clinical data.</p>
Environment Population Health Standards	<p>Criterion 1.0 reads: The organization’s physical environment, contributes to the well-being of clients, staff, and visitors.</p> <p>Criterion 2.0 reads: The organization uses equipment, supplies, medical devices and space safely, efficiently and effectively.</p> <p>Criterion 3.0 reads: The organization minimizes potential hazards and risks wherever the clients receive services.</p> <p>Criterion 4.0 reads: The organization prevents and controls infections.</p> <p>Criterion 5.0 reads: The organization is prepared for disasters and emergencies.</p> <p>Criterion 6.0 reads: While providing services, the organization protects and improves the health of the environment, in partnership with the community and other organizations.</p>	<p>All of these criteria are considered by CCHSA to be PH relevant and to a degree they are. Yet, there is so much more about the community as an environment that needs to be recognized.</p>

There are some teams that have recommendations from the previous accreditation; these are also addressed generally at the end of the analyses.

Finally, I report on the teams' responses to the last question of the interview (Question 11), which dealt with issues such as whether the accreditation process spoke sufficiently to population health concerns, what successes they may have had in implementing population health initiatives in their programs, and what they thought could be done to improve population health.

5.3 Team 1

Analysis A of the data captured from the members of this team revealed that they had a good knowledge of the concept and practice of population health in general and they understood the strengths and challenges associated with the implementation and delivery of a population health approach.

The analysis of their responses to some of the more direct accreditation questions revealed that they had a fairly good understanding of the criteria that had a population health focus across the four core teams and why it was relevant to the work that they do. However, there were some answers that emerged revealing that the community is not at the fore front of their thinking due to client service concerns. One of the participants replied:

I think it needs to become a priority, not only for Health Regions but for provincial and federal governments also. It's a soft service and we go through times, for example housing in the 1980's was a big issue and there was lots of federal dollars for housing and then we went through a time where all of that started to wither away and there was fewer and fewer dollars for that. It is difficult for Health Regions or for provincial governments to prioritize this against hips and knees and hearts all of those other kinds of issues that legitimately need prioritization, but it's good that we are moving in the direction of tackling smoking because I think that is going to have a positive impact down the road. I think we should be doing

more related to that. I am not sure what resources the Health Region is going to come up with regarding support to staff and support to the community around smoking. I think it will be a little, if it is anything but if we really took that on and said we are going to educate and support people who are trying to quit smoking and we are really going to try to target young people because if we can reduce that by any significant amount that is going to have a huge impact 20 years and 30 years from now on the health of the community. The trouble is that it is 20 to 30 years away; nobody wants to look that far down the road, so that is the challenge.

With respect to the standards for population health all of the team members knew that they existed, although only one member could confidently claim knowledge of their contents.

The responses to the four core standards for Team 1 revealed that the Leadership and Partnerships Standards were well understood by the team members and they all mentioned that they had taken part in the interdisciplinary and partnering type of activities that the CCHSA writes as being an important component of a population health approach. They all spoke to the importance of Human Resources Standards in trying to address population health needs. They recognized that as some partnering happens and different facets of program delivery come into play, different skill sets will be required to be able to deliver a population health mandate. With respect to Information Management Standards, all of the participants on this team articulated the importance of good data gathering and information management in order to be able to meet client and community needs, now and for future programming needs based on best practice evidence gathered through this data system. With respect to the way in which this team replied to the Environment Standards, they all thought that they were important; they described how the place where they deliver service, i.e. treatment facilities and offices, had been improved. The criterion that speaks to providing services, and the way in which the organization

protects and improves the health of the environment, in partnership with the community and other organizations, was not mentioned. This team had been very cognizant of the need to do more in the community yet, when describing the environment, it was all about the clinical and not about the community. There could be several reasons why this would happen. Some of these may include that client focus is still the biggest part of the way this team delivers its services; that will have an influence on what a team would hold most important with respect to how they view their environment. The criteria in this standard speaks to all environment issues, both institutional and community. However, only one criterion addresses community per se, the rest deal with hospital and other built structures that attend to the needs of clients. Perhaps a more thorough writing of the criteria for Environment Standards is required to address community issues more completely.

5.3.1 Strengths, Challenges, and Improvements Identified by Team 1

Although everyone on this team understood the importance of partnering, had had experience with it, and considered it a strength, there were still some issues around the depth or level of involvement across the various agencies in the partnerships. They all expressed that there had been improvements in this area since the last accreditation but they thought that even more of this type of work was necessary.

How well is the Health Region organized and how actively do they participate in improving the health of the community? I think there are a number of programs and Public Health is probably the biggest example of that, but is there a really strong strategy that the Health Region has to say that they are going to be investing to improve the health of this community and what they are going to do and how they are going to participate in that? I don't think so, I haven't seen that.

They identified that there had been human resources challenges in filling some of the positions. They identified that with respect to information management they were not part

of the region's data system. They considered the improvements to where they work to be a strength, but did not speak to the community environment as a challenge when asked directly about the Environment Standards.

5.3.2 Question 11 Team 1

With respect to the final question of the instrument, (Question 11), this team thought that the accreditation tool did capture population health in some respects. They were encouraged that the partnership aspects had been addressed but felt that there was a need for a more focused approach with respect to the needs of the community.

All of the participants on this team, when asked about how to go about improving population health, replied that there is a strong need for health promotion and prevention activities. One of the members of this team replied thus:

I think one of the things would be to develop a strategy, if we are going to have an impact on the health of the community. One of the issues we need to focus on, and everybody always talks about it but we don't do it, is to invest upstream and if we are not able to do that, even in a small way, we are just never going to get ahead of the game. So I think we talk about it, but we don't do it in any strategic way. If programs like Public Health, or Mental Health and Addictions or Home Care are able to find some ways to do that they are certainly supported, but there is not a strong investment by the Region in doing that, there are pockets of that, the smoking strategy is a good example, there is more and more of that, but I think we need to be much more aggressively identifying strategies in that way.

This raises the question again that if upper management says they are investing more upstream and do have a strategy and others disagreed, it becomes difficult to reconcile this difference. Perhaps better communication among health workers would help alleviate the differences in understanding across the strata.

5.4 Team 2

In Analysis A, the data captured from the members of Team 2 revealed that they had a basic knowledge of the concept and practice of population health in general but they did not have a broad understanding of the strengths and challenges associated with the implementation and delivery of a population health approach.

The analysis of their responses to some of the more direct accreditation questions revealed that they had some understanding of the criteria which had a population health focus across the four core teams and why it was relevant to the work that they do.

With respect to the standards and their inclusion of a population health perspective, all of the team members knew that they existed. They all seemed very sure that they knew what they were because they sat on the accreditation team for their service delivery program.

The responses for this team to the four core teams' population health criteria were not as focused on population health for some of the criteria as other teams had displayed. The Leadership and Partnerships standards were well understood by the team members and they all mentioned that they recognized had taken part in the interdisciplinary and partnering type of activities that the CCHSA writes as being an important component of a population health approach. They all spoke to the importance of Human Resources in trying to address occupational health and safety concerns. They mentioned that there had been collaboration with some other agencies both in the region and some from within the community to help deal with some of the challenges around working in a safe work place. The standards for Information Management were considered as important by the team. They considered that there had been improvements since that last accreditation because

more information is reaching them and thus they are able to keep better track of the people they are delivering service to. However, one of the participants was quick to mention that the manual gathering of information when trying to put together a report is very cumbersome and expressed a desire for a more efficient system. A different participant mentioned that they see this area as something that can help inform budget processes, utilization rates, cross sectoral tracking and the ability to track service by population.

I think there have been improvements in term of we are trying to be more specific in quadrant reporting. We have the city divided into 4 quadrants and I think that we have done some work in that end so that we are able to see the city in terms of those quadrants and neighbourhoods where people are assigned. We are better able to get at information; we have a long way to go but I think we are making progress.

The responses with respect to the population health criteria used in the Environment core team standards were similar to some of the other teams. The concern again came down to the workplace. Even though they had mentioned the importance of the community earlier in the interview process, when it came time to offer comment on criterion six of the this standard no one chose to elaborate on the community as a part of the environment in which they work and live; immediate work concerns such as the facility, equipment, and safety issues dominated the responses.

5.4.1 Strengths, Challenges, and Improvements Identified by Team 2

The fact that they all understood that there are accreditation standards that address population health is a strength. As with the other teams they all recognized Leadership and Partnerships as being a very important component to a population health approach and were able to articulate those ideas. The Human Resources standards brought responses

around population health and safety issues. Information management was considered an important aspect in order to inform the direction of programming needs. The Environment standards elicited responses that spoke to the work place; there was not much mention of the community as the environment.

5.4.2 Question 11 Team 2

The responses that Team 2 gave to Question 11 were mostly positive with respect to how they viewed the adequacy of the accreditation process to address population health. One of the participants said it was good but did not understand some of the bigger issues; this gave that participant a way of learning about how the other parts of the organization works with particular programs. Another participant pointed out that it is a start but that the region was not where it needed to be in order to adequately get a better picture of the populations health needs; there was a long way to go in order to gather the kind of information that would allow for changes in programs that would make a difference. Another participant thought that the accreditation process addressed a population health approach well.

I think it does a pretty good job of doing that. It does talk about the changing needs and the health status of the community, the work force, and the environment in which these people are providing and delivering service. I think that it is important from that perspective and I think they capture it well.

The team in general was mixed in their responses to whether they thought that there had been some initiatives within the Health Region that helped further a population health initiative. Things such the naming of a Director of Quality, the relationship with the Health Quality Council and that body's development of the provincial satisfaction audit

of patients were viewed as positive steps.^h However, it was also noted that that provincial program is based on acute care; the team recognized that a baseline is needed but that the Health Quality Council at present would be gathering data based only on institutional clients and not on responses or issues as seen by people in the community.

Other positive initiatives were noted. The focus given to the Aboriginal population was considered encouraging, as were some of the programs that have an effect in the community such as the Child Hunger Education Program (CHEP), the White Buffalo Youth Lodge, the Primary Health Centre in Nutana, for the elderly population there.

(These organizations were described in Analysis A). As one participant said:

The recognition of a young aboriginal and growing population of urban aboriginals and some of the population health issues that they face like poverty, jobs, education those kinds of things. I would say that that is one of the ones that the region has identified and is doing something about in a focused way.

One of the participants was unable to identify initiatives that had made a difference to a population health approach but thought it would help if the managers of SHR would consult with staff when deciding on how to deliver programs.

