

Community Profile

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Health System Planning Group
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Glossary, Data Dictionary, and References

This document contains a glossary for key terms used in the Community Profiles, a reference list, and a full list of data sources presented in the profiles. This document is intended to be read in conjunction with the detailed Community Profiles for each Community Health Network.

GLOSSARY (SELECTED TERMS)

2013 Community Health Plan: The Health Plan contains the joint recommendations of all seven CHBs within Capital Health. The process of creating a Community Health Plan is central to the Community Health Boards legislated mandate. The information collected to inform the health plan indicates that access to information and community based services continue to be key issues for our citizens.

Aboriginal: Aboriginal identity refers to whether the person reported identifying with the Aboriginal peoples of Canada. This includes those who reported being an Aboriginal person, that is, First Nations (North American Indian), Métis or Inuit and/or those who reported Registered or Treaty Indian status that is registered under the Indian Act of Canada and/or those who reported membership in a First Nation or Indian band.

Aboriginal population: Aboriginal people living in a geographic area as a proportion of the total population.

Adult unemployment, 15 years and over: Proportion of the labour force aged 15 and over who did not have a job during the reference period. The labour force consists of people who are currently employed and people who are unemployed but were available to work in the reference period and had looked for work in the past 4 four weeks. The reference period refers to a one-week period (from Sunday to Saturday) that usually includes the 15th day of the month. The unemployment rate is a traditional measure of the economy.

Age-specific fertility rate: Number of live births per 1,000 females in a specific age group compared to the number females in the age group.

All cancers, deaths: Age-standardized rate of death per 100,000 population

All other circulatory diseases, deaths: Age-standardized rate of death per 100,000 population.

All other respiratory diseases, deaths: Age-standardized rate of death per 100,000 population.

Ambulatory care sensitive conditions: Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, per 100,000 population under age 75 years.

Arthritis: Population aged 15 and over who reported that they have been diagnosed by a health professional as having arthritis. Arthritis includes rheumatoid arthritis and osteoarthritis, but excludes fibromyalgia.

Asthma: Population aged 12 and over who reported that they have been diagnosed by a health professional as having asthma.

Average Age of a Community: a measure based on the median age of a community, which is categorized into five quintiles, ranging from youngest to oldest.

Average Family Income: Average income after tax is total income, which includes government transfers, less income tax. An economic family is a group of individuals sharing a common dwelling unit who are related by blood, marriage (including common-law relationships) or adoption.

Average Individual Income: refers to the dollar amount obtained by adding up the total income of all individuals aged 15 years and over who reported income for 2010 and dividing this sum by the number of individuals with income.

Body Mass Index (BMI): A number calculated from a person's weight and height and a fairly reliable indicator of body fatness for most people.

Bronchitis, emphysema and asthma, deaths: Age-standardized rate of death per 100,000 population.

Breast cancer, deaths: Age-standardized rate of death per 100,000 population. World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Breast cancer [C50]. Rates for breast cancer (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) code C50) were calculated for females only.

Census: population counts by various demographic variables. Census is taken every five years in Canada.

Cerebrovascular diseases, deaths: Age-standardized rate of death per 100,000 population.

Chronic obstructive pulmonary disease (COPD): Population aged 35 and over who reported being diagnosed by a health professional with chronic bronchitis, emphysema or chronic obstructive pulmonary disease (COPD).

Circulatory diseases, deaths: Age-standardized rate of death per 100,000 population due to circulatory diseases including ischemic heart disease, cerebrovascular disease and other circulatory diseases.

Community: A group of people living in the same locality with boundaries defined by Nova Scotia Community Counts.

Community Health Boards (CHBs): Active volunteer advisory board within Capital Health representing the people and neighbourhoods within the health board area.

Community Health Network: Five Community Health Networks (CHNs) across the Capital Health district will serve as the foundation for planning and in the future, organize care delivery so that citizens will receive more coordinated and continuous care through a network model of community-based providers. The Community Health Network boundaries are aligned with the boundaries of the seven Community Health Boards.

