

5.1	OVERVIEW.....	5-1
5.2	LIST OF PRIMARY SOURCES OF INFORMATION.....	5-2
5.2.1	MANITOBA HEALTH (2003 & 2004) NORTH EASTMAN REGIONAL HEALTH PROFILE. AUGUST 2003 & MARCH 2004. (PROFILE).....	5-2
5.2.2	MARTENS, P. ET AL. (2003) THE MANITOBA RHA INDICATORS ATLAS: POPULATION-BASED COMPARISONS OF HEALTH & HEALTH CARE USE. MCHP. JUNE. ATLAS).....	5-4
5.2.3	STATISTICS CANADA WEB SITE: HTTP//WWW.STATCAN.CA.....	5-5
5.2.4	ACUMEN RESEARCH (2004) COMMUNITY HEALTH SURVEY 2003 – NORTH EASTMAN. JANUARY. CONDUCTED IN NE DURING NOVEMBER/DECEMBER 2003. (2000 NE PROVINCIAL SURVEY)	5-5
5.2.5	NORTH EASTMAN RHA DATA.....	5-10
5.2.6	MANITOBA HEALTH INJURIES OF MANITOBA - A TEN YEAR REVIEW. JANUARY	5-10
5.3	PRIMARY SOURCES OF QUALITATIVE INFORMATION	5-11
5.3.1	FOCUS GROUPS.....	5-11
5.3.2	COMMUNITY VALIDATION MEETINGS “AN OVERVIEW OF YOUR COMMUNITY’S HEALTH STATUS”	5-16
5.3.3	NEHA HEALTH PROGRAM COMMUNITY CONSULTATIONS	5-19
5.3.4	GLOSSARY OF STATISTICAL TERMS	5-19
5.4	SUMMARY / CONCLUSION.....	5-19
5.5	REFERENCES.....	5-20

APPENDICES

- 5-1 North Eastman Provincial Survey Questions and Corresponding Responses-November/December 2003
- 5-2 Focus Group Correspondence Letters
- 5-3 Validation Workshop Collation Template
- 5-4 Glossary of Common Statistical Terms

5.1 OVERVIEW

This section discusses the major data sources used in this report including their strengths and weaknesses.

The value of having a variety of information sources is that it has the ability to validate each other's information. Having said this the most fundamental problem is that one must compare sources with extreme caution, due to differences in dates, geographic boundaries, collection methods, target group differences, and how information is collected, or even analyzed.

In this report definitions are provided at the beginning of the indicator in the regional sections six and seven and often are repeated at the health district level. The regional section provides a more detailed account of the indicator's purpose. Understanding the indicator will assist in prioritizing areas of concern.

The information contained in this report focuses on the North Eastman (NE) region. Comparisons if available are made between NE, district level information, Manitoba and Rural South. When information comes from the Atlas, Rural South refers to "... an aggregate of all southern and mid-province RHA's except the urban centres of Winnipeg and Brandon." ¹ The primary information resource contains other valuable information. It is recommended that one review these documents for more detailed information.

Some research standardizes age and sex. If this has occurred it is mentioned either in the table, graph or notes. At times, crude numbers are given as this provides a "... realistic look at the effect of the population burden of illness on the region's health care system." ²

Each piece of information should be reviewed in the context of the whole to see if there are similar trends. As information is being reviewed, it important that the following be noted:

- Time period e.g. is it over one year, ten years etc.? Some information contained in this report may be felt to be 'old' already. It is important to review what has been achieved by NEHA and partners since the information was collected.
- Rate by which the population is being referenced to e.g. by 1,000, 10,000 or 100,000 population.
- Is the information by percentage of a particular population?
- Who is the population e.g. certain age category, gender, a region, health district or province?
- Is the research generalizable to the broader population?

Knowing this assists in the interpretation of the information. These factors will vary between sources.

Information has been categorized using the Manitoba's Health Performance Measurement Framework (MHPMF). Most indicators were derived from a list of indicators developed by the Working Indicators Group (WIG), a subcommittee of the Community Health Assessment Network (CHAN). These indicators were grouped within the dimensions of the Performance Measurement Framework. As other information is collected, it is placed into the appropriate dimension or category.

Refer to Section 4 for an explanation of the MHPMF.

Indicators in this report are shaded in yellow. An example of how this is presented in the CHA report is:
Asthma Prevalence.