This team thought that the health region needed to be the leaders, the drivers of a population health approach. This is consistent with what other teams have suggested. One

^h The Health Quality Council (HQC) “is an independent agency that measures and reports on quality of care in Saskatchewan, promotes improvement, and engages its partners in building a better health system. Led by an appointed panel of provincial, national, and international health leaders, the HQC advises government, regional health authorities, and health care professionals on a wide range of issues related to health system quality and performance. It is the first agency of its kind in Canada. Our mandate is to:

- Develop evidence-based standards in health care delivery. This will include providing advice on the use of existing treatment options and identifying outdated or ineffective treatments;
- Promote effective practices to professionals across the province;
- Conduct research into the effectiveness of care and quality improvement initiatives;
- Monitor and assess the performance of the health system. This will include providing advice on human resource needs;
- Provide advice on appropriate drug prescribing practices;
- Evaluate new technology, drugs and other clinical developments; and,
- Inform the public about the quality of health services in Saskatchewan.”⁵²

of the participants wondered why more wasn't being done around chronic illness and identified the responsibility of the health region to work with clients to keep them well so that they would not have to return several times for the same health problem. Another thought that information to share with other agencies was vital in order to show how a population health approach can work and why it is in everybody's interest.

5.5 Team 3

Analysis A of the members of Team 3 revealed that they had a broad understanding of population health as a concept and as a practice. There were some concerns raised about the effectiveness of their data gathering and dissemination. Overall however, they did speak to the need for initiative to improve a population health focus.

Team 3's responses to some of the more direct accreditation questions revealed that they were similar in their understanding of the criteria which had a population health focus across the four core teams as most of the other teams.

Regarding the standards and a population health perspective, all of the team members knew that they existed. The extent to which they could address which standards did what specifically varied with the participant from very thorough knowledge to simple awareness.

The responses for this team to the standards for the four core team areas standards regarding population health were similar to what other teams had displayed. The Leadership and Partnerships standards were well understood and mention was made about the importance of addressing the community needs and how important partnering and networking were to that process. This team spoke more to the need for Human Resources to think ahead with respect to ensuring there is sufficient staff to meet the

needs of the community and less about occupational health and safety concerns, although those were also mentioned. Information Management was thought to be important in order to identify future programming needs and they suggested that there had been significant improvements in this regard. The Environment standards brought more responses about the state of the facilities in which services were delivered. Emergency preparedness was mentioned by every team member but nothing was said about the community as the environment.

5.5.1 Strengths, Challenges, and Improvements Identified by Team 3

The fact that all of the team knew that population health concerns were a part of the accreditation standards is a strength. Similarly the fact that they all identified the importance of Leadership and Partnerships is also a strength. The team spoke to the need to ensure that there will be sufficient staff for the community being served by their programs. The fact that this is recognized could be considered a strength, on the other hand it also identifies a challenge that perhaps those needs will not be met. Identifying the importance of and their involvement in their own data gathering initiative is a strength; the fact that they are not connected regionally represents a challenge. The Environment standards were again about facilities as it has been with most of the teams; only Emergency Preparedness received any mention as a community environmental initiative. This is a challenge as well. This team was cognizant of the importance of community through the other portions of the interview; however, they did not mention it during the questions for this standard.

5.5.2 Question 11 Team 3

This team was mixed in their response to Question 11 with respect to whether the accreditation criteria captured a population health approach. Two thought that it was well laid out and did in fact address population health. Another participant disagreed.

I think it could have been laid out a little more clearly, just because for me, I am sort of grappling with that; it wasn't always that obvious. I think it could have been more concise. Maybe if they had focused on that a little more, the population health component might have been more obvious.

As far as population health initiatives went, one of the team was able to articulate that partnering with organizations in the community was an initiative that has worked. The multi faceted approach has brought about the ability to “target very low income high needs clients around issues to do with their daily life-housing, food, but it includes Mental Health and Addictions issues, etc. So, we partner with those groups now, we have a lot of partnership arrangements with the schools.”

As far as what the health region should be doing to further a population health approach or address the non medical determinants of health, the leadership component surfaced with this group as it has with all of the others. This group also mentioned the importance of putting strategies in place that will address problems before they become problems, “I think that it should be a major role rather than just focusing on illness treatment because in the long run I don't think we are going to be able to afford that. So, I think it needs to be a big part of what we do.” A similar thought was expressed by another member of the team addressing how to manage resources.

Well, I guess what it needs to be is that it needs to become a more visible partner with the City, with other major players in the community and it needs to dedicate some time, energy, resources to that and it needs to be able to do that in spite of the fact that we are continually being challenged to provide resources just to manage the services we have. If we don't do it,

all we are doing is running around putting out fires and we never really do anything in a preventative way.

Team 3 was well aware of the importance of partnering and the need for the region to show leadership. They also expressed the importance of upstream interventions being performed in order to be proactive with respect to implementing changes in the way service is being delivered in order to slow the onslaught of acute care needs. Overall, this team understood the importance of population health as a surveillance mechanism and as a discipline to address non medical determinants of health.

5.6 Team 4

In Analysis A all members of this team clearly understood population health as a concept, and practice, and were able to articulate strengths and challenges.

The analysis of their responses to some of the more direct accreditation questions revealed that they believed that they had a very thorough understanding of the accreditation AIM tool and how it related to a population health focus. They were able to speak to what the criteria were trying to capture and how that was relevant to a population health approach. However, one of the participants identified that when the team is going through the self assessment process some of the members were wondering exactly what a population health approach is. It was mentioned that there was a lot of education that had to take place during that AIM process in order to have the other team members make comment on how it was important to their work. A need for more education, especially in the AIM literature and procedures about population health was identified.

Team 4 responses with respect to the standards for the four core team areas revealed that they understood the relevance of the criteria identified in these standards as they relate to a population health approach and they understood how the standards were

important in their own program delivery. Here again, as in the other teams, the importance attached to Leadership and Partnerships was well recognized, particularly in terms of the need to have leaders recognize the value of community development. The need to work with other groups within the health region as well as other groups in the community was identified. The Leadership and Partnerships standards were considered important to further those initiatives. The Human Resources standards responses revealed that this team had a good understanding of the importance of staffing issues to address program needs.

So, if we don't have the resources to work within the community we will not be able to make a difference in the community in a way that we believe is right and that's through team work and through integration of the services that we have. I very much use our human resource folks to help support the work that I do. I mean even as simple as supporting the fact that job descriptions need to be rewritten to support a population health approach

The rest of the team went on to describe the importance of sufficient staffing in order to implement and deliver programs that had a population health perspective. The Information Management standards were considered very important by the members of Team 4 because they thought data management could help inform the direction of their programs. They suggest that it can help reduce duplication of services and identify areas where synergy may be possible. When discussing the standards with respect to the Environment only one member of this team identified the community as the environment. Others spoke to the community at length throughout the rest of the interview, but did not mention it when discussing this standard, even though Criterion 6.0 reads: "While providing services, the organization protects and improves the health of the environment, in partnership with the community and other organizations." Is there a need to write the

criterion more clearly or to write a separate criterion that specifically asks about the community as the environment?

5.6.1 Strengths, Challenges, and Improvements Identified by Team 4

This team was fully cognizant of the standards and the ways in which the standards addressed a population health approach and how that was important to help inform the direction of their program design and delivery. They all spoke to the way in which the criteria were useful to them to identify population health concerns. There was a challenge identified around the need to be more inclusive of the community when discussing environment.

5.6.2 Question 11 Team 4

There was some discrepancy on this team around question 11. One of the team members thought that the AIM tool did a good job of identifying a population health component. The remaining two members of this team thought that the AIM tool did not go far enough in addressing community issues and that the tool was written with too much emphasis on the individual client.

I tend to, when I am going through those standards, and I think it applies across the board, is that the focus, and that's the paradigm of health, is that there is a focus on looking at more of a medical model and that curative kind of thing. And certainly I appreciate that they have introduced some of these pieces, but, for example, when we were sitting down and answering these as a group, sometimes it is hard to figure out where the fit is, because we don't feel like the population health promotion piece is really, truly captured in how the question is being asked. It seems to be more catered to an institutional almost type setting, not that population health isn't part of institutions, but that community piece of it sometimes I feel that it is a little bit lacking.

This was echoed by another member of the team, who replied,

...for example the community development team works with groups in the community and so when we talk about the team and when we talk about clients sometimes we will change that and note that we are talking about a population in the community and everything is so geared towards the client, client, client and that is an individual and to me population health is about a group of people sometimes.

The team thought that there had been good strides made with respect to nutrition education, diabetes initiatives, and food security, (i.e. the Child Hunger and Education Program, CHEP). The In-Motion initiative was seen as a positive population health program. They expressed a challenge that could become a strength if properly implemented; that challenge was working in silos; that strength would be liaising with other departments and sectors to build a broader approach to population health initiatives and then implementing the delivery of the fruits of those partnerships across that broadly defined spectrum.

The team mentioned that the health region could take steps to further leadership and partnership initiatives. This is consistent with what other teams had mentioned. There was a sense of optimism on this team that because these steps were being implemented at an upper management level there would be some tangible results and credibility to the whole idea of improving a population health approach.

What we are looking at is actually some VP (Vice President) leadership on a committee that is going to specifically look at population health issues and to me that is very important because it is important that it is seen at that level where there is going to be some time, energy, and a focus on that activity and it is going to be seen as important and it is going to allow people like myself who are kind of down a couple of levels to be able to actually say this is what I am doing and it is going to be seen as important and therefore I can continue to work in a way that provides health for a population of people.

There were some challenges identified with respect to funding and being able to make a difference in communities. It was expressed here, as it has been throughout the other teams, that acute care seems to have access to most of the resources, while community issues are left in need of resources.

And I would say that since the Lalonde Report we have been struggling to try to get resources into our communities, out of our acute care and into our communities and we are not anywhere near successful on that, but we are getting there; you know, it's a struggle, we are the poor cousins in the community, it's true, but it's okay we like it. We like working there.

Team 4 had a very good understanding of the need for partnerships and networking across the region and through the community. They also clearly expressed their knowledge of and reasons for more work in the community to address non medical determinants of health to have an effect on the health of the populations. Overall, this team clearly understood population health both as a surveillance tool and as a concept of health.

5.7 Team 5

In Analysis A, only some of this team's members clearly understood population health as a concept or a practice. One team member was only able to describe it as a measurement of the health of populations, and did not express much knowledge of community interventions to improve the health of populations.