Crude birth rate: Birth rate is the number of live births, of a given geographic area in a given year, per 1,000 mid-year total population of the same geographic area in the same year.

Current smoker, daily or occasional: Population aged 12 and over who reported being a current smoker. Daily smokers refer to those who reported smoking cigarettes every day. Does not take into account the number of cigarettes smoked. Occasional smokers refer to those who reported smoking cigarettes occasionally.

CTAS: the Canadian Triage and Acuity Scale; attempts to accurately define patients needs for timely care and to allow Emergency Departments to evaluate their acuity level. CTAS levels are designed such that level 1 represents the sickest patients and level 5 represents the least ill group of patients.

Deprivation index: A relative scale from 1 (20% least deprived) to 5 (20% most deprived) for the indication of total, material and social deprivation.

Diabetes: Population aged 12 and over who reported that they have been diagnosed by a health professional as having diabetes. Diabetes includes females 15 and over who reported that they have been diagnosed with gestational diabetes.

Disability: Canadian adults whose daily activities are limited because of a long-term condition or health-related problem

Dissemination area: Determined by Statistics Canada, it is an area comprised one or more neighbouring blocks of house representing a population of 400 to 700 persons.

District Health Authority: Health services Nova Scotia are delivered by nine district health authorities (DHA) and the IWK, including Capital Health, which is Nova Scotia's largest health services provider. Capital Health serves over 400,000 residents as well providing specialist services to all of Atlantic Canada.

Food insecurity: The inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so.

Fruit and vegetable consumption, 5 times or more per day: Indicates the usual number of times (frequency) per day a person reported eating fruits and vegetables. Measure does not take into account the amount consumed.

Geographic Information Systems: A geographic information system (GIS) is a computer system for capturing, storing, checking, and displaying data related to positions on Earth's surface. GIS can show many different kinds of data on one map. This enables people to more easily see, analyze, and understand patterns and relationships (http://education.nationalgeographic.com/education/encyclopedia/geographic-information-system-gis/?ar_a=1)

Health Indicator: standardized measures of health and health care that can be used to monitor the health status of the population and performance of the health care system across time and across the country (CIHI, 2011).

Heavy drinking: Population aged 12 and over who reported having 5 or more drinks on one occasion, at least once a month in the past year. Heavy drinking refers to having consumed five or more drinks, per occasion, at least once a month during the past year.

High blood pressure: Population aged 12 and over who reported that they have been diagnosed by a health professional as having high blood pressure.

High school graduates aged 25 to 29: Population aged 25 to 29 who have a secondary (high) school graduation certificate or equivalent. 'High school certificate or equivalent' refers to the possession of a secondary (high) school graduation certificate or its equivalent, regardless of whether other educational qualifications are held or not

Hospitalized acute myocardial infarction (AMI) event rate: Age-standardized rate of new AMI events admitted to an acute care hospital per 100,000 population age 20 and older. New event is defined as a first-ever hospitalization for an AMI or a recurrent hospitalized AMI occurring more than 28 days after the admission for the previous event in the reference period.

Immigrant: For the 1991 to 2006 censuses, the term 'immigrants' refers to persons who are, or have ever been, landed immigrants in Canada. A landed immigrant is a person who has been granted the right to live in Canada permanently by immigration authorities.

Incidence Rate: The number of persons contracting a disease per 1,000 population at risk, for a given period of time.

Influenza immunization, less than one year ago: Population aged 12 and over who reported

Injury mortality: Unintentional injury mortality is the age-standardized rate of death per 100,000 population. Unintentional injuries are classified according to the World Health Organization, International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) and can include external causes such as transport accidents, falls, poisoning, drowning and fire, but not complications of medical and surgical care

Ischemic heart diseases, deaths: Age-standardized rate of death per 100,000 population.

Language spoken most often at home: refers to the language the person speaks most often at home at the time of data collection. A person can report more than one language as "spoken most often at home" if the languages are spoken equally often.

