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"Community Health Assessment: Input on Optional Indicators and Sharing Results with the Public and Community Organizations"

Local Health Involvement Groups

January 2014

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Preface

This report contains the ideas and feedback generated by the Local Health Involvement Groups over the course of 2 meetings held from October to November 2013.

In September 2013, the Board of the Winnipeg Regional Health Authority (WRHA) asked the Local Health Involvement Groups (LHIGs) to provide input on the development of the 2014 Community Health Assessment (CHA). They were asked to determine which optional indicators they felt would be important to include in the report, alongside the 80 core indicators. They were also asked to provide feedback on communication tools which would be used to share the findings of the CHA with the public, community health and social organizations, and government.

The Report includes:

- An overview of the methodology and context for the exploration of this topic,
- Background on Community Health Assessment and Engagement
- Information about Core and Optional Health Indicators and LHIG input on optional indicators
- Input on organizations to share CHA information with
- Feedback on community profiles for regional template and individual community profiles for the 12 community areas of the Winnipeg health region, and
- Suggested approaches for sharing CHA information and mobilizing community action

Appendix A -- Background document for the exploration of this topic
Appendix B – Feedback from LHIG on the existing community profiles
Appendix C – Community Health Assessment (2014) Core Indicators
Appendix D – Exercise to choose Optional Indicators
Appendix E – Community Profiles of the 12 community areas
Appendix F -- Map of the Community Areas in the Winnipeg Health Region
Appendix G -- Acknowledgements

It is hoped that this report will be useful to the WRHA Board and Senior Leadership who oversee the Community Health Assessment process and to the Director and Staff of the Research and Evaluation Unit as they continue their work on the 2014 Community Health Report.

Group members and staff would like to acknowledge and thank Dr. Colleen Metge and Dr. Xibiao Ye for their involvement and support and for planning and facilitating the first workshop/meetings on the Community Health Assessment for the LHIG.

This report was presented to the Board of the WRHA on January 28, 2014 by the Co-Chairs of the six Local Health Involvement Groups. This report was also presented to the WRHA Community Health Assessment Advisory Committee and the Community Facilitators.

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Executive Summary

The Local Health Involvement Groups (LHIGs) have been providing advice and their unique community perspectives on significant health issues to the WRHA Board for 12 years. They were formerly known as Community Health Advisory Councils (CHACs). In 2013, the Province of Manitoba passed Bill 6, *The Regional Health Authorities Amendment Act,* (Improved Fiscal Responsibility and Community Involvement). This Act mandated the creation of Local Health Involvement Groups (LHIGs) to strengthen local involvement in regional health authorities. The change in name did not impact the membership and role of the Councils in the Winnipeg health region.

There are 6 Groups that represent geographic community areas across the Winnipeg health region. Each Group is comprised of up to 15 individuals from diverse backgrounds, all with the desire to ensure that the health system and health services continue to meet the needs of people in the Winnipeg health region.

The Local Health Involvement Groups were asked by the Board of the Winnipeg Regional Health Authority to provide input on the development of the 2014 Community Health Assessment (CHA). They were asked to determine which optional indicators they felt would be important to include in the report, alongside the 80 core indicators. They were also asked to provide feedback on communication tools which would be used to share the findings of the CHA with the public, community health and social organizations, and government.

Process of exploring the topic

At the first meetings, Research and Evaluation Unit staff shared information about the community health assessment, why LHIGs were being engaged, how their input would be used, and provided LHIG members with a hands-on experience with health indicators and the community profiles for their community areas. LHIG members, working in small groups, participated in an exercise in which they discussed and prioritized 5 health indicators for their community area. They were then asked to consider which "optional" indicators they felt were important to include in the 2014 Community Health Assessment.

The focus of the second set of meetings was to provide input into the information sharing phase of the community health assessment. Prior to this meeting, they received community profiles for their community areas. Group members were asked to provide feedback on these profiles, considering readability, format, information, usefulness, etc. They then considered how this particular community health assessment tool could be reworked for use in their own communities.

Need the heart of the story of our community, not just the information.
(Members of River East/Transcona LHIG)

Background on the Community Health Assessment and Engagement

The Community Health Assessment is a legislated process in Manitoba undertaken to identify the strengths and needs of different communities in the Winnipeg Health Region. The CHA process is part of a strategic plan that describes the health and health needs of the community by collecting, analyzing, and using quantitative and qualitative data to:

- educate and mobilize communities;
- develop priorities;
- garner resources, and
- facilitate collaborative action planning.

The aim of the CHA is to enable the improvement of the health status of the community and the quality of life among multiple sectors of the population. The goal of the community profiles is to not only to build awareness, but to inspire and engage individuals and groups to take action to improve the health of their communities. Public engagement in the community health assessment is integral to its overall success. Opportunities for citizens (including the LHIGs) and other stakeholders to be engaged exist at different phases of the CHA process.

Health Indicators – Core and Optional

A health indicator is a single measure, usually expressed in quantitative terms, that captures a key dimension of health. Dimensions of health can include such things as how many people suffer from chronic disease or have had a heart attack. Health indicators also capture various determinants of health, such as income, and they capture key dimensions of the health care system, such as how often patients return to hospital for more care after they have been treated. (Canadian Institute for Health Information)

WRHA Research and Evaluation Staff participated in a process with other regional health authorities (RHAs) in Manitoba to choose 80 core indicators which must be reported on by all RHAs in their 2014 Community Health Assessment reports. Optional indicators refer to additional indicators that each regional health authority may choose to include in their report. The Groups were asked to consider which 10 optional indicators they felt should be included in the CHA report.

<u>LHIG Recommendation for Optional Indicators – 2014 CHA report:</u>

Domain #1 Health Status

1. Deprivation Index
2. Potential Years of Life Lost: CANCER deaths
3. Potential Years of Life Lost: RESPIRATORY disease deaths
4. Top five (5) causes of child mortality
5. Potential Years of Life Lost: CIRCULATORY disease deaths

Domain #2 Non-medical Determinants of Health

1. Socio-economic Factor Index (SEFI)
2. Life Stress

3. Reproductive health 15-19 years of age: Sexual activity, condom use, birth control pill use
4. Percentage (%) of population scoring high on Work Stress Scale
5. Average Household Income

LHIG input on community organizations, groups, etc. that would find information from the Community Health Assessment useful for planning, etc.