The analysis of this team's responses to some of the more direct accreditation questions revealed that they thought that they had a fairly good understanding of the accreditation AIM tool and the standards for their team.

The responses for this team to the four core teams' population health standards were similar to what other teams had displayed, yet, less understood by one of the members. That member felt that they had not been exposed to the Leadership and Partnerships standards or the concerns with respect to those standards due to the job that participant occupied. However, that participant was still able to articulate the importance of partnering with other organizations and other departments within the region. The other members of this team understood the importance of addressing the community needs through strong partnerships and proper networking. They expressed how this would be important for leaders to accomplish.

So, if you look at people who are living in poverty and are renting unacceptable or substandard housing there probably isn't a group that represents those people effectively. There are different lobby groups that may be concerned about housing in general, our role is to try seek out those clients and actually deal with the clients and empower them and support them in trying to improve their life. So, Leadership and Partnerships is fundamental to what our role is.

The Human Resources standards were considered as being very important to the future of the program delivery for this team. They spoke to how important it was to do some succession planning in order to ensure the right people were in place for future program design and delivery. There was also some discussion around the importance of utilizing the input of staff when designing programs and recognizing the proper staff mixes for the work to be done. This team thought that Human Resources standards did a good job of identifying staffing needs and other issues integral to delivering a program with population health approach. Occupation health and safety issues were also considered.

The team was also aware of the need to have data properly gathered and disseminated. One of the team members was not as aware of the importance of these standards as it was not something that person dealt with on a daily basis. The other team members were able to speak at length to the importance of Information Management standards.

Here, as with the other teams, two of the three participants identified that the environment is more than a building where people get treatment or services. It was articulated that the community is the environment and the concerns of that community must be included when discussing environment. The one person who did not articulate these concerns during this response has expressed the importance earlier in the interview. Is there an opportunity to address this important issue regarding the community as environment more thoroughly in the way the standard is written?

5.7.1 Strengths, Challenges, and Improvements Identified by Team 5

As with most of the other teams Team 5 identified that they knew there were population health criteria present in the standards. They all identified the need for strong leadership to develop broad partnerships and linkages within the region and throughout the community. They identified how human resources issues were identified in the standard and how important that was in designing and delivering programs. The team in general articulated how important information was to designing and delivering programs and they articulated how the standard addressed those issues. The community as the environment was well articulated either when asked about the Environment standard or elsewhere in the interview.

5.7.2 Question 11 Team 5

Here again, as with other teams there was a difference of opinion around how well the AIM accreditation tool addressed population health concerns. Two of the participants said that it did do a good job, then went on to articulate how it could be better. One of the participants suggested that it fell short of the mark and that it needed to be more inclusive of community concerns.

There should be standards that look at the care of the community in its entirety. If you look at some major health threats to the general populations such as tobacco use, obesity or issues like that, they are addressed through population health initiatives and yet I think the criteria here could be improved to test the organization's ability to respond to those kinds of major issues.

This group identified initiatives such as partnering and networking as being a success, much like other teams had done. Then they went on to describe ideas that they have had, that they would like to implement, but described how they had not realized success in those areas because of the various demands on resources. One example was with respect to research into conditions in communities that always had to be cancelled or postponed due to day to day demands that consumed all of the time of the staff. Other challenges around implementing more population health relevant initiatives were identified.

When asked about how population health could be furthered there was a variety of responses identifying ways of implementing a population health approach or educating people in positions of authority, with decision making powers so population health policy would be furthered. It was also identified that the whole population health approach is bigger than a few programs in a health region.

I think it's an across Canada piece of work, it's not one health region or one province but collectively as a country we need to work on these things together because health issues don't know boundaries, so the boundaries

of the provinces and the boundaries of the health regions are somewhat artificial. So I think it is an across Canada issue, and also say within our province it's not one health region taking it on, it needs to be a very broad collaborative effort.

Team 5 had a very good understanding of the need for partnerships and networking across the region and through the community. They were not as consistent as a team with respect to knowledge of and reasons for more work in the community to address non medical determinants of health. Overall, most of this team understood population health both as a surveillance tool and as a concept of health. Perhaps this discrepancy in understanding could provide the impetus for some in-service workshops for staff regarding population health and for the CCHSA to provide a more detailed population health assessment tool for teams to work with.

5.8 Team 6

Analysis A of the members of Team 6 revealed that they had an understanding of population health as a concept and as a practice. One of the team was able to only describe it as a measurement of the health of populations. However, this participant did express knowledge of community interventions to improve the health of populations and knew that a member of their program did some of that upstream work.

As with the other teams the analysis of this team's responses to some of the more direct accreditation questions revealed that they thought that they had a fairly good understanding of the accreditation AIM tool and the standards for their team.

Again, the responses for this team to the four core standards regarding population health were similar to what other teams had displayed. The Leadership and Partnerships standard was recognized as being important in their programs and they were cognizant of

the importance of and how the partnering with other organizations has had and will continue to have an impact on the way they deliver their programs.

Team 6 addressed the need for a safe work place and spoke to occupational health and safety concerns. They did not speak to how human resource considerations could help them make more of an impact in the community. A safe and healthy workplace was the main focus for this team.

Information Management was noted as being important to this team. It was particularly important with respect to programming and next steps. There was some frustration expressed by one of the team members who said that the need to go forward with the knowledge gained from the information existed but that the authority to take it to the next step was not apparent.

We have noticed that throughout our accreditation process; they want you to take that next step. We are working on it; I think that came up in our accreditation process as well. Follow up is an area where a few programs do follow up but a lot don't and whether we need to or not, I don't know if we have determined that, yet, I think it would be beneficial in the long run for maintaining outcomes and are we effective in the long run. We get to a certain point and we get people out and then we don't follow up and we don't know if there is anything we can do differently to sustain them. I think we do this pretty well, it is that piece of follow through....we are good at collecting data, we report it but have difficulty implementing change from it.

The Environment standard was seen as the place in which this group delivered services. There was a lot of mention regarding infection control issues in the institutions. Only one of the participants commented on the need to partner in the community in order to improve the health of the environment.

5.8.1 Strengths, Challenges, and Improvements Identified by Team 6

Team 6 identified that population health criteria present in the standards. They all identified the need for leadership to develop broad partnerships and linkages within the health region and in the community. However, the need to do that had not been accomplished as broadly as other teams had suggested it had. Team 6 thought that more could be done in this regard. They spoke to the occupational health and safety needs when discussing human resources. The information management standard elicited some responses that suggested that there was a need to be able to do more with the data that had been gathered. The environment was seen as that place where service is provided.

5.8.2 Question 11 Team 6

All of the members of Team 6 expressed that they felt that the AIM accreditation tool did not adequately address population health concerns. One of the team members suggested that nothing about population health jumped right out. A different member thought that the whole idea of trying to place a population health focus into an accreditation process was an incongruous mix.

My own opinion is they have tried to take a population health approach and integrate it into an accreditation framework and I am not sure the two match well together. It almost feels forced to me when I read the document. That doesn't mean that we shouldn't try to do it; I think they have made an attempt to do it which is good. They could do it better.

One of the members expressed that they did not have sufficient knowledge about population health to be able to offer a very good opinion.

All members of this team thought that there had been some good work done around partnering as an initiative to improving health outcomes. The need to address a broad spectrum of outcomes from a population health approach was identified. Things such as

partnering with the community, Aboriginal groups, etc. in order to address diabetes and other chronic diseases were identified. This team reported that this was ongoing and expressed the need to do more to this end.

With respect to what needed to be done, every member of this team spoke to the need to direct more resources toward implementing a population health approach. Some wanted to know why some jurisdictions received all the money, like Ontario; others just suggested more funding was needed to carry things forward. One of the members suggested that innovative ways of acquiring funding might be necessary.

I think we have to be prepared to invest in a longer term return on that investment and there have to be research grants out there, there has to be private money out there. I think sometimes we just get focused on the government will give us money but I think there are other organizations that are willing to fund some of this work and support some of this work. We feel a little unhappy about maybe having corporate support or put their name on a prevention strategy or a promotion strategy. I think we need to think out of the box a little bit.

Team 6 also identified some of the partnering that has existed and has carried some initiatives forward and they identified the need for stronger links within the community to create even more of these partnerships. They all agreed that more resources were necessary to further a population health approach.

5.9 Summary of Analysis B

5.9.1 Teams' Responses to Accreditation Questions about Population Health

In general most of the teams did have some knowledge of a population health approach. All of the teams had at least one of the three members able to speak at length about the importance of population health, both the need to accurately measure and do

surveillance, and the need to address the non medical determinants of health and the impact those initiatives would have on the programs that they deliver.

At least one member and often more than one spoke to the need to have the accreditation standards, language, and indicators written with a much stronger population health focus; something with a more community and less clinical flavour. Some of the members thought that the accreditation self assessment tool did an adequate job of addressing population health but most thought that there was a great opportunity for improvement when the CCHSA writes their next iteration of the standards.

All of the teams identified that Leadership and Partnerships was a very important component to a population health approach. All teams recognized the gains that could be made by removing the silos around programs and embrace intersectoral and cross discipline working relationships. The idea of synergy was discussed; there was a strong desire to have programs partner with each other and with other organizations in the community.

Human Resources needs and planning to have sufficient staff available was addressed by only two of the teams, the rest all spoke to the occupational health and safety concerns but did not speak to the personnel needs of the work in the community.

The following table shows in summary, some of the view points that were captured across the different teams regarding their knowledge of or the way they thought accreditation addressed population health through the core standards.