Life expectancy at birth: Life expectancy is the number of years a person would be expected to live, starting from birth, on the basis of the mortality statistics for a given observation period.

Life satisfaction (satisfied or neither/unsatisfied): Derived from the CCHS question: "Overall, how satisfied are you with your life in general?" and dichotomized into satisfied and neither/unsatisfied with life. Population aged 12 and over who reported being satisfied or very satisfied with their life in general.

Lone-parent families: The percentage of lone-parent families among all census families. Census family refers to a married or common-law couple or lone parent with at least one never-married son or daughter living in the same household.

Low-income cut-offs (LICO): Low-income cut-offs (LICO) represent levels of income where people spend disproportionate amounts of money for food, shelter and clothing. They are based on family and community size and are updated to account for changes in the consumer price index. LICO data exclude institutional residents and were not derived for economic families or unattached individuals in the territories or on Indian reserves.

Low income rate: Population in economic families and unattached individuals with incomes below the low-income cut-off (LICO). An economic family refers to a group of two or more persons who live in the same dwelling and are related to each other by blood, marriage, common-law or adoption.

Material deprivation: A component of total deprivation, and for this population health status report, determined from three factors: 1) the proportion of persons without a high school degree; 2) the ratio of employment to population; and 3) average personal income.

Median age: Median age is the age at which 50% of the population is older and 50% is younger.

Morbidity: frequency of poor health and disease in a population

Mortality: Mortality is the death rate, which can be measured as total mortality (all causes of death combined) or by selected cause of death. All counts and rates are calculated using the total population (all age groups).

Overweight or obese: A Body Mass Index greater than or equal to 25 kg/m². Body mass index (BMI) is calculated by dividing the respondent's body weight (in kilograms) by their height (in metres) squared. The index is calculated for the population aged 18 and over, excluding pregnant females and persons less than 3 feet (0.914 metres) tall or greater than 6 feet 11 inches (2.108 metres).

Perceived life stress: Population aged 15 and over who reported perceiving that most days in their life was quite a bit or extremely stressful.

Perceived health, very good or excellent: Population aged 12 and over who reported perceiving their own health status as being either excellent or very good or fair or poor, depending on the indicator.

Population density: Population density is the number of persons per square kilometer. The calculation for population density is total population divided by land area.

Population pyramid: a geographical representation that reflects the impacts of births, death, and migration in a population over time.

Post-secondary graduates aged 25 to 54: Population aged 25 to 54 who have obtained a postsecondary certificate, diploma, or degree. 'Highest certificate, diploma or degree' refers to the highest certificate, diploma or degree completed based on a hierarchy which is generally related to the amount of time spent 'in-class'. Post-secondary graduates exclude institutional residents.

Prevalence Rate: the number of existing cases of a disease divided by the total population count in which the cases were found at a given point in time

Prostate cancer, deaths: Age-standardized rate of death per 100,000 population. World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Prostate cancer [C61]. Rates for prostate cancer (International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10) code C61) were calculated for males only.

Respiratory diseases, deaths: Age-standardized rate of death per 100,000 population. World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). Respiratory diseases (excluding infectious and parasitic diseases) [J00-J99].

Rurality: Based on a review of the literature, a definition for rurality was adapted for Capital Health by Public Health & Primary Health Care to apply to the communities of Capital Health. Urban communities are defined as communities with greater than 280 people per km²; suburban communities are defined as having between 46 people per km² and 280 people per km² and surrounding an urban core; and a rural community is defined as <46 people per km² and/or identifying pockets of higher population density that may be above 46 people per km², but not surrounding the urban core

Self-reported mood disorder: Derived from the question: “Do you have a mood disorder such as depression, bipolar disorder, mania or dysthymia? (Interviewer Note: Include manic depression)” and dichotomized into two categories, have a mood disorder and do not have a mood disorder. For the population health status report, the population was aged 15 and over. For the peer ranking (Appendix D), the population was aged 12 and over.