5.2 LIST OF PRIMARY SOURCES OF INFORMATION

Quantitative Data

- Manitoba Health (2003 & 2004) North Eastman Regional Health Profile. August 2003 & March 2004. Referred to as the **PROFILE** document.
- Martens, P. et al. (2003) the Manitoba RHA Indicators Atlas: Population-Based Comparisons of Health & Health Care Use. MCHP. June. Referred to as the **ATLAS** document.
- Acumen Research (2004) Community Health Survey 2003 – North Eastman. January. Conducted in NE during November/December 2003. Referred to as the **2003 NE PROVINCIAL SURVEY**.
- RHA Data – This is information generated within NE Regional Health Association (RHA).
- Census Canada 1996 & 2001 – Retrieved from Web site information and from analysis done by Manitoba Health as contained in the **PROFILE** document.
- Canadian Community Health Survey Cycle. Stats Canada 1.1 2001. (**CCHSC 1.1**) as analyzed in the PROFILE document.
- Manitoba Health. (2004) Injuries in Manitoba. A Ten Year Review. January.

Qualitative Data

- Health District Focus Groups (June to November 2003). Referred to as: **2003 Focus Groups**
- Validation Workshops: “An Overview of Your Community’s Health Status Workshops” (April / May 2004). Referred to as: **2004 Validation Workshops**

The strengths and limitations of each primary data source is discussed below.

5.2.1 Manitoba Health (2003 & 2004) North Eastman Regional Health Profile. August 2003 & March 2004. (Profile)

The profile document was composed from a variety of information sources by the Health Information Management Branch of Manitoba Health.

- Manitoba Health : Medical Utilization Data
- Manitoba Vital Statistics
- Manitoba Health Hospital & Medical Claims Administrative Data
- Manitoba Health Information Monitoring System (MIMS)

The information from MIMS is from physician billing claims and from manual entry of immunization records by either MIMS clerks or Public Health Nurses (PHN's). The population is based on the Decision Support Services Population Data of June 1 for each year. There may be gaps in the information due to delays in registering or due to individuals who are not eligible for Manitoba Health benefits e.g. non-Manitoba federal inmates and federal employees.

For the Profile report, data was extracted on April 15, 2002, and only active files were extracted which means people who had died, moved out of province or whose Personal Health Information Number (PHIN) was

changed were not included. Approximately 1% of immunization records cannot be accessed for these reasons.

Limitations to MIMS

Gaps in the information are due to

- Physicians not always billing for immunizations provided.
 - Salaried physicians do not always “shadow bill.”
 - Hospitals are not required to submit information on in-patients, out-patient clinics, emergency rooms, or occupational health immunizations provided.
 - Private sector providers, correctional institutions long term care facilities re not required to submit data to Manitoba Health.
 - Human errors in inserting data.
 - MIMS data entry is not funded for all immunizations provided.
- CancerCare Manitoba. These include all cancers using ICD-9CM codes: 140-208.
 - Statistics Canada, Canadian Community Health Survey Cycle (CCHSC) 1.1

The CCHSC 1.1 is part of a “...federal initiative aimed at providing health information at the regional and provincial levels.” This project began in 2000. Cycle 1.1. is the first survey and was designed to provide information at the regional level. The survey targets individuals 12 years of age and older who live in private dwellings, covering approximately 98% of the Canadian population. The geographical boundaries correspond to the geography of the 1996 census. This is a potential limitation as our geographical boundaries have changed slightly. This must be taken into account when reviewing the information. Information was collected for one year beginning September 2000.³ Those surveyed in NE made up a total sample size of 522 people out of a total sample size of 131,535 surveyed across Canada.⁴

Limitations

- The respondent represents a 0.7% stratified sample of Manitobans (stratified by age, gender and RHA).
 - Excludes persons living on First Nations reserves and on Crown lands, residents of institutions, full time members of the Canadian Armed Forces, and residents of certain remote regions of Manitoba.⁵
- 1996 / 2001 Census of Canada, special purchase, Manitoba Statistics Canada Data Consortium. If Manitoba Health has done the analysis, the geographic information is accurate to our current geographic boundaries.

Limitations

- In some instances may exclude institutional residents.
 - Unemployment rates can be misleading as they reflect only those people who are actively looking for jobs, not people who may have given up looking for work.
- Manitoba Health Annual Statistics
 - Manitoba Health Communicable Disease Control Program.

Limitations

- Includes only laboratory-confirmed cases. There may be an underestimate of total incidence especially during years with outbreaks.
 - Tuberculosis (TB) new cases represent episodes and not individuals, therefore one individual may have more than one symptomatic episode.
 - Human Immunodeficiency Virus (HIV) cases may be under reported i.e. Health Canada estimates 30-40% not reported.
 - Chlamydia may be under reported in men, causing misleading gender rate ratio.
- Manitoba Health, Population Registry.

Residents were assigned using municipality of residence. This information will not capture RCMP or inmates of a federal penitentiary.