Table 3: Accreditation Knowledge Summary Across Standards

Summary of findings	Examples
Good knowledge of standards in four core team population health areas	So, if we don't have the resources to work within the community we will not be able to make a difference in the community in a way that we believe is right and that's through team work and through integration of the services that we have. I very much use our human resource folks to help support the work that I do. I mean even as simple as supporting the fact that job descriptions need to be rewritten to support a population health approach
Knowledge of standards in four core team population health areas not well focused	We have noticed that throughout our accreditation process; they want you to take that next step. We are working on it; I think that came up in our accreditation process as well. Follow up is an area where a few programs do follow up but a lot don't and whether we need to or not, I don't know if we have determined that, yet, I think it would be beneficial in the long run for maintaining outcomes and are we effective in the long run. We get to a certain point and we get people out and then we don't follow up and we don't know if there is anything we can do differently to sustain them. I think we do this pretty well, it is that piece of follow through....we are good at collecting data, we report it but have difficulty implementing change from it.
Thought that the standards did address population health	I think it does a pretty good job of doing that. It does talk about the changing needs and the health status of the community, the work force, and the environment in which these people are providing and delivering service. I think that it is important from that perspective and I think they capture it well.
Important areas the standards did not address	I think it could have been laid out a little more clearly, just because for me, I am sort of grappling with that; it wasn't always that obvious. I think it could have been more concise. Maybe if they had focused on that a little more, the population health component might have been more obvious. I tend to, when I am going through those standards, and I think it applies across the board, is that the focus, and that's the paradigm of health, is that there is a focus on looking at more of a medical model and that curative kind of thing. And certainly I appreciate that they have introduced some of these pieces, but, for example, when we were sitting down and answering these as a group, sometimes it is hard to figure out where the fit is, because we don't feel like the population health promotion piece is really, truly captured in how the question is being asked. It seems to be more catered to an institutional almost type setting, not that population health isn't part of institutions, but that community piece of it sometimes I feel that it is a little bit lacking.

5.9.2 Recommendations from Previous Accreditation 2001

Those teams who received recommendations from the last accreditation all commented that they recognize the need to develop stronger links across teams to do more interdisciplinary work. There was very little difference in the responses across the teams. The recurring theme throughout these teams' answers was that they recognized the validity of most of the comments made about their program during the last accreditation and that they have made some strides in addressing those considerations but still had work to do to achieve those results. There was also a sense that the accreditation survey from 2001 did not understand or acknowledge some of the work that had already begun in these areas and that was still continuing. One of the participants thought that the assessment did not go deep enough in addressing population health efforts.

I agree partially with that assessment. I think it stops short. What jars with me is that it ends with "related to services". I think that health care is much more than health services which embrace more the area of healthy public policy. If you think about the bylaw development in the area of tobacco or the work in helping the grocery store get built in the inner city or even the advocacy work with the restaurants in terms of food safety as an example. So I think it falls short and what jars with me is the focus on the services because we are more than just a health care business and service we actually have advocacy and policy pieces that aren't accurately embraced in that sentence.

There was a mix in how the teams saw the previous 2001 accreditation assessment as it applied to their teams and programs. Some of the groups considered the recommendations made in that assessment to be on point while others saw their role as more of secondary treatment and did not see the program they delivered as actually having a prevention aspect to it; this was said after having previously mentioned that there is a portion of their program that employs prevention and education workers.

6. SUMMARY OF RESULTS AND DISCUSSION

In this chapter I will attempt to make some sense to the results analyzed in the previous chapter and to offer some recommendations as to what I see that would further a population health approach. I will briefly synthesize some of the points made from the previous chapter in order to encapsulate those responses that answer the sub questions. This chapter will conclude with a discussion on what the discoveries from the interviews might lead to by way of education or policy opportunities for health regions and for the CCHSA.

6.1 Discussion of Analysis A

6.1.1 Concept, Practice, and Policy Implications:

How do senior management, middle management, and front line health staff with a population health mandate understand population health as a concept and as a practice?

6.1.2 Concept:

Upper management presented a clear understanding of the concept of population health, middle management less so, and some front line staff said they don't know how to describe it, yet later in the interview described the idea of at least the non medical determinants aspect of population health quite well. However, as well informed as many of the participants were about the non-medical determinants of health, many focused on the financial savings to health care facilities that they saw as possible through a population health approach (more on this later). There were other participants, particularly at the upper management level, that were able to articulate the importance of

population health to broad societal concerns and how population health initiatives would further a more robust community. However, there were many health workers who did not understand population health well and thus much room for increasing knowledge about a population health approach.

This leads to the question: Is there an opportunity here for the health region to provide some in-service with respect to population health training across disciplines? All of the people who were interviewed in this piece of research sat on an accreditation self-assessment team, yet some of them are struggling to come up with a definition or a way to express their understanding of population health. I see this as an opportunity for the health region to provide the in-service mentioned. I would like to see an in-depth education component provided to all staff within a health region that would address a population health approach. I think everyone working in the health region would profit from in service workshops that not only outlined what population health is but how, if properly implemented, it would have a positive impact on all programs that are delivered within the health region.

The case study explored in this paper examined the views of population health across teams and people that have a specific population health component identified as a part of their program design and delivery. This selection of teams was by no means exhaustive as many other teams in the health region consider themselves to have some population health perspective in their programs. Not all programs with an identified population health component were surveyed, but there was a deliberate attempt to capture those with the most population health relevance. It is obvious that those teams with a population health component would profit most from such an educational opportunity. However, I

think that even acute care and critical care programs would profit to some extent by an in-service education around how upstream interventions throughout the community would have an impact on the number and severity of patients/clients that those programs would need to attend to. Further, the more people who understand a population health approach the greater the spread of that understanding throughout the community. A broad based understanding would ultimately lead to a society that would welcome more broad based non medical determinant interventions and initiatives within the community. This would lead to a healthier society and a more robust community.

As mentioned above, upper management and middle management described the streams of population health such as population health surveillance and the non-medical determinants of health. There were some comments that spoke to the non-medical determinants of health in a way that privileged medical health services and were not really about the broader aspects of health. These types of comments revealed the tension between medical care and the importance that it receives and the non-medical determinants of health, a tension noted throughout the literature review.¹⁹

There was another comment that was quoted in the results that spoke to the non-medical determinants of health in terms of keeping the population strong and healthy so that they would not need treatment in a hospital setting. This is what the CIAR spoke to in their view of population health and which other writers critiqued as being too medically based and capitalistic and not sufficiently focused on society.^{11,27} Many participants drew attention to this ‘side’ of population health. While their arguments make sense economically,²⁸ many other writers describe that population health is more than that. They write that it is more about population health being a vehicle or at least

provide some direction to inform policy decision makers about how and why they need to develop policy that can provide for a more inclusive society; a society where the community comes first and individual needs, while addressed, are not the most important consideration. Butler-Jones (1999) offers:

The pursuit of health should, therefore, include an increasing understanding of other contributors to a broadly defined 'good health', of aspects over which the individual and the community have influence in a constructive way. These include among others, 1) the development of supportive communities, what some have termed "civic society", 2) involvement in arts and music with creative and health enhancing benefits to both participant and observer, 3) an active lifestyle, both physically and mentally, to whatever extent individuals are capable, 4) voluntarism and the giving of oneself to others, in the process receiving the intangible benefits that contribute to well-being, 5) friends and family, who provide support and counsel in both good and bad times, and 6) spirituality and faith, which represent having a belief in something greater than oneself and a supportive faith community, both of which may encourage health. (p.S63)⁵³

Other writers also describe this as an important element of population health. Hayes and Dunn (1999) write:

A population health framework situates the importance of social relations centre stage. Social structure is recognized as a crucial factor in shaping health and well being, which moves the focus of discussion away from obsession with individual biology and/or personal choice. (p. S9)⁵⁴

They go on to describe how many factors such as housing, global capitalism, gender, power and other considerations are considered important and have been assigned as numerical variables but not enough attention is devoted to understand how or why they are important, and are often ignored completely from the research arena.⁵⁴

This is important to policy since all of those variables have an impact on health and societal outcomes. It is important to write and implement policy that will address and serve those conditions. Therefore, the need to dialogue with the public about the

importance of such concerns takes great importance. It is not easy to show people how policies put in place now will improve society and therefore everyone's position in the community in the years to come. Influencing the political will around these ideas is a challenge.

Of course population health prompts many more policy challenges as well. Among them is that a relative lack of public currency and understanding of a population health perspective provides precious little political motivation or public appetite for developing an integrated policy framework dedicated to promoting just and equitable social relations. (p.S9)⁵⁴

In closing the discussion around how people viewed population health as a concept I want to focus on the following: Knowledge of population health as a concept varied from participant to participant and across the strata of employee. While upper and middle management understood it best, there is still the need for an in-service education session that would not only describe the non-medical determinants of health to the employees but would also stress the fact that policy pertaining to these determinants greatly influences why these determinants are important. It is not enough to simply know that poverty, education, and other social determinants have an impact on health outcomes, it is also vital to understand how policy impacts on those determinants. Through a broad education component delivered in the health region as well as provincially and nationally, all health workers, their friends, and their families will have a better understanding of what it will take to achieve a better community and therefore better health and social outcomes. It is up to all of us to speak about this whenever and wherever we can.^{31,55} Informing staff of the importance of these considerations will help to further the word about population health.

Another point that needs to be mentioned is upper management stratum's responsibility to work with funding authorities and the governments to ensure that policy with respect to working toward a more egalitarian society is written and delivered. It is important that they work with those same agencies to ensure that the necessary resources remain in place to deliver the policies. It is partially through these measures that a more robust society can be realized and enjoyed.

6.1.3 Practice:

As a practice both upper management and middle management understood the population health components of the programs that they delivered. They were quite cognizant of efforts that had been made in the community to strengthen relationships but saw the need to do even more. Many spoke to the need for an increase in the number of relationships with all levels of government and with community based organizations. They recognized the importance of partnerships to deliver the programs more effectively and to use the partnerships to spread the word about population health. This is an important consideration when discussing ways to further population health. From the results associated with practice I learned that this is another area where all strata have an important role to play in influencing the way in which policy is written. But if upper management and middle management have a better understanding of a population health approach and how that knowledge needs to help inform policy, it is also important to note that the front line worker stratum has a lot of information about practice in the programs that needs to be captured to help influence policy development. They see the impact that the current policies have on the programs they are delivering.

Members of the front line staff have a wealth of input to offer. They bring a great deal of valuable information to the policy setting arena due to their hands-on involvement in programs with a population health component. To ignore the contribution that this stratum of employees offers would be foolish; they are invaluable in providing direction to programs and in determining whether the interventions are having the desired effect. They need to be made aware of what a population health approach is in very broad terms in order to understand better what impact their role will have on population health outcomes. The work they do in the field is important and it is the first, best chance of providing population health interventions to the people who most need it. A comprehensive in-service education session regarding population health would go a long way to strengthening this stratum of employee in their knowledge about the importance of population health, the importance their work brings to a population health approach, and the benefit we can all derive from involving them and their valuable experience in the decision making process. The in service education sessions would not be simply a one way flow of knowledge, but rather, would utilize the experience, understanding, and information that front-line workers and indeed all strata of worker would have to offer. This flow of information from bottom to top could be useful in providing policy writers with hands on information and could influence the direction that policy would take. Also, it is important that all strata of employee are cognizant of a population health approach so they are able to better articulate its importance in their work place and in their community as advocates and community organizers.