Sense of community belonging: Population aged 12 and over who reported their sense of belonging to their local community as being very strong or somewhat strong. For the population health report, the population was aged 15 and over.

Sex: The biological and physiological characteristics that define men and women.

Social deprivation: A component of total deprivation, and for this population health status report, determined by three factors: 1) the proportion of persons living alone; 2) the proportion of single-parent families; and 3) the proportion of persons who are widowed, separated or divorced.

Social determinants of health: Factors that influence the health of populations, including income and social status, social support networks, education, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, gender, and culture.

Suburban: Suburban areas are peripheral communities located some distance from the centre core. Suburban areas do not have a specific population density but are generally residential districts typically surrounding a city.

Total, all causes of death: Age-standardized rate of death from all causes per 100,000 population.

Total deprivation: Composed of material and social deprivation, and determined from six factors: 1) the proportion of persons without a high school degree; 2) the ratio of employment to population; 3) average personal income; 4) the proportion of persons living alone; 5) the proportion of single-parent families; and 6) the proportion of persons who are widowed, separated or divorced.

Transportation: defined as the predominant method of transportation to and from work

Visible minority: Visible minority refers to whether a person belongs to a visible minority group as defined by the *Employment Equity Act* and, if so, the visible minority group to which the person belongs. The *Employment Equity Act* defines visible minorities as 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour.' The visible minority population consists mainly of the following groups: South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean and Japanese. Visible minority is reported for the population in private households.

Youth unemployment: Proportion of the Labour force for youths, aged 15 to 24 years, who did not have a job during the reference period. The labour force consists of people who are currently employed and people who are unemployed but were available to work in the reference period and had looked for work in the past 4 four

weeks. The reference period refers to a one-week period (from Sunday to Saturday) that usually includes the 15th day of the month. The unemployment rate is a traditional measure of the economy.

Youth population: referring to the population aged zero to nineteen years (<20 years of age). Used synonymously with child/youth population (refers to same age bracket)

Community Profile Semantics

Suffix / Qualifier	Example	Meaning
-est	"Highest" "Lowest" "Oldest" "Youngest" etc.	In the top quintile/category; highest within the CHN and also one of the top for the district
-er	"Higher" "Lower" "Older" "Younger" etc.	Not in the top quintile/category for the district as a whole, but is the highest category within the CHN (stands above or below all of the other communities within the specific CHN, but is not one of the highest in the district)
Neighbourhood/ pocket	"There is a pocket in Dartmouth North..."	A dissemination area within a community

DATA DICTIONARY

Boundary Files (Geography)

1. DHA boundaries defined by the Nova Scotia Health Authorities Act (2000)
2. Community Health Board boundaries defined by the Nova Scotia Health Authorities Act (2000).
3. Community Health Network boundaries defined by the Community Clinical Services/Health System Planning Steering Group, Capital Health (2014). Halifax, NS
4. Community Boundary files courtesy of: Government of Nova Scotia, Nova Scotia Community Counts Division, Department of Finance (2014). Halifax, NS.
5. Dissemination area boundaries courtesy of Statistics Canada, based on 2011 Canadian Census data
6. Polling district boundaries are provided courtesy of the Halifax Regional Municipality via Halifax Open Data. There is no municipal polling district for West Hants.

Community Engagement Results

1. 2013 Community Health Plan is produced by the Capital Health Community Health Boards based on extensive consultation and community conversations
2. The top 5 health concerns per CHB were identified during Community Consultations in the preparation of the 2013 Community Health Plan. Raw data was provided by Patient and Public Engagement, Capital Health.