Members of the Local Health Involvement Groups were asked for their suggestions of community organizations, groups, agencies, etc. that would benefit from and be interested in receiving information about the health of their community. This information could be in the form of profiles that provide information on demographics and health and other socio-economic indicators, workshops, posters, etc. Members from all six LHIGs recommended that the following types of organizations and groups receive information from the community health assessment:

- Community organizations and groups that provide important social services
- Community organizations that provide services to vulnerable/marginalized population
- Faith groups
- All three levels of government departments including agencies that provide or plan community services Business-related groups
- Service Clubs like Kiwanis and Lion's Club
- Health-related organizations
- Recreation groups
- Organizations that provide educational services

Ideas for community profiles for the community areas – a regional perspective

At the second set of meetings on the community health assessment, LHIG members had an opportunity to provide feedback regarding the existing community profiles. Community profiles contain demographic information and key health indicators specific to each of the 12 community areas in the Winnipeg health region and that also compare health indicators/health status between community areas. The community profiles were originally developed for use by staff working in health planning and for community health agencies as well as the community at large.

> ***Give me what I need to know and then put tables, etc. in the appendix. People might read 5 pages but they wouldn't read 10 to 15 pages. Typically, people will skim through this document so it needs to be formatted so you can do it.***
>
> (Members of River East/Transcona LHIG)

> ***How do our indicators compare to other areas in the city and why would it be a priority here and not somewhere else? Why is there a difference? What is the history of that issue?*** (Members of Downtown/Point Douglas LHIG)

<u>Suggestions:</u>

- It would be good to have community organizations reflect on the data from their community profile to help them to understand what the data really means, the context for a health indicator, ideas to address, etc.
- We should beta test or have focus groups of non-health care professionals review and provide feedback on draft community profiles.
- Executive summary to highlight what is included, what the priorities are. What is the most important thing to know about health in my community? What is the priority? The most significant issue? Signal what some of those priorities might be.
- Put demographics and geography in the beginning of the profile – a smart way to open it up
- Organize the information into sections so you can go to those sections that you are interested in.
- Needs to be written in plain language so everyone can understand.
- Make available in different languages
- Make it more visual and include more graphics, like Info graphics and pictograms.
- Get trends in health indicators over time – as far back as possible and compare health indicators across community areas.
- Include what community members see as strengths in the community, threats to the community, and what the community can do to curb the threats.
- Have links (from the community profiles) to different parts of the entire Community Health Assessment Report
- Relate statistics to potential actions -- Include information and ideas for improving health indicators

Ideas and recommendations for approaches to sharing community health assessment and community profiles with the public and community organizations

LHIG members were asked for their suggestions of how to get the CHA report and community profiles out into the public and into the hands of citizens and community organizations that will be inspired to take action to improve the of their community.

LHIG members provided a range of ideas and recommendations from engaging the media, to using social media, setting up a volunteer speaker's bureau to get information to community groups and creating posters with health indicator information with links to the Community Health Assessment website.

The Groups felt that it was critical to work with groups to build skills and knowledge so that they could present and distribute the information to the broader community.

> ***It is helpful if it's a conversation, not just a presentation.***
>
> (Members of Downtown/Point Douglas LHIG)

They also felt that the focus in engaging the media needs to be on getting a good headline in order to get media attention.

We need the head line to get the media attention to tell the story and then engage the public and community groups. (Members of St Boniface/St Vital LHIG)

Suggestions to make Community Profiles Unique for Community Areas and Approaches to Engaging Citizens and Community Groups

LHIGs provided overall suggestions for how to create information sharing tools, like a community profile. In developing profiles for each of the 12 community, LHIG members provided ideas for how the community profile could be made unique to be of interest to their own community areas. The following comments are some of the suggestions included in the overall feedback from each Group:

<u>Downtown and Point Douglas community areas</u>

1. Needs to be more personal – need to hear a real person's voice so that people will connect to it
2. Include information and statistics gathered by other organizations, for example, West Broadway – have done several assessments – gathered income data, housing, etc.
3. As a process – community organizations and clinics could play central role in digging through the Community Health Assessment for statistics, etc. – they could animate and bring in other community organizations -- they could be the hub for getting the information out, aware of partners in community to bring in

<u>River East and Transcona community areas</u>

1. Needs to be a living document – not just a book –and be distributed to stakeholders who really could use it, need to know information about health indicators to plan and meet community needs.
2. WRHA should hold meetings with Local Health Involvement Group members and community groups – what story should we tell – to provide "focus" of community profile
3. Provide more than just statistics. Should also give information about how to prevent different health issues and how to improve health outcomes

<u>River Heights and Fort Garry community areas</u>

1. Put in memorable stories that connect to people, that shock people
2. There have been drastic changes in health behaviours and outcomes in the past 30 years – we should celebrate and tell that that very positive story
3. Create posters with a picture of each community with some statistics put in places all around community area. Include health issues/indicators that are significant and then provide link to report.

<u>Seven Oaks and Inkster community areas</u>

1. Make the community profile available in different languages.
2. Set up Pinterest – with the CHA information and tools.

3. Give the information to teachers to include in their discussions with classes – math, social studies, health/physical education, language arts, etc.

St Boniface and St Vital community areas

1. Provide a summary – what is the most important thing to know about health in my community? What affects the most number of people? Identify significant and dramatic changes in indicators.
2. Use Info graphics to promote the CHA in community newspapers. Highlight the most significant issues. Identify where things are improving or getting significantly worse and provide links to more data, community profile, and the CHA report.
3. Connect information from the WRHA's annual report – budget, programs to address, and changes in health indicators --- to priority indicators to address.

St James-Assiniboia and Assiniboine South community areas

1. Format profiles so that sections can be pulled out and used in other formats, like newsletters.
2. Consider package material to make it appropriate and accessible for different cultural groups.
3. Use "vines" – 6 second videos to share information from the CHA for youth, especially.