I have discussed the need for a more comprehensive view of society when writing policy regarding population health and the need to ensure that there are sufficient

resources available to deliver the programs that come about from that comprehensive policy. I also discussed the need to include a variety of workers to inform the direction of the policy development.

6.2 Discussion of Analysis B

6.2.1 Teams' Responses to Accreditation Questions about Population Health

How well has this concept and practice been put in place by teams with specific mandates for population health?

Much of this question has been answered in the previous chapter. However, I think it is important to note that of the criteria with a population health mandate, as described in the four core teams (especially in the Leadership and Partnerships Standards), there was a very strong indication from all teams around the importance of interdisciplinary and cross sectoral teams. Another area that was identified as important was that of Information Management; people felt their programs could be delivered more effectively with a better vehicle to disseminate data and share knowledge and information. Human Resources staffing to address the needs of the community was rarely mentioned, opting instead to focus on Occupation Health and Safety Issues of the facility in which they worked. The Environment Standard most often referred the facility in which the workers were working, not the community in which they were delivering services. The standards for the four core team areas all received some comments as mentioned. All of the core standards do provide for an avenue to make some comment with respect to the community and the need to share information, provide sufficient resources to deliver programs, and identify the environment in which people deliver the programs (including one criterion about the community), but most of these criteria do not specifically focus on community

programming, resourcing, or ways to disseminate information broadly to community members. Some of the participants were able to speak to the community needs and population health more broadly when discussing these criteria but it was mainly because they had some knowledge of a population health approach and found a way to fit the conversation into the criteria. The CCHSA, health workers, governing authorities and other partners would all benefit from CCHSA writing a more population health focused set of standards. With a more comprehensive component of population health written into the core standards, more agencies would be able to grasp an understanding of population health because more health workers would be able to describe it more completely and recognize the effect of cross sectoral work.

With respect to the direct question (Question 11) regarding the CCHSA and whether the standards adequately address a population health perspective the results were mixed. Some participants thought that the standards were acceptable, while others felt that there was an opportunity for improvement in how the standards addressed population health. There was at least one member of each team who felt that the standards did not address population health well. The need to identify more community concerns was articulated across the teams.

As I identified above, most participants spoke at length to the need for networking, partnering, interdisciplinary and cross sectoral work. Since this is what most of the discussion focused upon and since this networking represents the best single way to advance a population health initiative,³¹ I will now discuss the results presented in Analysis B to identify the concerns that have policy implications and ways in which improving partnering and networking will impact that policy discussion.

With respect to partnering and cross sectoral work, according to some of the responses, there have been efforts to see that this happens. Some of the cross sectoral and interdisciplinary work with various community based organizations and work across interdisciplinary teams was mentioned. This was identified in the 2001 Accreditation of Saskatoon District Health. However, in that accreditation the opportunities for improvement suggest that these relationships needed to become broader, stronger, and that there be more of them.³⁷ This is consistent with what was identified across the teams I interviewed, irrespective of program. This came through as one of the most important considerations. All teams recognized the value of the partnerships. This has policy implications that health regions and the CCHSA need to consider. By identifying that cross sectoral partnerships involve more people in the community than just the health region, it lays the ground for population health programs to be delivered. I see this as the impetus for CCHSA to write a more population health focused self-assessment tool.

Hayes offers:

The population health framework makes it clear that health is most robustly a shared responsibility. Issues of social justice and equity never go away, but they may be responded to in prudent, less violent, more humane ways. Sharing the responsibility for bringing this about involves advocating for the broader kinds of change in social welfare policy that will most improve health and well-being. It involves having the courage to speak out to share the information assembled within the population health framework. It involves having the wisdom to understand and respect our connections with distant others. And it involves having the strength to act upon the information in a way that is consistent with the ultimate objectives: improved health and well-being and reduced health inequalities. (p.S17)³¹

Other writers describe the importance of partnering. They suggest that a multi pronged approach to address the needs of the community. Butler-Jones describes ways to collaborate:

To address the determinants effectively, we require a broad intersectoral approach. This can range from the collaborative work of health boards and government departments with other community and government agencies, through to the components of health promotion that can fit into a busy clinical practice as a complement to community efforts. Tools, simple interventions, reinforcing advice: each can support other community-based actions. While individuals or groups alone may not be able to effect significant policy or program changes, working together complements strengths and maximizes effectiveness. (p.S64)⁵³

The points described above are consistent with what many writers describe as an important consideration when considering policy regarding population health.^{28,30,54}

However, difficulty in implementing such partnerships may be encountered until clear expectations and definitions of responsibilities are understood. Frankish et al explain:

The involvement of non-health sectors in population health decision making suggests both a shift in the role of traditional government stakeholders and health professionals, and an emergence of new partnerships. With a shift to greater intersectoral participation, the role(s) of health professionals in population health may become unclear. Tensions emerge as health professionals feel threatened by an uncertain future and a reduction in their influence, analogous to the changing role of academic researchers involved in participatory research within communities for example.(p.S74)⁵⁶

In the same paper they write that there will be challenges with respect to understanding the information if there is to be involvement by program planners and policy makers charged with addressing the broad determinants of health. They also mention how it will be important to ensure that resources are equitably distributed across the various levels of government (provincial/state, regional, municipal).

While there will likely be some “growing pains” in the formation of such partnerships as is suggested, I think it will be well worth the effort. Population health professionals will still be required to provide input to the policy arena. Their input is valuable because they as much as any group who have studied the impact of the social determinants of

health and have much to offer the decision making process. The mention of a link between funding agencies such as provincial and federal governments would be valuable in this set of standards as it would help reflect the importance of a population health approach when health regions are working on budgets with their funding authorities. They would also be made aware that governments are very much a partner in policy development that affects how these partnerships will work.

The Leadership and Partnerships set of standards elicited the most response, almost all of it from all strata and all teams speaking to the need for increased networking across the communities at multiple levels, from community based organizations to governments. The other core team areas of Human Resources, Information Management, and Environment did not yield as much discussion regarding the community. To me that is an important point. In order for more discussion to take place in these other core team areas, there needs to be a more complete picture of community needs built into each of these standards. A criterion that addresses sufficient personnel to do work in the community would be of benefit in the standards for Human Resources. A criterion that addresses having data that represents the situation in the community, so those needs could be addressed, would benefit the standards for Information Management. Only criterion 6 of the Environment Standards actually addresses the community per se. Because there is so much more attention given to the facilities throughout this set of standards, comments on the community itself were often scarce by interview participants. A more specifically community focused set of criteria would be beneficial in addressing community needs in the standards for Environment. Some of the participants were able to identify some of the issues associated with these standards as they related to the community because of the

work in their program. However, the lack of discussion by the other participants or the inability for other participants to be able to identify how these standards were important in the community tells me that a more community focused set of criteria needs to be written into these standards.

6.3 Study Strengths, Limitations, and Future Research Opportunities

One of the limitations in doing this work was the sample size; though reasonably large for a Masters level study of this type, it did not cover many potential program areas where population health could or should have a component. At the same time, there was a lengthy interview instrument used to collect the necessary data, which made using more than twenty participants impractical.

A strength when doing this work was the fact that due to my experience in a program with a strong population health component assigned to it and from all of the course work I have done with respect to population health, I was able to understand what the participants were saying with respect to population health. I was cognizant of the tensions that exist around population health and I could easily see where the participants stood on that matter. Also, the fact that I am well known in the health region allowed people to feel quite comfortable in their responses to me. The participants were very generous in their responses and I enjoyed a one hundred per cent participation rate.

A future research opportunity might be to conduct two focus groups; one group from the original research (i.e. this work) and another group that had no participation in this work at all. Each group could be provided with a two page briefing note of what I discovered, through this research, to see if the groups agreed or disagreed with my

assessment of population health knowledge in the region and in the CCHSA literature. Such a method would add more robustness to my conclusions.

6.4 Conclusion

Through this research I wanted to learn what understanding of population health exists in a health region and how that level of understanding has an impact on the way programs are informed and delivered. I also wanted to know if the CCHSA “Achieving Improved Measurement (AIM)” self assessment tool had a population health component that was meaningful to people who were involved in the accreditation of a health region. Further, I wanted to analyze the findings to see what policy implications arose from what I discovered. To accomplish these tasks I conducted a case study of the Saskatoon Health Region and interviewed health workers in the region who served on accreditation teams. I did notice some differences among the teams which could be related to discipline and also seem to be related to their primary orientation. If population health is to be part of the core function of a health system, then understanding better what those differences are and whether they in fact are tied to disciplines or specific functions and not simply tied to individual differences is something that merits some more consideration or work as an area of further inquiry.

I learned that although there is a fairly good understanding at the upper management and middle management levels about what a population health approach is, there is room for improvement at the front-line stratum. As good as the understanding with respect to non-medical determinants of health was at in the upper strata, there was also room for improvement there. Very few participants spoke to how the social determinants of health need to be addressed. As mentioned they were able to articulate the importance of them

regarding health outcomes but did not address the policy implications as well as they might have. I therefore would like to see some in-service education delivered throughout the region to improve knowledge in this area. This is consistent with the tensions I described in the literature review regarding the differences not only in practice, but also as it pertains to the understanding of community involvement and the structural social inequalities being the two least understood pieces around population health. There is room for growth in the understanding about what effect a policy will have on a society and how that translates into improved or worsened health outcomes.

I was encouraged by the ample discussion by almost all participants with respect to the need for increased partnering and networking across various organizations in the community. However, their inability or reluctance to speak to the other core standards revealed that CCHSA has an opportunity to improve the way in which the core standards are written. In their next iteration of the “Achieving Improved Measurement (AIM)” a more community and policy focused set of standards ought to be developed.