Community Health Network Inventory

1. Locations for the grocery stores/fast food sites provided by Dr. S. Kirk, Dalhousie University (2011); adapted from Population Health Status Report, Public Health, CDHA (2013)
2. Nova Scotia Liquor Commission Data, by Community Health Board, for period 2006-2011 provided by Population Health Status Report, Public Health, Capital Health, 2013; Nova Scotia Liquor Commission data for time period 2006-2011; Nova Scotia Liquor Commission, Store Information (2014), retrieved August 15, 2014 from <http://www.mynslc.com/Pages/storeInformation.aspx>
3. Halifax Open Data provided GIS Map Files for HRM bus routes. This was supplemented by transportation data from the 2006 Census.
4. HRM Park Recreation Features and Trails data information was provided by the Restricted and Limited Use Land Database, Government of Nova, 2013; and Halifax Regional Municipality, HRM Parks, 2014; Halifax Regional Municipality, Trails, 2014 via Halifax Open Data
5. Public/Affordable Housing data was provided by Housing Nova Scotia and public housing communities were identified by the Department of Community Services (2014). Data regarding homelessness in the HRM was provided by the Affordable Housing Association of Nova Scotia

Community Demographics

1. The 2006 Canadian Census is the source for method of transportation to work, data for components of the deprivation index, low income families, average individual income, average family income, education, employment rate
2. The 2011 Canadian Census is the source for community populations, Community Health Board populations, population density, and population age groups
3. The 2011 National Household Survey is the source for percentage of the population identifying as a visible minority, percentage of the population identifying as Aboriginal, percentage of the population identifying as being an immigrant to Canada, lone parent families
4. Population projection data reporting population change from 2014-2019 and 2014-2024, by community, is from Environics Analytics Group LTD., 2014, modeled from Census Canada data, 2011
5. Deprivation by community was calculated using data provided by Dr. M. Terashima, Dalhousie University, and analyzed for Capital Health by Dr. D'Angelo Scott, Public Health, for the Population Health Status Report (2013) and Community Profiles (2014). The scores for communities within CDHA were extracted and sorted into equal quintiles which were ordered to represent a range of lowest deprivation (1) to highest deprivation (5) for material, social and total deprivation. Data for the six factors comprising material and social deprivation is from 2006 Canadian Census data. Community boundaries were defined by Nova Scotia Community Counts (Government of Nova Scotia, 2011).
6. Employee Support and Income Assistance was provided by the ESIA Administrative Database from the Nova Scotia Department of Community Services (2014)
7. To describe birth rate patterns in the Capital District Health Authority, birth data for one year was provided by Public Health, Capital Health (2012-2013). Birth rates were calculated to identify an average annual rate per community per 1000 women. Maternal age was considered in this calculation, with rates being a measure per 1000 women of a selected maternal age group, ranging from 15 to 49 years of age (age specific fertility rate)
8. Crime data for the Capital Health district was obtained from 2008-2012 from the Halifax Regional Police and analyzed for Capital Health by Dr. D'Angelo Scott, Public Health, for the Population Health Status Report (2013) and Community Profiles (2014). Data was also obtained from the RCMP for one calendar year (January 1, 2013 to December 31, 2013). Halifax Regional Police Data is based on five year's worth of data; therefore, crime totals are reflective of that count. RCMP data represents one year of data; thus, the two are not comparable. Also note that the total number of crimes occurring in a community are not necessarily committed by residents of that community, it is reflective of where the crime occurred.
9. School Test Results were provided by the Nova Scotia Department of Education for the 2013-2014 academic school year, with the exception of Grade 8 math, which is from the 2012-2013 academic year) As reported by the Chronicle Herald newspaper: <http://thechronicleherald.ca/novascotia/1216114-interactive-school-test-data-map>; published June 19th, 2014