5.2.2 *Martens, P. et al. (2003) The Manitoba RHA Indicators Atlas: Population-Based Comparisons Of Health & Health Care Use. MCHP. June. (Atlas)*

Manitoba Centre for Health Policy (MCHP), Manitoba Health and non-Winnipeg RHA's worked collaboratively to provide information to assist Manitoba RHA's in planning appropriate services.

Most of the indicators are standardized rates to create a fair comparison among regions, unless specified otherwise, meaning that they are age and sex adjusted in order that a comparison can be made with other regions. Most indicators in the Atlas provide comparisons between the RHA's and within each RHA at the district level. The district comparisons are valuable as they provide information for RHA's to review health status and health needs within the RHA itself. As clearly articulated in this report, NE has considerable variation in health status and health care needs within the RHA. Rates are attributed to where a person lives, not where a person receives services.

Two time periods are reviewed: the first being pre-RHA and the second time period post RHA. With respect to the Atlas report, current geographical boundaries were used. The "assignment of unorganized territories and First Nations communities was based on six – digit postal codes in North Eastman." ⁶ There is one change that Manitoba Health and MCHP are aware of and will be changing in future reports. This refers to Seddons Corner. In NE geographical boundaries, it is located in the Winnipeg River Health District, not in Brokenhead Health District as indicated in the Atlas on page 282.

The reason that Rural South [includes North and South Eastman, South Westman, Central, Marquette, Parkland and Interlake] is included in the Atlas figures is that

"The Manitoba rate is heavily weighted toward the Winnipeg rate, since over half the population of the province resides in Winnipeg RHA. Therefore the other groupings of the Rural South and the North were considered extremely useful comparisons for the non Winnipeg RHA's." ⁷

Statistical significance was also calculated for Rural South using the Atlas ordered data. Where relevant this is mentioned in the discussion notes beside the figures.

A "1, 2, t or s" may be observed after the location of information on the graph. This refers to whether the rate is statistically significantly higher or lower when compared with Manitoba. Statistically significant refers to the

fact that "...you will be at least 95% sure that the difference was not due to chance alone. So you expect to see "statistically significant" differences occurring about 5% of the time merely through chance." ⁸

"When you see a large difference that is NOT statistically significant, it is telling you that this rate is probably not different from the comparison rate, and that it could fluctuate greatly from year to year. This could be due to the rate being based on small numbers... so it could change from year to year and may be higher, similar or lower than the comparison the next time it is measured. Most graphs show the statistical significance testing in brackets. ..." ⁹

- 1 = indicates the area's rate is statistically different from Manitoba average in the first time period shown.
- 2= indicates area's rate is statistically different from the Manitoba average in the second time period shown.
- t = indicates change over time is statistically significant.
- s = indicates data suppressed due to small numbers. The Atlas reports rates if there are more than five cases.

5.2.3 Statistics Canada Web Site: <http://www.statcan.ca>.

Because of the boundary limitations especially in Blue Water and Northern Remote, this source had limited use.

Limitations

- Statistics Canada is using their definition of RHA so it will not give accurate representation of our current geographic boundary within NE Health Districts.

5.2.4 Acumen Research (2004) Community Health Survey 2003 – North Eastman. January. Conducted In NE During November/December 2003. (2000 NE Provincial Survey) ¹⁰

Acumen Research, 226-388 Donald Street, Winnipeg, Manitoba, R3B 2J4, Telephone: 204-989-8002 was contracted by eight of our eleven RHA's in Manitoba to conduct a survey based on information that wasn't readily available in the various sources already described. These areas were identified as:

- Health System Performance
- Quality of life
- Safety/injury prevention

Since not all RHA's participated, this survey cannot represent results for Manitoba, "...reference in this report to findings for "all RHAs, "overall" findings or "combined" findings should be understood to refer to combined findings for all eight RHAs participating in this study." ¹¹

Each RHA also had the opportunity to insert 1 to 2 questions. Consultation occurred with the NEHA Community Health Assessment Consultation Team and the Core Steering Committee members to determine the question submitted. NE 's question was number 34, related to whether the participant was knowledgeable about a variety of health services offered in their area.

Survey respondents were contacted through Random Digit Dialed (RDD) telephone numbers. The researchers felt that a telephone survey represented the most accurate, reliable and cost-effective means of conducting the survey. One limitation of a telephone survey is that it will not reach populations who don't have a telephone.

Interviews began November 12 and were completed December 7, 2003. There were 400 residents (204 males and 196 females) 18 years and older interviewed in NE. To ensure residents were located in our geographic area, postal codes and community names were included in the survey questions. One error was made with respect to including Ostenfeld in NE. On discussing this with Acumen we were reassured that this would not compromise the integrity of the data, as it was only one survey. RHA employees were not excluded from the study.

All the data was weighted by age and gender. The quotas set initially were to reflect the gender of our population using Manitoba Health June 1, 2002 Population Report. The data was age and gender weighted to ensure that the information proportionally reflected our population. The other RHA's were also weighted to their population.