With respect to policy implications the opportunity here is at once exciting and somewhat daunting. To conclude what I opened in the discussion portion of this chapter, there is some concern with respect to partnering. There is a real concern over what will be possible and whether it can be achieved because of all of the competing interests. Hayes explains:

Implementing population health approaches to public policy presents innumerable challenges to both politicians and public servants. By definition, the “big picture” is complex and whatever is held up as “the framework” is contestable. The timeframe of a life course perspective greatly exceeds the temporal horizon of political mandates, and it is extremely difficult to muster support for policy options that make sense from a longer term perspective but are at present unpopular or threatening

to specific interest groups or advocate on behalf of marginalized groups that are not politically/economically powerful. (p. S15)³¹

This sentiment is shared by other writers and is articulated well by Butler-Jones:

There are two particular issues facing health care today as the past catches up with us: “Health Imperialism” describes the situation wherein health practitioners come to recognize the importance of non-health sectors in affecting health and thus make efforts to direct others’ programs or increase their accountability for health. Given health’s dominance in government budgets and a relative lack of collaborative action with other sectors, such imperial assertions are sometimes greeted with resentment and scepticism. For example, those in a non-health sector who have been trying to address social determinants for decades, while hospital ate up the budget, might say, “where have you been?” (p.S63)⁵³

Yet, even though the above concerns are important, it remains equally and maybe more important to continue to strive to work in partnerships as described by other writers and brought to light by the participants in this research. There is a need to step out of the silos and move toward a new way of writing policy and delivering programs. It must include a wide variety of participants. Ruger (2004) offers:

A capability approach to the social determinants of health thus recognizes the importance of addressing health needs on multiple fronts, in multiple domains of policy that affect all determinants of health (not just socioeconomic inequalities). It emphasizes the integration of public policies into a comprehensive set of health improvement strategies delivered through a plurality of institutions. (p.1092)⁵⁷

This is important as outlined earlier. Through research focused in this direction, hope exists that agencies will work together to achieve more equitable social and health outcomes. Frankish et al provide:

Population health research is concerned with whole communities or populations, not just individuals or groups, generally more distal rather than proximal determinants of health; greater intersectoral action beyond only the health sector; and with making populations more self-sufficient and less dependent on health services and professionals. The population health perspective is concerned with explaining differences in health and has the intent of doing so at the population rather than individual level. It

describes the analysis of major social, behavioural and biological influences upon overall levels of health status within and between identifiable population groups and subgroups, attempting to identify aspects of the social and cultural milieu that affect differences in health status. (p.S71)⁵⁶

I also think it is important to recognize that the North American notion of capitalism may not be the pinnacle model of society as is so widely believed. I believe, from growing up on this continent, that the current view of the North American market driven economy is considered 'sacrosanct'. Anyone who disagrees with this assessment is often challenged. Yet, other capitalist economies that exist in the world have far better health and societal outcomes than we experience in North America. Coburn and Denny write:

We need research that will help us understand why some capitalist countries with strong social democratic political parties and resilient welfare states, such as Sweden and Norway, have much lower health inequalities and better average population health than Canada or the United States. (p.394)²⁹

Perhaps with sufficient input from a variety of research efforts changes to the current model can be realized and hope for a more egalitarian society can be achieved.

I have written a great amount in the above pages about the importance of understanding population health as more than a tool for measurement and that it is more than just recognizing the non- medical determinants of health. I have also written that it is important to understand why those social determinants have an effect on health outcomes. It is important to inform the policy writing process that these determinants need to be addressed through a variety of methods through many organizations. Therefore I conclude that education about measurement, the non-medical determinants, and policy affecting those determinants be offered to health region employees.

As much as I think that a broad based education in-service is required to inform staff about different aspects of population health, I also think that since there is no common consensus as to its definition or the way in which policy needs to be written. Yet, I remain hopeful that if sufficient knowledge about all aspects of population health is afforded staff, including considerations for the policy realm, there can be an improvement not only in their practice and disciplines but broadly throughout society. The more staff know about population health, the more they can help with its implementation.

The need to have the accreditation instrument be more reflective of a population health perspective was identified in the CCHSA section of this work. Broad partnerships were considered very important and the challenges and promises of writing policy with respect to partnering were identified.

I am optimistic that population health initiatives can yield better health outcomes that will be realized by our communities. Through the combination of research, partnerships, and broad based stakeholder input, policy can be written that will have the desired effect. In spite of the challenges presented with respect to partnerships and networking, I still think it offers our greatest chance for success. Programs do not operate in isolation from each other. The participants in this research spoke to the need for more partnering across many sectors. Perhaps Rudolf Virchow was correct all those years ago when he stated, “medicine is a social science, and politics is nothing more than medicine in larger scale. (p. 423, (as quoted in Waitzkin 1983:74).)”⁵⁸ If we accept that this assertion is at least partly correct and that there are policy implications across all or nearly all policy realms then it is important to include a vast variety of stakeholders in the policy decision making process. It is through the combined efforts of many spheres that I believe we have the best

chance of improving the knowledge, practice and attitudes of health workers and all people with respect to population health.

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Appendix A: History of the CCHSA

- 1917: The American College of Surgeons (ACS), of which Canada is an active member, begins developing a hospital standardization program. The first Minimum Standard for Hospitals is developed and the requirements fill just one page.
- 1918: The ACS begins on-site inspections of hospitals. Only 89 of 692 hospitals surveyed meet the requirements of the Minimum Standard.
- 1926: The first Standards Manual is printed and consists of 18 pages.
- 1951: The accreditation program becomes too large and complex for one organization to administer. The American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association join with the ACS to create the Joint Commission on Accreditation of Hospitals (JCAH). It is an independent, not-for-profit organization whose purpose is to provide voluntary accreditation. Responsibility for the hospital standardization program is formally transferred to JCAH on December 6, 1952.
- 1953: The Canadian Hospital Association (now the Canadian Health Care Association), the Canadian Medical Association, the Royal College of Physicians and Surgeons, and l'Association des médecins de langue française du Canada, establish the Canadian Commission on Hospital Accreditation. The commission's purpose is to create a Canadian program for hospital accreditation.
- 1958: The Commission realizes its goal with the incorporation of the Canadian Council on Hospital Accreditation. The Council's purpose is to set standards for Canadian hospitals and evaluate their compliance. The accreditation program is voluntary, free from government intervention, national, bilingual, and not-for-profit.
- 1960-1988: The accreditation program continues to grow in popularity. In 1960, there are less than 350 accredited hospitals in Canada. By the end of 1980 there are 850, and in 1988 the number of accredited facilities approaches 1,300.
- 1963: Accreditation of smaller and special hospitals begins.
- 1964: Accreditation of mental health hospitals begins.
- 1978: Accreditation of long-term care centres begins.
- 1980: The Canadian Long Term Care Association (now the Canadian Association for Community Care) joins the Council's Board of directors.
- 1981: Hospital administrators join physicians and nurses as surveyors. The composition of the Council's Board of Directors changes.

L'Association des médecins de langue française du Canada withdraws, while the Canadian Nurses Association becomes a member.

1985: The accreditation of rehabilitation facilities begins.

1988: The Council changes its name to the Canadian Council on Health Facilities Accreditation (CCHFA) in time to celebrate its 30th anniversary.

1990: Standards documents are revised to focus on structure and process, and begin to look at outcomes.

1992: The Council's Board of Directors expands to include representatives from the Association of Canadian Teaching Hospitals, the College of Family Physicians of Canada, the Canadian College of Health Service Executives, and a consumer representative.

1995: To more accurately reflect its clients and customers, the Council changes its name to the Canadian Council on Health Services Accreditation (CCHSA).
The client-centered accreditation program is launched with the distribution of client-centred standards for acute care facilities and cancer treatment centres. This revised accreditation program focuses on an organization's patient care processes. The philosophy of continuously improving the quality of care and service is also incorporated and organizations are asked to begin developing and using performance indicators.
An accreditation program for comprehensive (regional) health services is launched. The accreditation of community health services begins.
The Performance Indicators Project is launched. Council selects six generic performance indicators and pilot testing of the project begins.

1996: The accreditation of home care services gets underway.

1997: Work on The AIM Project (Achieving Improved Measurement) begins.
This project, to be launched in 2000, sees the accreditation program revised to emphasize better measurement.

1998: Council is surveyed by international accrediting organizations.
A new team is established to better serve Québec's specific needs.
A draft accreditation program is developed for Acquired Brain Injury Services and the first pilot test organization has its survey.
A draft accreditation program is developed for First Nations and Inuit Substance Abuse Services. Draft standard for the AIM project is prepared and ready for phase 1 pilot testing. The Board of Directors decides to move to a policy governance model.

1999: Phase 1 and phase 2 of AIM pilot testing is completed.
Pilot testing for six acute indicators is completed.

First Nations and Inuit Substance Abuse Services draft standards are approved and five pilot organizations are surveyed. Medical Services Branch of Health Canada agrees to fund the launch and implementation of the program. Seven pilot surveys are completed for Acquired Brain Injury.

2000: A new logo and corporate identity is unveiled.

Council moves, within the same building, to a more spacious office that includes most of the first and second floors.

International Services is inaugurated.

The National Surveyor Conference 2000 is held in Toronto.

AIM standards document is prepared and ready for delivery in early 2001.

2001: Continued advancements are made in the use of technology as we move towards automation of our Accreditation Program.

New products and services are refined.

The one-stop customer service model is introduced which sees the implementation of Accreditation Specialists to assist health service organizations.

There is continued development of new standards and programs for a number of markets.

2002: A series of regional Surveyors' Conferences are held in locations across the country. A separate Education Development arm is implemented and work in this area has intensified.

Work towards a pilot comparative report is initiated.

Regular communication efforts with stakeholders intensifies.

CCHSA undergoes its own accreditation survey through ISQua.

<http://www.cchsa.ca/default.aspx?section=History&group=1>

Appendix B: Population Health (Continuum of Services)

There are no AIM standards entitled “population health;” population health is a concept that is woven throughout the AIM Program.

The following is a list of population health (continuum of services) indicators that are available with national definitions and for national use. These will assist you in planning and evaluating your services.

There are also excellent sources of information at the local, regional, provincial, and territorial level.

Organizations should select some population health indicators that are relevant to the service, site, and population served and that fit in the preceding sections (i.e. Leadership and Partnerships, the support sections, and the appropriate client services sections).

Health Status

Health Conditions

Activity Limitation

Well-being

Non-medical Determinants of Health

Health Behaviours

- Smoking Rate
- Youth Smoking Rate
- Smoking Initiation (average age)
- Regular Heavy Drinking
- Physical Activity
- Breastfeeding

Living and Working Conditions

- High School Graduation
- Post-Secondary Graduation
- Unemployment Rate
- Long Term Unemployment
- Youth Unemployment
- Low Income Rate
- Children in Low Income Families
- Income Inequality

- Housing Affordability
- Crime Rate
- Youth Crime Rate
- Decision-Latitude at Work

Personal Resources

- School Readiness
- Social Support
- Life Stress

Environmental Factors

**Health System Performance
Multiple Measures**

Canadian Council on Health Services Accreditation "AIM Achieving Improved Measurement" 3rd Edition, O., 2004. Ottawa, 2004, published by the Canadian Council on Health Services Accreditation, (p.43 – 56)

Appendix C: Interview Guide



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Project: How do health regions integrate a population health component in the design and delivery of services?