Health Status

1. Self-reported health status indicators by CHN and compared to CDHA and Nova Scotia and Canada, where available, are based on 2009/2010 Canadian Community Health Survey (CCHS) data except for NS and Canada (2013 CCHS data where available). It is important to note that the 2009-2010 sample data was provided specifically to Capital Health.
2. CPCSSN chronic disease prevalence rates are provided by the Maritime Family Practice Research Network as part of Canadian Primary Care Sentinel Surveillance Network study (CPCSSN; 2014) – prevalence of index conditions based on two year contact group, n=36,640 patients in urban and rural family practices. Prevalence rates derived from extraction from EMR based on clinical algorithms.
3. Sexually transmitted infection incidence rates per 10,000 population of sexually transmitted infections in Capital Health (2013) are based on 1 year's worth of data provided by Public Health, Capital Health.
4. Disability data is provided by the Canadian Survey on Disability, 2012, as retrieved from statistics Canada.
5. Life expectancy for communities in Capital Health is provided by Dr. M. Terashima, Dalhousie University (2011) for time period 2003-2007 (from Doctoral Dissertation). District and Provincial averages: Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2007/2009
6. All cause of death data provided by Statistics Canada, Canadian Vital Statistics, Death Database and Demography Division (population estimates), 2005/2007, with the exception of premature mortality which is from 2006/2008.
7. Requested and received data for the number of patients who have seen a provider (Family Physician (FP), Nurse Practitioner (NP), or specialist (SPEC) for a certain diagnosis (billing code) in a postal code. Physician Billing Data was obtained for family physician billings for four chronic conditions: Diabetes Mellitus (DM), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Hypertension (HTN) based on patient postal code information. The data source was billing data provided by the Department of Health and Wellness from 2011/12 and 2012/13. Data was analyzed and there was no great variability between the two years; therefore, for generalization purposes, an average of the two years was calculated to estimate annual patient visits. This information provides a measure of how many individuals received care from a family physician for one of the four chronic conditions within a certain geographic area. The # of patients and # of visits by postal code were aggregated to the community level using the aggregation method described. Data provided via the Department of Health and Wellness BIAP division.

Service Delivery Locations

1. Service delivery locations for Capital Health Community Based Programs and Services locations, by Department/Program Area, were derived from the Community Inventory created in Fall 2013 by the Community Clinical Services/Health System Planning Steering Group. Note: not an inclusive list of programs offered because does not include district wide programs without physical space – refer to the community program and service inventory for a full listing.

2. Family Practice locations identified via the DDFP Database (Medical Services Information System; CDHA; DDFP Members; April 2014). Family physician FTE per 1000 population was calculated using the Department of Health and Wellness Physician Resource Plan 2012 Billings
3. Primary Health Care Connections data was obtained from March 2011 – June 2014: 784 Patients or families placed; does not include those who were directed to website resource or list of FP accepting. 636 provided and had valid postal codes. Placed or patient call date: the placed date refers only to historical requests and the patient call date is for InfoPath requests
4. Community-based pharmacy locations provided by the list maintained by the Pharmacy Association of Nova Scotia (PANS), 2014
5. Nursing Home and Residential Care Facility locations were provided by Integrated Continuing Care, Capital Health, April 2014, as retrieved from <http://novascotia.ca/dhw/ccs/documents/Nursing-Homes-and-Residential-Care-Directories.pdf>