Responses of "don't know / refused" were excluded in the tables in the Acumen report. Percentages may not total exactly 100% due to rounding.

Table 5.1 Provincial Survey Report Demographics

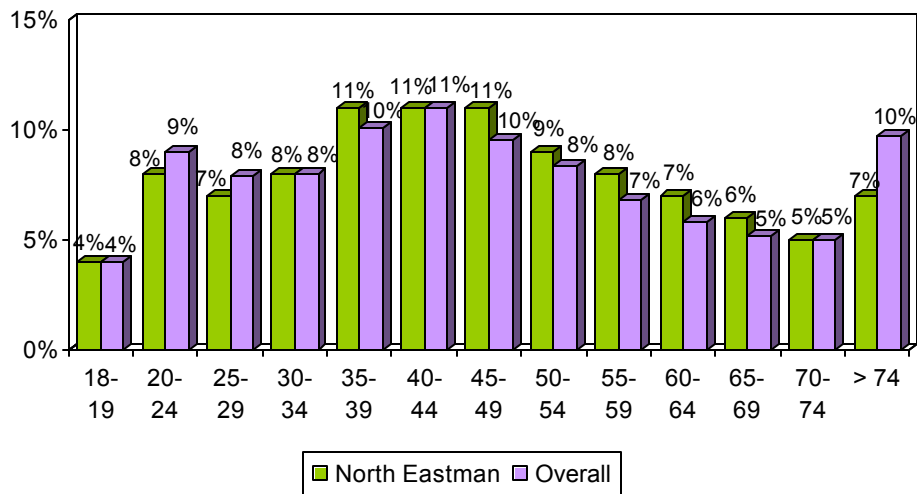
Q1 NORTH EASTMAN RESPONDENTS RESIDE IN 44 DIFFERENT COMMUNITIES / Table 11

City, town, reserve, or community	Surveys (#)	City, town, reserve, or community	Surveys (#)
Albert Beach	1	McMunn	1
Anola	29	Oakbank	40
Beausejour	83	Ostenfeld	1
Belair	4	Pinawa	38
Bloodvein River I.R. #12	1	Pine Falls	21
Brokenhead	2	Pointe du Bois	2
Cloverleaf	2	Powerview	3
Cook's Creek	4	Prawda	2
Dugald	10	Rennie	1
East Braintree	2	Sapton	1
Elma	2	Seddon's Corner	1
Fort Alexander	1	Seven Sisters Falls	4
Fort Alexander I.R. #3	1	Springwell	1
Garson	7	St. George	4
Great Falls	6	Ste. Rita	3
Hadashville	7	Traverse Bay	6
Hazelglen	1	Tyndall	10
Hazelridge	8	Victoria Beach	3
Hillside Beach	2	Vivian	1
Hollow Water I.R. #10	5	Wanipigow	1
Lac du Bonnet	60	Whitemouth	13
Little Black River I.R. #9	3	TOTAL	400

Sex

There were 50.9% males and 49.1% females, slightly more males than females surveyed. This is similar to NE's total population as of June 2001, i.e. males 51% and females 49%.¹²

Figure 5.1 Age of Respondents in Acumen Survey



Demographics as Discussed in Survey

- Seven out of ten respondents of First Nations/Aboriginal/Metis descent are in the 18 to 44 age brackets.
- Respondents in one-person households tend to be aged 65 or older, whereas those living in larger households (four or five to 10 people) tend to be between the ages of 35 to 44.
- Respondents aged 65 and over form a larger proportion than average of those with incomes under \$20,000. Conversely, those with incomes \$60,000 or over are more likely to be from 25 to 54 years in age.

Within the CHA report, the 2003 NE Provincial Survey information is presented in this format:

2003 Acumen Research Survey - NE Provincial Survey Findings on Hospital or Ambulance Utilization

Q- Have you used a hospital or an ambulance service in the past 12 months? [Don't know or refused excluded]

Yes	No
33%	67%

Acumen Research (2004) Community Health Survey 2003
North Eastman. November/December. P.91,92.

The Q refers to the “question” asked within the survey. What may follow is a discussion about who answered the question.

Throughout the report there may be a reference to the 1997 NE Provincial Survey, if questions were similar. If this is available, it will follow the 2003 NE Provincial Survey and is presented as follows:

NE Survey 1997

Question Section B # 2: “Overall how would you rate the quality of health care services for people your age in your community?”

Excellent 250 (15%) Good 1,089 (67%) Poor 301 (18%)

[No responses were excluded from percentage]

No responses refer to respondents who did not answer the question.