Key Recommendations from the Report

1. **Optional Indicators** – the Groups recommend that the following optional indicators be included in the 2014 Community Health Assessment Report:
    - Deprivation Index
    - Potential Years of Life Lost: CANCER deaths
    - Potential Years of Life Lost: RESPIRATORY disease deaths
    - Top five (5) causes of child mortality
    - Potential Years of Life Lost: CIRCULATORY disease deaths
    - Socio-economic Factor Index (SEFI)
    - Life Stress
    - Reproductive health 15-19 years of age: Sexual activity, condom use, birth control pill use
    - Percentage (%) of population scoring high on Work Stress Scale
    - Average Household Income

2. **Feedback on future process to engage community regarding optional indicators** – the Groups recommend that future engagement of the Local Health Involvement Groups or the public on the optional indicators be conducted as part of a half day workshop on the community health assessment

3. **Community organizations and groups to send CHA information to** – the Groups recommend that CHA staff send information to health and social organizations across the Winnipeg Health Region – the potential lists for consideration are contained within the Groups' meeting notes at the back of the report

4. **Community Profiles – regional perspective** – format, language, data and information to include, etc. – the Groups recommend that CHA staff use their suggestions on a template for a community profile – details are included in the report

5. To **customize community profiles for each of the paired community areas** based on feedback from the LHIG and further consultation with WRHA community facilitators working in those community areas with a broad range of community organizations – the Groups recommend that CHA staff use each Group's suggestions to create unique community profiles for the community areas – details are included in the report

6. Recommended **approaches to sharing information from the community health assessment** – Groups members recommend that CHA staff use social media, advertising, work with the

media, partner with community organizations, establish a volunteer speakers' bureau, and create posters as part of an overall strategy to engage organizations.

7. Additional **opportunities for engagement at the different phases** of the community health assessment – the Groups recommend that further engagement on the community profiles be carried out – including sharing draft community profiles with community members and groups.

Section I

Report Summary

Introduction and Methodology

The Local Health Involvement Groups were asked by the Board of the Winnipeg Regional Health Authority to provide input on the development of the 2014 Community Health Assessment (CHA). They were asked to determine which optional indicators they felt would be important to include in the report, alongside the 80 core indicators. They were also asked to provide feedback on communication tools which would be used to share the findings of the CHA with the public, community health and social organizations, and government.

The Local Health Involvement Groups are comprised of 80-90 residents of the geographic community areas that each Group represents along with some representation from the Boards of health organizations also located in the community areas. The Groups are diverse in terms of culture, socio-economic status, professional backgrounds, work experience, age, and gender. Members of the six LHIGs participated in an orientation session prior to beginning their exploration and provision of input on strategic priorities of the health region.

Population Health Framework and Perspectives from their community

The Local Health Involvement Groups use a population health framework when exploring health issues – taking into consideration the social, environmental, economic, and other factors that impact the health of a population. A population health approach helps identify factors that influence health, to analyze them, and to weigh their overall impact on our health.

Process of exploring the topic

The Director and lead epidemiologist from the WRHA's Research and Evaluation Unit were actively involved in the planning and facilitation of the first meetings of the LHIG on the community health assessment topic. The purpose of the first meeting was to provide ample background information on the community health assessment and health indicators so that LHIG members could provide input on the optional indicators to be included in the 2014 CHA.

At the first meetings, Research and Evaluation Unit staff shared information about the community health assessment, why LHIGs were being engaged, how their input would be used, and provided LHIG members with a hands-on experience with health indicators and the community profiles for their community areas. LHIG members, working in small groups, participated in an exercise in which they discussed and prioritized 5 health indicators for their community area. They were then asked to consider which "optional" indicators they felt were important to include in the 2014 Community Health Assessment.

At the second set of meetings, LHIG members had an opportunity to reflect on the results of the feedback on optional indicators. The focus of the meeting was to provide input into the information sharing phase of the community health assessment. Group members were asked for their suggestions of community organizations and groups that would find the community health assessment information useful. Prior to this meeting, they received community profiles for their community areas. (Appendix E). At the meeting, they were asked to provide feedback on these profiles, considering readability, format, information, usefulness, etc. They then considered how this particular community health assessment tool could be reworked for use in

their own communities. LHIG members contributed their ideas for how the community health assessment could be made known to the public and how information could be shared with community organizations and the general public. The goal of the community profiles is not only to build awareness, but to inspire and engage individuals and groups to take action to improve the health of their communities.

Presentation to the Board of the Winnipeg Regional Health Authority

Staff developed a draft report which was then shared with members of all of the Local Health Involvement Groups for their input and feedback. This report was presented to the Board of the WRHA on January 28, 2014 by the Co-Chairs of the six Local Health Involvement Groups. It was also presented to the Advisory Committee for the 2014 Community Health Assessment and to Community Facilitators.

Background on the Community Health Assessment and Engagement

This topic comes from the WRHA's strategic direction of fostering public engagement – working with the community to improve its health and well-being by forging partnerships and collaborating with those we serve.

The Community Health Assessment is a legislated process in Manitoba undertaken to identify the strengths and needs of different communities in the Winnipeg Health Region. The CHA process is part of a strategic plan that describes the health and health needs of the community by collecting, analyzing, and using quantitative and qualitative data to:

- educate and mobilize communities;
- develop priorities;
- garner resources, and
- facilitate collaborative action planning.

The aim of the CHA is to enable the improvement of the health status of the community and the quality of life among multiple sectors of the population.

The first step in the CHA process is to decide what information is needed by selecting health indicators in partnership with the larger community. Information on these indicators is then gathered and analyzed and a report is produced every five years

Opportunities for public engagement and input into the CHA – LHIG and other stakeholders
Public engagement in the community health assessment is integral to its overall success. Opportunities for citizens (including the LHIGs) and other stakeholders to be engaged exist at different phases of the CHA process.