Health Services Utilization Data

1. Emergency Room Data for Adults was provided for all Capital Health EDs, with the exception of the rural Collaborative Emergency Centres (located at Tri-facilities hospitals) for fiscal year 2013-2014 by the EDIS Database. Visits were categorized by CTAS level. Emergency Room Data for children and youth was provided for the IWK Health Centre ED by Meditech Registrations for time period fiscal year 2012-2013. The Aggregation Method was applied to both data sets.
2. Hospital admission data, hospital re-admission data, and data for ambulatory care sensitive conditions was provided by Discharge Abstract Database (DAD) for Fiscal Year 2012-2013 for the top 5 hospital diagnoses identified for each CHN and for the district. Provincial and National benchmarks are provided by CIHI, where available.
3. IWK Health Centre service utilization data was provided by the Meditech registration system for fiscal 2012-2013 for the following IWK clinics: IWK CHOICES program, IWK Mental Health Diagnostic and Therapeutic Services, Dentistry Clinic, Diabetes Clinic, Chest Clinic, Reproductive Mental Health Services, Halifax Regional School Board (HRSB) Nurse Visits, and IWK Primary Health: Support for Parents (Groups/Classes). The Aggregation Method was applied to all data sets.
4. Capital Health Addictions Community-Based Services data STAR and Addictions Assist (Provincial Database) for time period April 1, 2012 – September 30, 2013. The Aggregation Method was applied for data obtained for the following sites:
 - a. AIPP: Dartmouth - Wyse Rd CBS, Halifax-Bedford Row CBS
 - b. CBS General: Cole Harbour CBS, Dartmouth - Belmont House CBS, Dartmouth - Wyse Rd CBS, Halifax Bayers Road CBS, Halifax-Bedford Row CBS, Middle Musquodoboit CBS, Musquodoboit Harbour CBS, Sackville CBS, Sheet Harbour CBS, Spryfield CBS , Windsor CBS
 - c. CBS Nicotine: Cole Harbour CBS, Dartmouth - Wyse Rd CBS, Halifax Bayers Road CBS, Halifax-Bedford Row CBS, Middle Musquodoboit CBS, Sackville CBS, Sheet Harbour CBS, Spryfield CBS , Windsor CBS
CBS DWI: Cole Harbour CBS, Dartmouth - Wyse Rd CBS, Halifax Bayers Road CBS, Halifax-Bedford Row CBS, Middle Musquodoboit CBS, Musquodoboit Harbour CBS, Sackville CBS, Spryfield CBS , Windsor CBS
 - d. RMV Medical Referral: Dartmouth - Wyse Rd CBS, Halifax-Bedford Row CBS
 - e. For visit types: Direct Service Recipient, status: "Occurred"

- f. Exclusions: Withdrawal Management Day: Dartmouth Day; ORT (Opioid Replacement Therapy): Dartmouth ORT, visits intake (face to face/phone)
5. Community Mental Health data was provided by STAR Registrations from time period April 2012 – Sept 2013, Capital Health. The Aggregation Method was applied to data obtained for the following sites:
 - a. Community Mental Health (5 sites):
 - i. Bayers Road, STAR CutCode: MHBR
 - ii. Bedford/Sackville, STAR CutCode: MHB
 - iii. Cole Harbour, STAR CutCode: MHH
 - iv. Dartmouth, STAR CutCode: MHC
 - v. West Hants, STAR CutCode: MHCH
 - b. MH Connections (Hubs)
 - i. STAR CutCode: MHHW for Halifax (OutpatLoc: MHWH), Dartmouth (OutpatLoc: MHWD) and Bedford/Sackville (OutpatLoc: MHWB)
 - c. Visit types include clinic and phone consult
 - d. Exclusions: Chart Chk visits where client is not present (case conference, chart review, etc)
 6. Youth Health Centres and top 5 concerns reported by location were provided by Public Health, Capital Health, 2014.
 7. Visits to the Community Health Team per 1000 population were provided by Primary Health Care, CDHA, STAR Registrations for time period Fiscal 2012/13.
 8. Rehabilitation and Supportive Care, CDHA, STAR Registrations for NSRC, DGH, HCH, CCHC, and Tri-Facilities for time period Fiscal 2012/13 (all locations) was the source for community occupational therapy and physiotherapy data. CUT Codes for Community OT/PT data and Acquired Brain Injury data included: MHPS, NLG, NLGM, NT, OT, OTDE, OTSS, PGYN, PT, RABI, RABIA, RABIC, RABID, RABIE, RABIL, RABIO, RABIR, RAM, RBTX, RHB, RHEMG, RHOR, RHPE, RHPR, RMS, RMSK, RNE, RSC, RST, RTB, SW, VOC. Data was integrated across all sites to provide an integrated view of community OT/PT need across the district. The Aggregation Method was applied.
 9. The Integrated Continuing Care, Capital Health, client overview and community occupational therapy and physiotherapy data was provided by STAR Registrations April 1, 2013 to March 31, 2014 for polling districts in HRM and West Hants. Polling district boundaries were provided by Halifax Regional Municipality Open Data and a manual calculation method was used to align polling district data with Community Health Networks. Data regarding home care, nursing support services, and care plans by type was provided by the Nova Scotia Department of Health and Wellness, Continuing Care Branch, SEAScape Database for time period fiscal 2013-2014.
 10. Data for four select Ambulatory Care clinics was from STAR registrations, provided by the Department of Medicine and were based on visits during fiscal year 2011/2012 and 2012/2013, averaged for one year. The Ambulatory clinic visits are based on the following codes:
 - a. Endocrinology: CUT Code: EN (Endocrinology) (QEII location only)
 - b. Hypertension: CUT Code: GMHY (Hypertension) (QEII location only)
 - c. Cardiac Heart Function: CUT Code: CARHF (Cardiac Heart Function Clinic) (QEII location only)
 - d. Respiriology: CUT Code: CPP (Pulmonary Rehab), RS (Respirology), RSPF (Pulmonary Functions) (QEII, Cobequid, Dartmouth General, Hants County locations)