The Acumen provincial survey provides more detailed information on the methodology and findings especially related to some of the verbatim responses. The CHA report does incorporate a few responses, but is not as comprehensive as the Acumen report.

Provincial Survey Summary ¹³

Quality of Life Summary

- More than half of all NE respondents said their health is “excellent” or “very good.” (56%).
- Self -reported health generally declines with age and improves with higher education.
- Three out of four respondents had not experienced any physical difficulties that limited their normal activities within the previous 30 days of the survey.
- Nine out of ten respondents (86%) had not experienced any similarly limiting emotional difficulties within the previous 30 days of the survey.
- Almost half of all respondents had someone who will listen to them when they are anxious or upset. One in 10 have no one to listen to him or her. Those over 65 years and those living in a single-person household were amongst those most likely to lack a confidant.
- Walking, running, and eating healthy foods are health improvement measures practiced most often by respondents.
- Thirty eight percent of respondents could suggest no community changes that would improve their own health. Of those who did make suggestions the most frequent was associated with recreational activities (31%). Another suggestion was improved access to health services (11%). Of this, 8% of respondents suggested better access to doctors.

Safety / Injury Prevention Summary

- Sixteen percent of respondents suffered an injury severe enough to limit normal activities.
- Males, First Nations/Aboriginal / Metis and French respondents were most frequently injured.
- The likelihood of injury declines with age.
- The most prevalent injury sites was a person's home (43%), followed by a park or other place for recreation (14%), then a factory / warehouse/construction site (13%), followed by a farm (excluding farmhouse) at 11%.
- The most prevalent injury type reported was a sprain/strain (41%), followed by whiplash or spinal injury, then dislocation.
- Injuries were treated most often by alternative therapists (36%) followed by hospital emergency / urgent care (30%).
- More than half of injury sufferers required a one-day absence or less.

Health System Performance Summary

- Nine out of ten respondents have regular health care providers.
- Women are more likely than men to have a regular health care provider.
- Sixty-nine percent said it is either "somewhat easy" or "extremely easy" to get an appointment with a health care provider.
- Eight out of ten respondents were able to get the health care they needed, when they needed it.
- Fifty – eight percent knew "where to go" to get a concern addressed.
- A little more than eight out of ten respondents knew where to find information (85%).

Health Promotion

- One in three (34%) have used health promotion services in the past 12 months.
- Respondents over 65 years and those with less than a high school education assign extremely high importance to health promotion as well as being the main users.

Community Services

- One in five or 21% have used community services within the past 12 months.
- Respondents who are between the ages of 25 to 44 years and First Nations/Aboriginal/Metis were more likely to use community services.

Home Care / Personal Care Home (PCH)

- Two percent have used home care or PCH.

Hospitals and Emergency Medical Service (EMS)

- One in 3 have used a hospital or an ambulance service within the past 12 months of the survey.
- Users of the service were more likely to be between 25 to 34 years and either employed full time or not employed at all.
- With respect to the importance of services: hospitals and ambulance services ranked as the most important.

Refer to Appendix 5-1 for a copy of the survey and NE results.

5.2.5 North Eastman RHA Data

Information that was obtained internally from NEHA looks at the number of people receiving services within our RHA. It does not look at the utilization burden on our system when we care for residents from other RHA's, for example, during the summer months when our population doubles and we care for many people outside our region and perhaps the province and/or country.

Most of the quantitative information comes from the statistical reports generated by the finance department. There are various measurements used depending upon the area being examined, for example:

- *Active cases*- refers to the total number of cases open including new cases and cases carried forward from previous months/years.
- *Open cases* refers to the number of cases opened.
- *Units of services* – diagnostic department and dietitians categorize one unit = one minute, however in other programs it may mean one unit = 1 hour of service.
- *Direct contacts* – may refer to contact with an individual, family, group or community. The specific contact is not usually specified.

As NEHA participates in this survey, another source used in relation to human resource indicators: staff turnover rates, length of time position is vacant and staff management ratio was *the Annual Benchmarking Survey 2001 and 2002*, conducted by the Human Resources Benchmarking Network. This document contains 'benchmark' statistics that are divided into the health care sector and municipal sector. The averages from the survey are taken from the health care sector.

5.2.6 Manitoba Health Injuries of Manitoba – A Ten Year Review. January 2004

This information comes from three sources:

- a) Manitoba Vital Statistics Deaths Data Base.
- b) Population data from Manitoba Health's Registration System.
- c) Data on injury hospitalization comes from Manitoba Health's hospital discharge abstract database.

The information includes:

- a) Hospitalization data – 1992-2001
- b) Deaths occurring from injury - This information includes all Manitobans who died in Manitoba during the calendar years 1992 to 1999.