<u>Phases of the Community Health Assessment and Engagement</u>

1. Decide what information is needed -- LHIGs provide input on the optional indicators
2. Review existing health information on core and optional indicators
3. Gather new information on core and optional indicators
4. Analyze the information to identify needs and strengths in communities – community organizations can be engaged
5. Engage community in selecting WRHA priorities using evidence from the CHA
6. Invite feedback from community and stakeholders – opportunity for forums/focus groups with participation of LHIG members along with other stakeholders
7. Share and facilitate use of CHA findings – LHIGs providing input on approaches and formatting of information
8. Evaluate the CHA process – LHIGs will provide feedback on their engagement experience

Health Indicators – Core and Optional

A health indicator is a single measure, usually expressed in quantitative terms, that captures a key dimension of health. Dimensions of health can include such things as how many people suffer from chronic disease or have had a heart attack. Health indicators also capture various determinants of health, such as income, and they capture key dimensions of the health care system, such as how often patients return to hospital for more care after they have been treated. (Canadian Institute for Health Information)

WRHA Research and Evaluation Staff participated in a process with other regional health authorities (RHAs) in Manitoba to choose 80 core indicators which must be reported on by all RHAs in their 2014 Community Health Assessment reports. (See Appendix C) Optional indicators refer to additional indicators that each regional health authority may choose to include in their report.

The Groups were asked to consider which 10 optional indicators they felt should be included in the CHA report. The core and optional health indicators were organized into 4 domains – health status, non-medical determinants of health, health system quality, and community and health system characteristics. Groups provided their suggestions for optional indicators from the domains of health status and non-medical determinants of health.

At the first meetings on the Community Health Assessment topic, Group members participated in 2 exercises about health indicators. The first exercise was a hands-on approach to building understanding about what a health indicator is and how an individual or organization would go about ranking or prioritizing health indicators in their community. The second exercise was to review, in small groups, the potential optional indicators in the domains of health status and non-medical determinants of health. Each Group came up with their top 5 optional indicators for each domain. They were asked to approach this by considering what other information they felt the organizations and citizens in their community would want to know about health.

After the small groups reported back, the exercise was debriefed and LHIG members shared how and why they choose the optional indicators in their small groups. The results from each Group were rolled up and the final recommendation became a “regional” recommendation based on the feedback of all 6 Groups. One of the LHIGs, St Boniface and St Vital, challenged the “regional” results and suggested that each member of their Group individually choose optional indicators (via email) and then we could compare the “individual” results to the “regional” recommendation. This was done and the results were fairly similar and they chose to support the “regional” recommendation.

LHIG Recommendation for Optional Indicators – 2014 CHA report

Domain #1 Health Status

1. Deprivation Index
   A generic health status index, developed at McMaster University's Centre for Health Economics and Policy Analysis, which measures health status and health-related quality of life as one number.

2. Potential Years of Life Lost: CANCER deaths
   Potential years of life lost (PYLL) for all malignant neoplasms, is the number of years of life "lost" when a person dies "prematurely" from malignant neoplasms before age 75.

3. Potential Years of Life Lost: RESPIRATORY disease deaths
   Potential years of life lost (PYLL) for all respiratory disease deaths, is the number of years of life "lost" when a person dies "prematurely" from any respiratory disease before age 75.

4. Top five (5) causes of child mortality
   The top 5 causes of deaths among children age 1 to 19 years

5. Potential Years of Life Lost: CIRCULATORY disease deaths
   Potential years of life lost (PYLL) for all circulatory disease deaths, is the number of years of life "lost" when a person dies "prematurely" from circulatory disease before age 75.

Domain #2 Non-medical Determinants of Health

1. Socio-economic Factor Index (SEFI)
   The percent (%) of residents within geographic areas (RHAs, WCAs) who are: lone-parent families, unemployed, have greater than high school education, females who are participating in labor force (components of the Social Economic Factor Index (SEFI).

2. Life Stress
   Level of chronic life stress reported by the population aged 15 and over, based on their responses to a series of 17 questions about their personal situation.

3. Reproductive health 15-19 years of age: Sexual activity, condom use, birth control pill use
   - Proportion of teens 15 to 19 who responded on CCHS that they were/had been sexually-active, and average age of first sexual intercourse.
   - For sexually active teens, the average age of first sexual intercourse.
   - Percent of sexually active teens who reported using condom on last encounter.

- Percent of sexually active 15 to 19 year old females who reported use of the birth control pill as their usual method of contraception.

4. Percentage (%) of population scoring high on Work Stress Scale
   The annual percentage (prevalence) of the working population (age 15 to 74) who scored "None"/"Low" or "Medium" or "High" on the Work Stress scale. This indicator is derived from the CCHS survey, and reflects a respondent's perceptions of work, including job security, social support, monotony, physical effort required, and the extent of participation in decision-making.

5. Average Household Income
   The weighted mean total household income (pre-tax, post transfer) of individuals 15 years of age and over who reported income.

LHIG input on community organizations, groups, etc. that would find information from the Community Health Assessment useful for planning, etc.

Members of the Local Health Involvement Groups were asked for their suggestions of community organizations, groups, agencies, etc. that would benefit from and be interested in receiving information about the health of their community. This information could be in the form of profiles that provide information on demographics and health and other socio-economic indicators, workshops, posters, etc.

They came up with organizations that provide recreation, health, social, faith, and education services and supports to members of their community. They also suggested that politicians, namely city councillors, and all three levels of government would also be interested in receiving information from the community health assessment.

Members from all six LHIGs recommended that the following types of organizations and groups receive information on the community health assessment to help them with planning and identifying emerging community health issues:

1. Community organizations and groups that provide important social services for the following populations:
   - Seniors
   - LGBTT
   - Aboriginal, First Nations, Metis, Inuit
   - Youth
   - Women
   - Families
   - Cultural groups
   - Newcomers

2. Community organizations that provide services to vulnerable/marginalized population – such as:
   - Food banks and groups focused on food security issues
   - Justice – like the Elizabeth Fry Society
   - Community kitchens
   - Salvation Army
   - Shelters
   - Winnipeg Poverty Reduction Group

3. Faith groups

4. All three levels of government departments including agencies that provide or plan community services like – police, libraries, community centres, city and housing planners, etc.

5. Business-related groups like: SEED Winnipeg, Community Economic Development Network, Chamber of Commerce, large employers/corporations, financial institutions, Manitoba Public Insurance, small businesses, workplace health and wellness/health and safety groups, unions, etc.

6. Service Clubs like Kiwanis and Lion's Club

7. Health-related organizations including: community health centres, chronic disease organizations, Seven Oaks Wellness Centre, mental health groups, personal care homes, health planners, Canadian Red Cross, etc.