The Aggregation Method was applied.

Description of the Postal Code Aggregation Method

The Aggregation Method was applied to all data received at the postal code level and aggregated to community level.

Note: this process differs if individual patient data or overall visit data was received. The same general process was applied.

Data example:

YEAR	PROVIDER_TYPE	PT_POSTAL_CODE	SPECIALTY_GROUP	VISITS	PATIENTS
2011	PH	B2T0A7	GENP	#	#
2011	PH	B2T0A7	SPEC	#	#
2011	PH	B2T0B1	GENP	#	#
2011	PH	B2T0B1	SPEC	#	#

- Through a ratio calculation, the GIS software estimates the number of visits and patients in a community
- This ratio calculation distributed the number of visits and patients uniformly based on the area intersection between the postal code polygon and the community.
- When this ratio policy was done at the community level, some questionable results were found for the rural communities that aligned with larger postal code areas.
- It was determined that the method to convert the postal code data to the community level data needed to account for population densities of the communities in addition to the areas.
- To simplify this process, the intersect between postal code areas and communities is constant and independent of the patient data, therefore a weighted factor can be calculated once and then applied to the patient data
- Data for the population of each community is used to calculate a 'measure of prevalence':
*number of patients (with a billing or visit) living in the community / population of the DA or community * 1000 = percent of the population receiving care for that disease (for that provider type) for a population of 1000*
- Data for the population of each community is used to calculate a 'utilization measure':
number of visits from patients living in the community / number of patients (with a billing) living in community = visits per patient (for that provider type, clinic type, etc)

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² The Population Health Status Report was a foundational document in the creation of this report and many of the data sources used were originally obtained through the creation of this document. This document was also used to help create the glossary of this supplement to ensure consistency in definitions across reports.

The Community Profiles for each of the five Community Health Networks (herein referred to as the “reports”) are intended to be a composite of technical planning documents, with the primary audience being decision makers and planners at Capital District Health Authority (“Capital Health”).

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Best efforts were made to ensure accuracy and correctness in data collection, interpretation, presentation, and GIS Mapping outputs and methodologies. All data are believed to be accurate by authors and reviewers; however, accuracy is not guaranteed. Data layers were compiled from various sources and are not to be construed or used as a "legal description".

Acknowledgement of all data sources and contributors was completed to the best of the authors’ ability. Time reporting periods varied (e.g., calendar year(s), fiscal year(s), etc) and therefore, there may be inconsistencies and readers should consider this when cross comparing data. Formal statistical analysis was not completed for the purpose of this project; therefore, direct associations between data elements presented cannot be assumed. Interpretation was based on observation only and interpretations have not been subject to an extensive reviewing process beyond review by Steering Group members.

Any errors, omissions, questions, or comments regarding any of the data or methodologies used to prepare these reports can be directed to Primary Health Care, Capital Health by [email](#). Feedback is welcomed.

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