The rates in the injury report are crude rates therefore, a direct comparison of North Eastman data to Manitoba overall is not possible. The crude rate does not take into account differences in distribution of the population by age or sex. You are able to compare a specific age group in North Eastman to the same age group in Manitoba.¹⁴ For all information, the residence of the injured person determines their RHA, not the location of their hospitalization or death.

5.3 PRIMARY SOURCES OF QUALITATIVE INFORMATION

During the current CHA project, we conducted two major qualitative studies, one being the Focus Groups and the other the Community Validation Workshops entitled: “*An Overview of Your Community’s Health Status.*”

5.3.1 Focus Groups

A Focus Group provides the ability to examine a specific topic from different perspectives in a safe environment. A Focus Group is meant to be informal in order to encourage open discussion among the participants. In NE the NEHA staff community consultation team designed several questions. A Focus Group generally involves 6-12 people that broadly represent a particular segment of the population. Our Focus Groups were made up of specific age groups located in five of our health districts.

Focus Group Strengths¹⁵

- a) Provides a venue for learning about the group’s needs.
- b) Participants frequently feel good about the discussion, as there often is consensus about various topics.
- c) The informal environment is less intimidating for participants.
- d) It is one way to gauge the opinions of the public.

Focus Group Limitations¹⁶

- a) Recruitment criteria can create biases in the opinions. Refer to recruitment process below. Our selection criteria were not specific to a particular organized group. One exception was the youth groups (except Seymourville, Manigotagan, and Bissett) who were selected by the schools.
- b) Limited number of participants, therefore it isn’t a representative sample from the community. It is felt however that when opinions were similar across or between ages and health districts, this was in all likelihood an important idea or concerns that may require some follow up.
- c) There is always the potential for participants to be influenced by the interaction among group members. This limitation was minimized due to the fact that our facilitator was experienced.
- d) Resource intensive. It was very time consuming, recruiting, setting up and conducting these workshops. Although participants were not paid they could claim mileage.

NEHA Focus Groups- June to November 2003

NEHA hired a professional researcher, Lesley Anne Fuga, to facilitate the Focus Groups. She was asked to conduct twenty community Focus Groups and one staff Focus Group. The CHA Assistant was assigned the role of assistant to the facilitator i.e. recruiting, organizing and documenting the discussions of the Focus Groups. This worked well as it ensured consistency between Focus Groups. Two additional Focus Groups were held with the aboriginal people in Seymourville, and were facilitated by NEHA staff members.

The CHA Consultation Team assisted in the development of questions for the Focus Groups.

Purpose (developed by the CHA Core Team)

To understand and explore the community's perception of health and health maintenance, its awareness of the health status of district communities, and its perceptions and feelings regarding accessibility of programs, services and supports. This information would then be used for program planning and ensuring appropriate delivery of services in order to meet the needs of our client population.

Questions

Note: The questions asked of staff were the same as those asked of community members.

The topic themes were broken down into four categories

- 1) Knowledge of health issues, which included questions such as what does good health mean and how does the community promote or support healthy living.
- 2) Knowledge of health services, which included questions on what health related programs people use, are the appropriate services available and knowledge on how the services can be accessed.
- 3) Barriers, which included questions on programs and services, which might be under utilized or not readily available, what NEHA could do to improve public awareness, acceptance, and participation to promote healthy lifestyles?
- 4) Communication which included questions on the awareness of articles like "Health Corner" and "Wellness Tips" that are in the local weekly newspapers, and how residents could be encouraged to participate in community consultation.

Community Focus Groups

a) Springfield, Brokenhead, Iron Rose, Blue Water, Winnipeg River

In total twenty community Focus Groups were held within North Eastman's five districts. The initial two Focus Groups were held in June, providing valuable feedback influencing how future groups were conducted. The remaining 18 Focus Groups were scheduled from August to October 2003.

In each health district, Focus Groups were divided by age. We asked community leaders involved in various service clubs, organizations and recreational activities to provide names of possible participants.

The average number of participants in each Focus Group was seven. The total number of participants in all Focus Groups was 164 consisting of 56 males and 108 females.

b) Seymourville Focus Groups

Although Seymourville is in Blue Water Health District, it was felt to be valuable to hear from aboriginal people in our consultation process. Debbie Viel (Manager of Primary Health Care) and Myrna Suski (Manager of Public Health) facilitated two Focus Groups in Seymourville. The adult group consisted of two females and two males, whose ages were 65+ (1); 46-65 (1) and 18-45 (2). The youth group consisted of two females aged between 14 –17 years.

During the collation of the focus group information, the youth group was integrated into the other youth focus groups, and the adult group was integrated into the young adult group, as two out of the four participants were within this age group.