8. Recreation groups like fitness centres, community centres and clubs, and the YM-YWCA.

9. Organizations that provide educational services like – schools, school divisions, school boards, universities, colleges, parent Groups, etc.

Ideas for community profiles for the community areas – a regional perspective

At the second set of meetings on the community health assessment, LHIG members had an opportunity to provide feedback regarding the existing community profiles. Community profiles contain demographic information and key health indicators specific to each of the 12 community areas in the Winnipeg health region and also provide comparisons of health indicators/health status between community areas. The community profiles were originally developed for use by staff working in health planning and for community health agencies as well as the community at large. (Appendix E)

LHIG members were asked to consider readability, formatting, accessibility of information, and other information that the public and community organizations might be interested in – when providing feedback on the community profiles for their community areas.

The length and formatting of the profiles was important to all of the LHIGs:

> ***Give me what I need to know and then put tables, etc. in the appendix. People might read 5 pages but they wouldn't read 10 to 15 pages. Typically, people will skim through this document so it needs to be formatted so you can do it.*** (Members of River East/Transcona LHIG)

They commented on the power that statistics can have when learning about the health of their community.

> ***The numbers hit you in the face, especially in relationship to another community.*** (Members of River Heights/Fort Garry LHIG)

And, the story of their community, not just a document full of statistics, was fundamental to all of the Local Health Involvement Groups.

> ***Need the heart of the story of our community, not just the information.*** (Members of River East/Transcona LHIG)

It was important to the Groups that the profiles include comparisons between community areas and that priority issues be identified and explained.

> ***How do our indicators compare to other areas in the city and why would it be a priority here and not somewhere else? Why is there a difference? What is the history of that issue?*** (Members of Downtown/Point Douglas LHIG)

Members of the LHIGs, in reviewing and providing feedback, considered the following elements of the community profile and provided suggestions to address – process for creating profiles,

format, language/readability, visual elements, data and information to include, cues and links to more information, and how to encourage and motivate action to improve health indicators/outcomes. These comments and suggestions are reflective of all of the Local Health Involvement Groups.

Process for creating community profiles and other considerations

- Need to start from the premise that the goal of the community health assessment is to motivate people and organizations to do something to improve health.
- Each area will have its own issues to work on.
- It would be good to have community organizations reflect on the data from their community profile to help them to understand what the data really means, the context for a health indicator, ideas to address, etc.
- Need to consider (through engagement) community knowledge of the issue too – could hold meetings with LHIG members and community groups – what story should we tell?
- We should beta test or have focus groups of non-health care professionals to review and provide feedback on draft community profiles.
- The community profile needs to be print friendly in PDF format with not too many colours so that it is readable in non-colour printing.
- Must consider that if there's not follow-up, support, money, etc. to take action on priority indicators, groups might not do anything with this as they have their own priorities.

Format

- The community profile is a statistical "snapshot".
- Executive summary to highlight what is included, what the priorities are. What is the most important thing to know about health in my community? What is the priority? The most significant issue? Signal what some of those priorities might be.
- Put demographics and geography in the beginning of the profile – a smart way to open it up
- Organize the information into sections so you can go to those sections that you are interested in.
- Indicators need to stand out more with more information to follow.
- Include storytelling -- put in memorable stories that connect to people, that shock people.
- What is different or unique about our neighbourhood and what do we need to find solutions for?
- Have ideas/prompts to encourage action to improve health outcomes, address health issues.
- Format the information into sections so that it can be pulled out and used in other formats, like newsletters.

Language – readability, style, plain language

- Needs to be written in plain language so everyone can understand.
- Make available in different languages
- Write in active voice so that it is engaging
- Balance society's want for short sound bite versus good information that takes longer to read.

Graphs, pictures, unique approaches, etc.

- Make it more visual and include more graphics, like Info graphics and pictograms.
- Include some data tables to refer to.
- Include maps of community areas, with boundaries in between identified.

Data/Information to include

- Household income average
- Chronic diseases at a glance
- Include definitions
- Show income and age related to many of the indicators – right now only – geography, income, and sometimes age
- Demographics -- Who lives in our community? Breakdown of demographics – bullets, descriptors, explanations to identify trends over time. Include ethnicity in the profile.
- Get trends in health indicators over time – as far back as possible and compare health indicators across community areas.
- Can we identify why rates go up or down for different indicators – relate to strategies, new services, etc.
- Local health matters – community groups and members can provide input into this.
- Include a section on mental health.
- Include what community members see as strengths in the community, threats to the community, and what the community can do to curb the threats.

Cues and Links for more information, to dig deeper

- Have links to other websites for more information
- Use social media links
- Explain that you can request more info on some indicators – cue to look for more info on WRHA website
- Accessible on-line – to choose the info that you'd like to look at – i.e. you're interested in stats on teen pregnancy –provide link to more information about specific health issues
- Have links (from the community profiles) to different parts of the entire Community Health Assessment Report

Background on health indicators/issues

- Definitions of the chronic diseases and summary of findings – have definition first
- Show further detail in some indicators to understand better – like smoking rates – includes age groups – might find out something that would change your mind about the need to address it – like most of the 20% of smokers are teenagers
- Relate statistics to potential actions -- Include information and ideas for improving health indicators
- Include information about what happened after last community health assessment, how new programs impacted health outcomes, etc.

How to encourage/motivate action to improve health indicators/outcomes:

- Provide sound advice on solutions, next steps, resources in our community
- How can we change our lifestyle, etc. knowing the facts?
- Poster with a picture of each community with some statistics and post in places all around community area with health issues/indicators that are significant to that community area. Provide links to report.

Ideas and recommendations for approaches to sharing community health assessment and community profiles with the public and community organizations

LHIG members were asked for their suggestions of how to get the CHA report and community profiles out to the public and into the hands of citizens and community organizations that will be inspired to take action to improve the health of their community. LHIG members provided a range of ideas and recommendations from engaging the media, to using social media, setting up a volunteer speakers' bureau to get information to community groups and creating posters with health indicator information and links to the CHA website.

Groups felt that it was critical to work with groups to build skills and knowledge so that they could present and distribute the information to the broader community.