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Interview Guide/Schedule for the Discussion of Population Health in a Health Region

Introduction

Statement of the Situation

There are programs in health regions that have a population health component described as being an essential element of the work delivered in that program. The extent to which staff understands the meaning and the breadth of population health issues is not particularly well known.

Purpose of the Study

The purpose of this study will be to explore the extent to which health region staff understands population health and to determine how the accreditation process addresses

population health perspectives. The goal is to ascertain the knowledge, practices, and attitudes of the staff with respect to accreditation and to population health in general in order to see how a health region integrates a population health component into its services.

INTERVIEW SCHEDULE:

Key Informant Interview Questions (to ask the research participants). The research participants will consist of the Sponsors, the Team Leads, and another member of the Accreditation Teams. This variety of input from across the teams will triangulate the responses. Also, for depth, interviews of selected personnel within the health region will be conducted (i.e. upper management). This will be a semi structured interview format allowing participants the freedom to provide a rich description of their population health knowledge, practices and attitudes.

The information gained from initial interviews will provide probes to use in subsequent questions. (I.e. if, during an interview, one of the participants identifies that a portion of the team's program has a particularly strong population health component, (i.e. component X), then that will provide a probe to ask of the next participant. Such as, "What about component X? Is that an aspect of your program that you are aware of? How do you think it has population health importance?" etc. Also, if particularly insightful comments are made during the interview of a team member and it is important for other participants to be aware of, irrespective of team, that information will also be used as probes to determine knowledge, practice and attitudes.

1. First, tell me a little bit about yourself:

- a) How long have you been working in the health system?
- b) How long have you been working for the Saskatoon Health Region (SHR)?
- c) In what capacities have you worked
Probes: (jobs, occupational roles, and extra work i.e. volunteering beyond regular roles, projects, special assignments, etc.)

2. a) What has been your formal training?

b) Have you received on the job training?

Probes: (i.e. in-service, health region courses, learning as required due to advancement in the organization, etc.)

3. I will read to the participants: The SHR Mission Statement reads,

“We work in partnership to improve health and well-being through excellence in consumer-centred service, education and research.”

http://saskatoonhealthregion.ca/about_us/goals.htm

a) What do you find the most challenging aspects of your job as it relates to the Mission Statement of the organization?

Probe: By this I mean about your job, as you see it, and not how you think the entire region is being run.

4. Both Saskatchewan Health and SHR have mandates to implement a population health approach in their work.

a) How would you define population health?

Probe: Or describe a population health approach.

b) How important would you say population health is to the work that you do?

Probes: (Information gained from previous interviews will provide probes to use in subsequent questions. i.e. the researcher will add examples from participants as probes)

c) Can you give some example of what you do that embodies a population health approach?

Probes: (Information gained from previous interviews will provide probes to use in subsequent questions. i.e. the researcher will add examples from participants as probes)

5. The Saskatchewan Health definition of Population Health has been adopted and is used by SHR. It reads,

“Population health is an approach that addresses the entire range of factors that determine health and, by so doing, affects the health of the entire population.”

http://www.health.gov.sk.ca/./ic_pub_3793_skh1thframework.pdf

a) Based on this definition, how would you rate your own knowledge of population health compared to others with whom you work?

Probe: (across the region)

b) Why do you think you rate yourself where you do?

c) Do you think your opinion of population health rests on your personal focus about population health or do you think your opinion is influenced by the work/program that you are involved in?

Probes:

That is, do you think your understanding of population health comes from where you work and is influenced by that versus perhaps say someone who would work in surgery; would their knowledge be as vast?

d) A few minutes ago you talked about the importance you assigned to population health. Do you think your rating of the importance of population health is different than or similar to how other teams or team members would rate its importance?

Probe: Why? (Why is this so important or not so important for your team?)

e) What training in population health have you received?

Probes: (university, in-service, reading, good practice through your work that informed you, i.e. experience in the region. other)

f) When was that?

6. The Canadian Council on Health Services Accreditation (CCHSA) identifies a number of standards and criteria in various programs with respect to population health for health care organizations in the Achieving Improved Measurement (AIM) self assessment document.

a) Are you aware of any of these standard or criteria?

Probes: for your own program area, what you think these standards and criteria might be given your knowledge of what a population health approach requires.

The core teams of Leadership and Partnership, Human Resources, Information Management and Environment are considered to be the basis of a continuum of care, which is required to support population health initiatives. These four core teams are the backbone of the organization. All other teams rest fundamentally upon these core teams.

Each of these core teams has specific standards that are considered integral to a population health initiative.

7. I am now going to give a handout of these standards and read to you these standards of the organization as a whole; then I will ask you whether these are important in your own work?

Leadership and Partnerships Population Health Standards:

Criterion 1.0 reads, “The organization anticipates and responds to the community’s changing needs and health status.”

Criterion 2.0 reads “The organization has broad and meaningful linkages and partnerships with other organizations and the community.”

Criterion 3.0 reads “The governing body and managers promote, support, and participate in ongoing community development.”

Criterion 13.0 reads “The organization uses research and best practice information to improve its performance.” [46]. (Canadian Council on Health Services

Accreditation. Accreditation Survey Report, Ottawa: Saskatoon District Health, 2001 June 24-29, 2001.)

a) So, how important are these in you own work?

1	2	3	4	5
Not	Slightly	Medium	Fairly	Very
Important	Important		Important	Important

(This scale and the ones used in questions 8, 9, and 10. will only be used by the researcher as a spring board for the participants; it will not be used in the write up of the interviews.)

b) Can you comment on why you gave the rating you did?

c) Can you provide any examples of where these criteria have been implemented in your program/workplace?

I am now going to read these standards to you again and from your knowledge of the organization do you think there have been improvements in meeting these over the last three years, since the last Accreditation.

d) If there have been improvements, can you give me some examples?

e) Have you faced any challenges in attempting to address these opportunities for improvement?

(The following specific teams had Opportunities for Improvement or Recommendations in Leadership and Partnerships)

The following question will be asked of specific teams to determine the breadth or depth of how the above criteria interact with that specific teams' Opportunities for Improvement or Recommendations. Each team will be given a handout during the interview of those opportunities for improvement or recommendation relevant to that team.

Addictions and Home Care (both received the same report): Opportunities for Improvement

-Develop stronger linkages with public health.

Recommendation

It is recommended that the team develop a process to ensure its links to, and partnerships with, public health and that the two are integrated fully to better serve the defined population. (Canadian Council on Health Services Accreditation. Accreditation Survey Report, Ottawa: Saskatoon District Health, 2001 June 24-29, 2001.)

Mental Health Services

Opportunities for Improvement

-Continue to ensure services are planned and developed to meet the needs of the most vulnerable and hard to service populations.

-Develop a mechanism to increase input from families and clients in the planning and evaluation of services

-Use the "Call to Action" population health data available in the District to continually plan and develop services.

-Continue efforts to integrate and co-ordinate services to enable clients to move through the system seamlessly.

Public Health Services

Opportunities for Improvement

-Develop a process to ensure that clients, groups, families, and communities are given and understand all relevant information about services.

Rehabilitation Team

Opportunities for Improvement

-Continue to broaden understanding of disease and injury prevention and health promotion.

-Improve linkages with the Medical Officer of Health, Public Health, and the Community Development Unit in Family Health to look at the development of strategies for linking in to other existing strategies. The relationship of Rehabilitation Services to Saskatchewan Government Insurance, the Worker's Compensation private industry is an asset that the team brings to such-prevention initiative along with their public credibility Board and because of their role in caring and helping to rehabilitate survivors.

Recommendation

It is recommended that the team work with the community and other such organizations such as the Medical Officer of Health and the Public Health team to enhance health promotion and prevention including identifying opportunities for prevention activities in motor vehicle collisions, workplace injuries and cardiovascular disease including stroke. (Canadian Council on Health Services Accreditation. Accreditation Survey Report, Ottawa: Saskatoon District Health, 2001 June 24-29, 2001.)

1. Do you agree with the assessment? Why or why not?

2. Can you support your answer with examples?

3. Has there been any change in those areas identified as strengths?

Stronger; Not as Strong?

Examples?

4. Have the opportunities for improvement been acted on?

Examples?

5. Do you know if the recommendation been implemented as suggested and how it is working?

Examples?

8. Let us continue along the same tack now, addressing the Human Resources Population Health Standards:

Criterion 1.0 reads: The organization's documented resources plan anticipates and responds to current and future human resources needs.

Criterion 9.0 reads: The organization's work environment is safe, healthy, and positive for staff, independent practitioners, and volunteers.

Criterion 10.0 reads: The organization is committed to the occupational health and safety of staff, independent practitioners, volunteers, and students.

- a) **How important are these in your own work?**
- b) Can you comment on why you gave the rating you did?
- c) Can you provide any examples of where these criteria have been implemented in your program/workplace?

I am now going to read these standards to you again and from your knowledge of the organization do you think there have been improvements in meeting these over the last three years.

- d) If there have been improvements, can you give me some examples?
- e) Have you faced any challenges in attempting to address these opportunities for improvement?

9. Now let us examine the Information Management Population Health Standards:

Criterion 1.0 reads: The organization's information management processes meets current and future information needs and enhance its performance.

Criterion 3.0 reads: The organization collects and reports relevant data and information in a way that is timely, efficient, accurate, and complete.

Criterion 5.0 reads: Staff, service providers, clients, and families have access to information to support decision making and improve knowledge.

- a) **How important are these in your own work?**
- b) Can you comment on why you gave the rating you did?
- c) Can you provide any examples of where these criteria have been implemented in your program/workplace?

I am now going to read these standards to you again and from your knowledge of the organization do you think there have been improvements in meeting these over the last three years.

- d) If there have been improvements, can you give me some examples?
- e) Have you faced any challenges in attempting to address these opportunities for improvement?

10. Now let us explore the Environment Population Health Standards:

Criterion 1.0 reads: The organization's physical environment, contributes to the well-being of clients, staff, and visitors.

Criterion 2.0 reads: The organization uses equipment, supplies, medical devices and space safely, efficiently and effectively.

Criterion 3.0 reads: The organization minimizes potential hazards and risks wherever the clients receive services.

Criterion 4.0 reads: The organization prevents and controls infections.