Staff Focus Groups

A staff Focus Group was held in November consisting of 12 staff, 10 females and two males. We had staff from the following job categories: Medical Records Technician, Community Mental Health Worker, Acute Care Licensed Practical Nurse (LPN), Diagnostics Technician, Public Health Nurse (PHN), Home Care Attendant, Personal Care Home (PCH) Recreation Worker, Office Assistant, Physician, Ambulance Coordinator, Volunteer from Palliative Care, and a Nurse Practitioner.

Table 5.2 - 2003 Focus Group Attendance

Gender	Youth Ages 14-17	Young Adult Ages 18-44	Middle Adult Ages 45-65	Seniors Ages 66+.	Seymourville		Staff
					Youth	Adults	
Males	17	7	13	15	0	2	2
Females	25	19	25	25	2	2	10
Total	42	26	38	40	2	4	12

Discussion

The first Focus Group question was meant to be an icebreaker i.e. Why did you come? This discussion is not included elsewhere in the CHA Report.

Responses:

- They were asked and were curious.
- They were interested in health.
- They wanted to have input and saw it as an opportunity to participate and learn.
- The 66+ age group were also interested in being able to help, to meet people, enjoy themselves and to be mentally challenged. Some of them had parents or they required health care.
- The 45-65 age groups expressed some concern about future resources, family members were experiencing health challenges, or they wanted to help their community and hear each other's points of view.
- The 18-44 age groups expressed interest in community participation. Some of them identified the event as an "evening out".
- Some of the 14-17-age group viewed attending as a way to get out of class and there was nothing else to do anyway.
- Additional comments in the staff group included that it may be in their best interest to attend or they were volunteered to attend.

At the end of the group meetings, the general feeling overall was that people were pleased that they came, felt they had learned something and seemed to have a good time.

Recruiting participants and ensuring attendance was challenging. The 66+ age group consistently attended as they said they would. Of the 18-44 and 45-65 age groups, approximately one third of those who had previously agreed to attend cancelled during the confirmation call. However there was only one person from all the groups who confirmed at the confirmation call and did not show. The 14-17 age groups were recruited by the schools and therefore were a "captured" group, but even then there were a total of four who did not show up at the sessions.

The 14-17 year age groups were recruited through their respective schools. The first Focus Group Workshop in this age group was held in Iron Rose. Because of time restraints for this Group, the CHA Assistant phoned each of the parents and obtained permission for their child to attend. For the three remaining Groups, the Facilitator sent a 'request for permission to attend letter' to the schools. The schools then forwarded the letter, with a permission slip for signature attached, to the parent/guardian. The students returned the signed permission slip to the school before the Focus Group workshops were held.

Although Focus Group participants were not paid they were given the opportunity to claim mileage if they lived outside of the community where the Focus Group was being held.

At the beginning of each Focus Group meeting the facilitator spoke on confidentiality and the importance of what was said in the room remaining there. A form outlining the importance of confidentiality was prepared and given to each participant before the meeting began.

Refer to Appendix 5-2 for Focus Group Correspondence Letters

Handouts at all the Focus Group meetings included: the form outlining confidentiality, the Community Health Assessment 2003/04 pamphlet, the NEHA Directory of Health Services, November 2002, and the NEHA Health Services directory cards by district.

Within the CHA Report Focus Group information is inserted by:

- 1) Age and then linking the response by wherever the health district the focus group was conducted in. Sections 6 and 7.
- 2) By age and specific health district. Sections 8 through 12.

In this way one is able to get an understanding of the regional context or zoom in on the health district. If there is an age group missing, this implies that there was no information related to that topic raised / discussed in that particular Focus Group.

The Focus Group information is presented as follows in the CHA Report.

2003 Focus Groups

Focus Group information was either quoted or summarized to reflect participant's perceptions. In some instances, their responses may not have always been factual, however it was felt that information, whether true or not, was an important indicator of the community 's knowledge and perceptions.

In order to have a detailed account of the process, there is a separate "process document" that includes the methodology and evaluation of this process.

5.3.2 **Community Validation Meetings – “An Overview Of Your Community’s Health Status”**

Members of the CHA Consultation Team volunteered to conduct two community workshops during April/May 2004 in each of our health districts: Springfield, Iron Rose, Brokenhead, Winnipeg River and Blue Water. The Validation Team was led by Elaine Heini, Staff Development Coordinator for Acute Care .

An education session was held March 16, 2004 for the facilitators to ensure that the workshops were conducted and material collated in a consistent manner.

The purpose of the Community Validation Workshops is to:

1. Present to the community at a district level some key health status information gathered during the current CHA process [inform].
2. Provide community/staff participants an opportunity to identify “key issues” for their health district [consult].

GOALS:

- Increase community understanding of their district's health status.
- Assist in identifying key issues affecting health at the district level.
- Continue to build a relationship with community members.
- Improve the quality of NEHA's health projects and/or programs by better understanding the community's view points.