> ***It is helpful if it's a conversation, not just a presentation.***
> (Members of Downtown/Point Douglas LHIG)

Group members stressed the importance of a communication strategy to include tools and communication support because health care providers/administrators aren't communications experts.

They also felt that the focus in engaging the media needs to be on getting a good headline in order to get media attention.

> ***We need the head line to get the media attention to tell the story and then engage the public and community groups.*** (Members of St Boniface/St Vital LHIG)

Engage the media

- Establish series in local papers highlighting one indicator at a time – expanding on it, telling the story.
- Use the North End Times and other community papers to get info out about the CHA.
- Create compact messages of 2-3 minutes.
- Highlight different statistics that may be of interest to Winnipeggers – "bring it home."
- Time release of information with events like "heart month" and as different initiatives roll out – work place wellness initiative about to roll out.
- Have volunteers/staff write articles for community newspapers – engage community papers to write about this.
- Profile community health assessment in Saturday paper – compare community areas.

Use advertisements to share information

- Promote community health assessment on bus shelters and buses with shocking indicator statistics.

- Info graphics – use to put in community paper – highlight most significant issues – where things are improving or getting significantly worse and link to more data.
- Advertisements on TV – use the media to get information out
- Radio advertisements like "My Right Care"
- Health magazine
- Newsletters
- Giant billboard
- Public TV Seniors Scope
- Cultural newspapers
- Coffee Time
- Breakfast television
- Use "60 Second Driver" approach and provide website information

Use Social Media

- Social media – tweeting, Facebook, Instagram – different ways of messaging, use communications' team expertise
- Use of YouTube as a medium to share the info – "the story of stuff" – story of community economics
- Links with Twitter -- Tweet out indicator statistics
- Put it on website – make it accessible to younger population
- Highlight/link to Winnipeg City website
- App on phones for the community health assessment
- Use Facebook – side column – put advertisement there about CHA
- Website – scroll down and click on data you're interested in
- Use "vines" – 6 second videos to share info – for youth

Get information out into the community

- Develop tools for community facilitators to share CHA and community profiles with community groups
- Poster with a picture of each community – with some statistics from their community profile and post in places all around community area (include link to the community profiles and CHA report)
- Use public health nurses to get the information out – they would know who to target certain information to – getting it to where it needs to go – schools – info on child health issues, seniors groups – information on seniors, mental health issues, etc.
- Share other mechanisms – like having a speaker, etc. to present the CHA information to their group.
- Roll out so it is specific to the organization and relevant to them
- Set up information about the community profile at every Access Centre so that community members can read about how healthy their community is. Include posters with highlights of health indicators.
- Share information with pharmacies
- Displays at libraries and health expos

Present to and work with community groups

- Work with the community facilitators to share the info with groups in their community areas
- Work with community groups to train staff/volunteers so that they can present the information
- Network to share information – a hub from members out to many more organizations – include tips for getting the information out into the community through your own connections.
- Could use presentations called "ignite" in which you have 5 minutes to tell your story with 20 slides that are on automatic.
- Develop volunteer speakers' bureau that can go out to community groups to present.
- Would be good to have different organizations reflect on data and help us to understand what the issue means, the context for a health indicator, change, etc.
- Share and present information at community kitchens
- Have people present info to targeted groups (work with the group to identify information that would be useful, have someone from the group present/co-present)
- Identify mentors within groups to share information and train others
- Create power point presentation with speaking notes and make accessible on website

Other ideas

- Use summer students/interns to work on tools, etc.
- Give the information to teachers to include in their discussions with classes – math, social studies, health/physical education, language arts, etc.

Moving forward…

- What support would different groups need in prioritizing what their community or organization wants to take action on? Help with networking, bringing together those groups. Could provide examples of what other groups have done to address different health issues/challenges.

Suggestions to make Community Profiles Unique for Community Areas and Approaches to Engaging Citizens and Community Groups

LHIGs provided overall suggestions for how to create information sharing tools, like a community profile. This will be important in developing an overall template for what a readable, interesting, and engaging tool can be developed to mobilize action to improve health. In developing profiles for each of the 12 community areas, LHIG members provided ideas for how the community profile could be made unique to be of interest to their own community areas.

Downtown and Point Douglas community areas

1. Needs to be more personal – need to hear a real person's voice so that people will connect to it
2. Would be good to have different organizations reflect on data and help us to understand what that really means, the context for a health indicator, change, etc.
3. Include information and statistics gathered by other organizations, for example, West Broadway – have done several assessments – gathered income data, housing, etc.
4. Needs to be broken down into more specific areas – even in Point Douglas – huge differences from one block to the next
5. How do we compare to other areas in the city and why would one indicator/issue be a priority here and not somewhere else? Why is there a difference? What is the history of that issue?
6. Income is related to health – we need to prioritize by neighbourhood and detailed income information at neighbourhood level is therefore important
7. As a process – community organizations and clinics could play central role in digging through the Community Health Assessment for statistics, etc. – they could animate and bring in other community organizations -- they could be the hub for getting the information out, aware of partners in community to bring in
8. Presentations – called "ignite" – you have 5 minutes to tell your story – 20 slides that are on automatic – are a good way to share this information in community settings

River East and Transcona community areas

1. Needs to be a living document – not just a book –and be distributed to stakeholders who really could use it, need to know information about health indicators to plan and meet community needs.
2. WRHA should hold meetings with Local Health Involvement Group members and community groups – what story should we tell – to provide "focus" of community profile
3. Provide more than just statistics. Should also give information about how to prevent different health issues and how to improve health outcomes
4. Average family sizes – family composition – extended family, parents, etc.?

5. Green space, walkability, and safety – important to also include in the community profile
6. Density of population – people living in big apartment complexes, etc.
7. Sound advice on solutions, next steps, resources in our community
8. Community centres that have computer access – provide posters with information on community profiles and then set up shortcuts on the computer to link to the community health assessment, profiles, etc.