Criterion 5 reads: The organization is prepared for disasters and emergencies.

Criterion 6.0 reads: While providing services, the organization protects and improves the health of the environment, in partnership with the community and other organizations. (Canadian Council on Health Services Accreditation "AIM Achieving Improved Measurement" 3RD Edition published by the CCHSA, Ottawa, 2004)

a) How important are these in your own work?

b) Can you comment on why you gave the rating you did?

c) Can you provide any examples of where these criteria have been implemented in your program/workplace?

I am now going to read these standards to you again and from your knowledge of the organization do you think there have been improvements in meeting these over the last three years.

d) If there have been improvements, can you give me some examples?

e) Have you faced any challenges in attempting to address these opportunities for improvement?

11. There is a lot of literature on population health, a lot of commentary on what population health ought to be for regional health authorities and not all of this is captured in the accreditation.

So, I am going to ask you some questions that go beyond the accreditation itself, about population health practice.

a) The sections of the standards we have discussed have, as part of their focus, a population health component; how adequately do you think the accreditation criteria capture a Population Health approach?

b) Why?

c) Can you describe things that you have thought of that would improve the SHR programs with respect to population health?

d) Have you been able to implement the ideas you have had?

e) Which population health determinants have received priority in the region and what have been the successful strategies in addressing them?

f) Have there been obstacles to your initiatives? Can you describe them?

g) How can health regions secure resources to continue to improve population health programs?

h) In closing, do you have any other comments you would like to make about what the role of a health region is in addressing population health determinants.

Appendix D: Interview Information Sheet and Consent Form



Interview Information Sheet and Consent Form

University of Saskatchewan
College of Medicine
Department of Community Health and Epidemiology
University of Saskatchewan
B103-107 Wiggins Road
Saskatoon, SK S7N 5E5

How do health regions integrate a population health component in the design and delivery of services?

INTERVIEW INFORMATION SHEET AND CONSENT FORM

You are invited to participate in a study entitled, “How do health regions integrate a population health component in the design and delivery of services?” Please read this form carefully, and feel free to ask questions you might have.

Researcher(s):

Terrance W. Gibson, College of Medicine, Department of Community Health and Epidemiology,
University of Saskatchewan, B103-107 Wiggins Road Saskatoon, SK S7N 5E5
Telephone 244 9486 (home), 655 6132 (work) E-mail: terrygibson@sasktel.net

Supervisor:

Dr. Ron Labonte College of Medicine Department of Community Health and Epidemiology
University of Saskatchewan, B103-107 Wiggins Road Saskatoon, SK S7N 5E5
Phone (306) 966 7930 E-mail: ron.labonte@usask.ca

Introduction:

The purpose of this study will be to explore the extent to which health region staff understands population health and to determine how the accreditation process addresses population health perspectives. The goal is to ascertain the knowledge, practices, and attitudes of the staff with respect to accreditation and to

population health in general in order to see how a health region integrates a population health component into its services.

Purpose and Procedure: Through this research I am attempting to capture the knowledge, practices, and attitudes that exist across programs in a health region. A case study of the Saskatoon Health Region (SHR) will be used to inform how a health region can integrate a population health component.

The participants are being selected from the sponsors and leads of the accreditation teams involved in the 2004 Accreditation of the Saskatoon Health Region (SHR) that are most connected to a population health perspective; other participants will be invited from those teams.

Participants will be asked to be involved in an interview that is approximately one and a half hours in length; these interviews will be conducted during the spring and summer of 2004. To aid in capturing responses accurately and to assist in writing the transcripts I will be audio taping the interviews.

Potential Benefit: Participants will have an opportunity to express their opinions about population health concerns. They may direct or influence the decision making process around how those programs get designed and implemented. The community may benefit due to the increased involvement of people in a position to have influence in the program. Of course these outcomes can not be guaranteed.

Potential Risks: There is no deception whatsoever involved in this research. There is a risk to you, as a participant, that you may be identifiable to other potential participants. This research is being conducted within a small group of individuals within Saskatoon Health Region and while your participation is anonymous and your responses are confidential, there is still a risk that you may be identifiable to the other participants. You are free to not answer any of the questions and to withdraw from the study at any time. It is also important to note that the results obtained during the interview process will not be shared with other research participants nor others involved in the Accreditation process lest it influence or direct the nature of their Accreditation Self-Assessment Process. I will do my very utmost to ensure this confidentiality and discretion since it would be most inappropriate to allow this research to interfere with or influence an ongoing accreditation. Results from this research will not be disseminated to research participants or Accreditation Team members until the Accreditation Self-Assessment Process is complete.

Storage of Data: In accordance with University regulations approved by University Council December 8, 1993, revised February 21, 1994, the written data and the interview tapes will be stored in a locked cabinet at the office of the research supervisor Dr. Ron Labonte, College of Medicine, Community Health and Epidemiology, University of Saskatchewan, for a period of 5 years, after which they will be destroyed.

Confidentiality: Your name will not appear anywhere in the study. The information will be arranged so that there is no way to trace the information back to you. Every attempt will be made to ensure confidentiality. The potential does exist for a

lack of anonymity given the small number of participants who will be all known to each other.

Although the data from this study will be published as a Master of Science thesis, the data will be reported in aggregate form, so that it will not be possible to identify individuals; and although I will report direct quotations from the interview, you will be given a pseudonym, and all identifying information (such as the participant's position etc.) will be removed from the report. Moreover, the consent forms will be stored separately from the collected data so that it will not be possible to associate a name with any given set of responses.

Because the participants for this study have been selected from a small group of people, some of whom are known to each other; it is possible that you may be identifiable to other people on the basis of what you have said. After your interview, and prior to the data being included in the final report, you will be given the opportunity to review the transcript of your interview, and to add, alter, or delete information from the transcripts as you see fit.

Right to Withdraw: You may withdraw from the study for any reason, at any time, without penalty of any sort. You are free to turn off the tape recorder at anytime throughout the interview. Refusal to participate or withdrawal from the study at any time will not affect your position with Saskatoon Health Region. If you withdraw from the study at any time, any data that you have contributed will be destroyed.

Questions: If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researchers at the numbers provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Sciences Research Ethics Board on (d/m/y _____). Any questions regarding your rights as a participant may be addressed to that committee through the Office of Research Services (966-2084). Out of town participants may call collect.

Consent to Participate: I have read and understood the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

(Signature of Participant)

(Date) _____

(Signature of Researcher) (Terrance W. Gibson)

Would you like to see the report on the results of this research project? YES NO (circle one)

Appendix E: Transcript Release Form



Transcript Release Form

University of Saskatchewan
College of Medicine
Department of Community Health and Epidemiology
University of Saskatchewan
B103-107 Wiggins Road
Saskatoon, SK S7N 5E5

DATA/TRANSCRIPT RELEASE FORM FOR

Project: How do health regions integrate a population health component in the design and delivery of services?

Principal Investigator: Terrance W. Gibson, Student
College of Medicine
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B103-107 Wiggins Road
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306 244 9486 (home) (Saskatoon)
terrygibson@sasktel.net

Supervisor:
Dr. Ron Labonte
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Department of Community Health and Epidemiology
University of Saskatchewan
B103-107 Wiggins Road
Saskatoon, SK S7N 5E5
Phone (306) 966 7930
E-mail: ron.labonte@usask.ca

FOR KEY INFORMANT INTERVIEW PARTICIPANTS

To be signed after you have had the opportunity to read and revise your transcript.

I, _____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Terrance Gibson. I hereby authorize the release of this transcript to Terrance Gibson to be used in the manner described in the consent form. It is understood that my name or my household name will not be used in any report and that some details may be altered to preserve my anonymity. I have received a copy of this Data/Transcript Release Form for my own records.

Participant

Date

Researcher

Date

Appendix F: University of Saskatchewan Ethics Approval Letter



UNIVERSITY OF SASKATCHEWAN BEHAVIOURAL RESEARCH ETHICS BOARD

<http://www.usask.ca/research/ethics.shtml>

NAME: Ron Labonte (Terrance Gibson)
Community Health & Epidemiology

Beh 04-101

DATE: May 28, 2004

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the Application for Ethics Approval for your study "How do Health Regions Integrate a Population Health Component in the Design and Delivery of Services?" (Beh 04-101).

1. Your study has been APPROVED.
2. Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Committee consideration in advance of its implementation.
3. The term of this approval is for 5 years.
4. This approval is valid for one year. A status report form must be submitted annually to the Chair of the Committee in order to extend approval. This certificate will automatically be invalidated if a status report form is not received within one month of the anniversary date. Please refer to the website for further instructions <http://www.usask.ca/research/behavrsc.shtml>

I wish you a successful and informative study.

A handwritten signature in cursive script, appearing to read "David Hay".

Dr. David Hay, Acting Chair
University of Saskatchewan
Behavioural Research Ethics Board

DH:ck

Office of Research Services, University of Saskatchewan
Room 1607, 110 Gymnasium Place, Box 5000 RPC University, Saskatoon SK S7N 4J8 CANADA
Telephone: (306) 966-8578 Facsimile: (306) 966-8597
<http://www.usask.ca/research>

Appendix G:Saskatoon Health Region Ethics Approval Letter

	<p>Research Services Unit Strategic Health Information & Planning Services (SHIPS) Joanne Franko, Manager Box 16, Royal University Hospital 103 Hospital Drive Saskatoon, SK S7N 0W8 Phone: 306.655.6796 Fax: 306.655.6489</p>
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DATE: May 31, 2004

TO: Terrance Gibson, Dept. of Community Health and Epidemiology, U of S

FROM: Joanne Franko
Manager, Research Services Unit

RE: RESEARCH PROJECT ETHICS COMMITTEE (EC)#: B2004-101
PROJECT NAME: How Do Health Regions Integrate a Population Health Component
in the Design and Delivery of Services?
PROTOCOL #: N/A

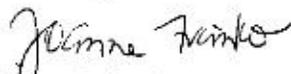
Saskatoon Health Region is pleased to provide you with operational approval of the above-mentioned research project.

Please advise me when the data collection phase of the research project is completed. I would also appreciate receiving a summary of the results for this research project. As well, any publications or presentations that result from this research should include a statement acknowledging the assistance of Saskatoon Health Region.

I would like to wish you every success with your project and encourage you to contact me if I can assist you with it.

If you have any questions, please contact my office at 655-6796.

Yours truly,



Joanne Franko, M.Sc.
Manager, Research Services Unit

cc: Donna Larsen, VP, Corporate Support, RUH