A major limitation was the low attendance in every health district. The facilitators indicated that the discussions were good and the feedback from participants indicated the process was valuable and beneficial. Because of the low numbers, the information collected cannot be generalized to the broader community.

Table 5.3 - 2004 Validation Workshop Attendance

Springfield	Winnipeg River	Iron Rose	Brokenhead	Blue Water
12	8	15	11	22

The workshop consisted of two main components:

Presentation by Facilitators consisting of:

- a) An overview of the CHA process.
- b) Explanation of the Population Health Model and its determinants.
- c) A “snapshot” of some health status information organized under each determinant of health. The information was health district specific where possible. Due to time constraints only selected information was presented to the community.

Consultation Exercise

This was an important component of the workshop. To avoid personal 'agendas' the facilitators reinforced the point that each participant was speaking as a member of their community and to keep the health of the community (rather than the individual) foremost in their mind.

Note: Participants were informed that information from the issues they identified and general discussions may be included in the Community Health Assessment Report.

- a) Participants were asked to review the issues under each of the health determinants. They were also asked to add any issues that they felt were important and not on the list i.e. 'raised issues.'
- b) The facilitators and participants added the "raised issues" to the list of existing issues under each health determinant. Participants were then asked to choose a limited number of issues under each determinant, that they felt were most important to the health of their community, and place a tick in the box beside the issue. The number of issues they could choose was dependent upon the number of issues under a particular determinant. For example, if a determinant had three issues or less then only one issue could be ticked.

Collation of Data

- a) The facilitators added up the number of ticks under each determinant, identifying the issues that participants as a group felt were most important. This information was shared with the group.
- b) When the two workshops within each health district were completed, facilitators collated the information into one record. The collated information was sent to the CHA Assistant.
- c) The CHA Assistant identified the top three key issues in each health district. This was accomplished by counting the responses from the participants for each of the issues identified under all health determinants. Only the top three issues were reported in this report. In the case where there was a tie, there may have been more than three issues flagged within a particular determinant of health.

CHA Report Information Presentation

a) The key issues identified per health district were placed in the either the health district section or in Section 7 depending upon the determinant of health being discussed.

Validation meeting data is presented in the report as follows:

2004 Validation Workshops

Winnipeg River- Three Top Key Issues Identified By Participants	% of participants choosing this issue
Increase in PCH Beds [<i>Raised Issue</i>] - Validation Workshop Participants felt that waiting time is too long. "Need more PCH beds". 2003 Focus groups - also mentioned the need for larger/more PCH beds (Blue Water, Springfield Seniors, and Winnipeg River).	50%

The above example was an issue 'raised' by a participant i.e. it was not discussed during the formal presentation. Fifty percent of the participants stated that this was one of their key issues. Because this topic was related to health services it was placed in Section 7 of the report.

b) We didn't want to lose information that was discussed during the workshops either about the other health issues or about raised issues. To limit repetitive information, the discussion information was presented only in the respective health district in which it was raised or in Section 7.

2004 Validation Workshops

SPRINGFIELD GROUP DISCUSSIONS ON HEALTH SERVICES – COMMUNICATION
Discussion - Participants felt there is a need for more and better corporate communications.

This information represents other discussions that arose during the workshop that were a concern to participants and not presented during the formal presentation.

*Refer to Appendix 5-3 for the collation template used
in the Validation Workshops by the facilitators.*

5.3.3 NEHA Health Program Community Consultations

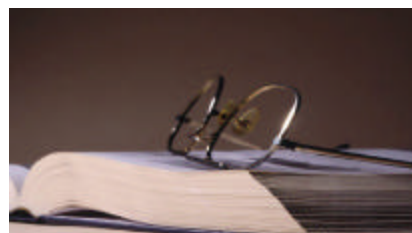
All program managers from Home Care, Public Health, Acute Care, Primary Health Care Long Term Care and Emergency Medical Services were asked to provide a summary of any consultations that had occurred within their program during the past several years. Consultations that took place at the regional level were also summarized.

5.3.4 Glossary of Statistical Terms

Statistical terms are not normally part of the daily vocabulary for most staff. A glossary of common statistical terms used in this report is provided.

Refer to Appendix 5-4 for a glossary of statistical terms.

5.4 SUMMARY / CONCLUSION



It is important that when a variety of data sources are used, that the strengths and limitations of the information are taken into account. Other factors should also be taken into consideration such as the variability between years, the research technique, and the ability to generalize to the broader population.

Variations such as dates of collection, collection methodology, information sources and how the information was collated are important factors to be considered when comparing data.

Focus group and Validation Workshop information, while valuable cannot be generalized to the broader communities.

5.5 REFERENCES

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