River Heights and Fort Garry community areas

1. Put in memorable stories that connect to people, that shock people
2. Show numbers/indicator values in a context – over time – could include examples of ways/strategies/programs to address
3. Identify resources in the community – overall – to describe the community's strengths – can include websites/links
4. There have been drastic changes in health behaviours and outcomes in the past 30 years – we should celebrate and tell that very positive story
5. Profile should reference ranges in health indicators so that you can see how a community area compares to others and how the indicator changes over time. A longer time range would be best as we could identify trends.
6. Show further detail in some indicators so that the public can understand it better. For example, the indicator on smoking rates could include age groups. We might find out something that would change their mind about the need to address it if they find out that 20% of smokers are teenagers, for example.
7. Can we identify why rates go up or down for different indicators? Relate changes to strategies, new services, etc.
8. Create posters with a picture of each community with some statistics put in places all around community area. Include health issues/indicators that are significant and then provide link to report.

Seven Oaks and Inkster community areas

1. Make the community profile available in different languages.
2. Map out community resources – like, recreation, health, education, social service organizations, etc.
3. Set up Pinterest – with the CHA information and tools.
4. Map out cultural/ethnic/newcomer groups.
5. Include a section on the strengths in the community, threats to the community, and what can the community do to curb the threats.
6. Include an animated section for kids to share the information. Work with schools to get high school or college kids to work on as part of their programs.

7. Promote the CHA in cultural newspapers – the Filipino community has 4!
8. Give the information to teachers to include in their discussions with classes – math, social studies, health/physical education, language arts, etc.

St Boniface and St Vital community areas

1. Provide a summary – what is the most important thing to know about health in my community? What affects the most number of people? Identify significant and dramatic changes in indicators.
2. Use Info graphics to promote the CHA in community newspapers. Highlight the most significant issues. Identify where things are improving or getting significantly worse and provide links to more data, community profile, and the CHA report.
3. Include a section on mental health.
4. Identify where things are getting worse.
5. Stories about what happened after last CHA, how new programs impacted health outcomes, etc.
6. Relate statistics to potential actions to address.
7. Connect information from the WRHA's annual report – budget, programs to address, and changes in health indicators --- to priority indicators to address.
8. Have people present information to targeted groups (work with the group to identify information that would be useful and have someone from the group present/co-present.

St James-Assiniboia and Assiniboine South community areas

1. Identify what the priority health issues are in the community based on the data.
2. Format profiles so that sections can be pulled out and used in other formats, like newsletters.
3. Consider packaging material to make it appropriate and accessible for different cultural groups.
4. Storytelling using a fictitious family to tell story about health indicators in the community.
5. Make sure that the community profile is print friendly in PDF format. Don't use too many colours. Test to make sure you can read it printing in black and white.
6. Beta test or have focus groups of non-health care professionals review and provide feedback before it is shared with public.
7. Provide data to educational institutions to start dialogue for what data means. Then engage them to develop tools to share.
8. Use "vines" – 6 second videos to share information from the CHA for youth, especially.
9. Network to share community profiles in the community. For example, can start with LHIG members who have links to many more organizations. Include tips for getting the information out into the community through your own connections.

Section 2

Notes from LHIG Meetings

Community Health Assessment Topic – Meeting number one

Debrief of Exercise One – Prioritizing Health Indicators in Community Areas

Downtown/Point Douglas

- Difficult trying to come up with values for 5 indicators – difficult to not go into problem-solving
- Difficult to compare each indicator to the other – to rank them while you're going through it
- Gave different scores for consequences for individuals affected versus how the community is affected overall
- Feasibility – struggled – feasible for health authority, or individual, or community?

River East/Transcona

- Mood disorders ranks low due to feasibility of addressing
- Community responsibility and ownership of health issues
- Started off without consensus, then what do you do? Moved on to other indicators and then went back to discuss

River Heights/Fort Garry

- Diabetes not as important to address as smoking, high blood pressure
- More benefit upstream from addressing smoking
- Going through this exercise, discussion in small group helps you decide when you have a myriad of issues to consider, you can decide which is most important for the community
- Interesting how when you worked through individually and then discussed – you could adjust your opinion – was shifting/movement to consensus
- Could relate personal experience about the issue(s) re: feasibility to address

Seven Oaks/Inkster

- (SO) Physical activity ranked lowest in region – surprising – people don't know what's available, Newcomers focus on getting home, etc., no access to vehicles, not sure how accurate 2005 data is – much more activity now than when the report was done
- (I) mood disorders ranked low – not a lot of information but do feel that the numbers are reporting low – hard to pinpoint because of the range of illness – people not coming forward, wouldn't report because of stigma
- (SO) mood disorders – not often identified, nor can it be easily addressed – multi-cultural piece makes it additionally difficult/barrier to people reporting

St Boniface/St Vital

- Process to arrive at numbers – decided whether or not it was important overall
- Sometimes people within the small group interpreted the numbers, data differently

- Spent a lot of time on the first indicator to work on process – back and forth, after the first two, it got easier
- Were in same ballpark – agreed
- If we disagreed, we discussed and looked at statistics, talked about reality of it
- Most difficult to assign value to mood disorders as invisible, stigma about it still

St James/Assiniboine South

- Group was surprised at some of the numbers
- Definitely see linkages between the indicators that they looked at
- What about the accuracy of self-reported data like physical activity?
    - Colleen M – they do join this with other data – like Body Mass Index – but a limited survey sample size
- If we've been touched by an issue, we'll have more insight into that issue, especially the feasibility of addressing it/improving health outcomes

Community Health Assessment – Meeting number two

Debrief on Exercise Two – Ranking Optional Indicators

Downtown/Point Douglas

- Worked individually and then polled group
- More difficult to choose from non-medical determinants of health
- Ranking based on experience? Work? Knowledge of community?
- Potential Years of Life Lost – not compelling – don't think it's a good way to communicate health status with a community – it is negative and confusing
- What about those who have sight, hearing barriers/challenges?
- Life stress might be a subjective tool
- Not sure of the meanings of some of the terms/indicators
- If there were 25-30 indicators to rank, not sure what I would have done
- Is there an intermediary step – things that jump out at you in a report that we should pay attention to? 5 or 6
- Big variations between community areas – income, demographics – i.e. ability to get to physical activity
- Connect with local community groups, clinics, etc. and talk to them about possibility of getting feedback
- Link data with the priorities of different community groups

River East/Transcona

- Aging community – want to know more
- Are these reliable, scientific?
- They are a bit subjective
- We could all look at a stat for a health indicator and have a different reaction to it – some think it is not too bad, others that it is really bad – no right or wrong – we go back to ourselves and our own connection to it – then move on to community level
- The indicators help explain and understand some of the other results/findings – help explain context
- Should be presented in a positive way – shouldn't use stats against each other (one community area against another)
- Need to be objective, factual
- Need to be able to see what the issue is
- Need a factual account and then be able to interpret – needs to be credible

River Heights/Fort Garry

- Interesting exercise

Seven Oaks/Inkster

- Questions about SEFI and the deprivation index – what do these tell us? Deprivation index – indicators that illustrate different issues holding people back – perception, stats – language barriers, mental health issues, etc.
- SEFI – more related to employment/education levels
- We are using our own experiences, limited knowledge to rank these optional indicators

St Boniface/St Vital

- Having gone through the first exercise with criteria did help us rank the optional indicators
- Read through exercise individually first and identified own ranking – then shared with small group – if there was agreement, we could rank highly
- Easier on first domain and then it got harder
- Looked for themes when we couldn't reach agreement in our small group
- A lot of reading first – similar process
- Each group member chose one per domain and then picked 5th one together
- Discussion of indicators – identified by a group member – mix of indices and something specific
- Make sure that it is explained properly
- Explain the difference between SEFI and deprivation index
- Some of the optional indicators are highly related – like household income, SEFI, and deprivation index – do we want to go forward with all three or do we want a bonus one?
- Concerned a little about these going forward – given feedback from members about how difficult it was – little time, somewhat confused
- Background info on the data/indicator – how it was gathered – stats, survey, etc.
- Might reflect what the groups choose, but individuals within the groups may have compromised to make those choices – should we have people complete individually and send in their ranking?
- Other people may have shared information that would have made me see it in a different way
- Action– colleen – send out 2 domains again to Group members to complete individually and then we will determine if there is a difference between individual rankings and the LHIG rankings

St James/Assiniboine South

- When prioritizing optional indicators, we were thinking about preventing something in the future – upstream
- We were conflicted between what we would want to know versus what we thought our neighbours might want to know
- Process for ranking in small group – starting by individually checking off -- shared with others and worked from there
- All chose 5 on our own then built from there
- Thought about upstream – starting with children, but elderly are also a priority
- What each of us do – does influence the indicators that we felt were most important-

- How does a perception of someone's own health relate to their health status – for example, I am a diabetic, but I consider myself healthy
- Baseline for being overweight – is it 5 lbs. overweight or some other amount?
- Take perceptions and balance with other indicators – to tell the story
- Could help with some planning, won't motivate for behaviour change

Downtown and Point Douglas
Local Health Involvement Group

Community Health Assessment – Meeting Two

1. **Can you think of groups and organizations in your community who would be interested in getting information from the Community Health Assessment and how it would be useful to them?**

Community Social Service Organizations
- 595 prevention
- Sage house
- Active living for older adults in Manitoba
- Age and Opportunity Inc
- Any group that provides programming for the community would be relevant
- Partners Seeking Solutions
- Cultural associations – like Filipino Seniors, several community centres – run programs for all ages
- Regional groups – in the Filipino community
- Manitoba Assembly of Chiefs
- Crossways in Common – West Broadway Outreach, and other groups
- Siloam Mission, Main Street Project
- Aboriginal Centre
- Elizabeth Fry Society
- Two Spirits Society of Manitoba (Albert McLeod)
- Rainbow Resource Centre

Recreational
- Community centres

Health
- Mount Carmel Clinic
- Hope Centre
- Health care facilities
- Community health
- Access Centres/clinics
- Body clinic –
- Klinic
- Nine Circles
- Women's Health Clinic
- Cancer Care
- Children's Hospital

Education
- Conferences
- Schools
- Parent Groups for schools

Faith
- Churches, faith groups

2. Feedback on the community profiles (developed for health planners using 2009 community health assessment data)

A. What do you like about the community profiles?
- Like the range of current estimates (high and Low) – compare to other community areas
- Know that it is hard to put in simple/plain language and be statistically accurate – most people would find the current language difficult to understand
- Definitions of the chronic diseases and summary of findings – have definition first

B. Ideas for improving the community profiles – so that they are understandable and motivate community members and groups to take action and address health issues?
- What info will groups connect to?
- Make it more visual, graphics
- Each area will have their own issues to work on
- Too many words will just put people to sleep
- "Draw my life" flipchart cartoony stuff
- This is a lot of stuff to do
- Needs to be more personal – connect to people, hear a real person
- Think about who is telling the story
- Statistical "snapshot"
- What does it mean when the population of seniors drops by 2000 in one neighbourhood in 5 years?
- Would be good to have different organizations reflect on data and help us to understand what that really means, the context for a health indicator, change, etc.
- West Broadway – have done several assessments – gathered income data, housing, etc.
- Animate it, be strategic – need to engage, make it exciting – use significant facts to get peoples' attention – something they would be interested in – what's different about our neighbourhood, what do we need to find solutions for

3. Community Profile for Downtown and Point Douglas community areas:

Process for creating community profiles and other considerations

- What info will groups connect to?
- Each area will have their own issues to work on
- Would be good to have different org's reflect on data and help us to understand what that really means, the context for a health indicator, change, etc.
- West Broadway – have done several assessments – gathered income data, housing, etc.

Format

- Needs to be more personal – connect to people, hear a real person
- If we present in bite sized chunks – groups will use different info
- Like the range of current estimates (high and Low) – compare to other community areas
- Statistical "snapshot"
- Make it specific for different groups – could partner with different health programs to identify info that org's that serve a certain population would want
- Needs to be broken down into more specific areas – even in Point Douglas – huge differences from one block to the next

Language – readability, style, plain language

- Know that it is hard to put in simple/plain language and be statistically accurate – most people would find the current language difficult to understand
- Too many words will just put people to sleep – keep it short and concise

Graphs, pictures, unique approaches, etc.

- Make it more visual, graphics
- "Draw my life" flipchart cartoony stuff
- Animate it, be strategic – need to engage, make it exciting – use significant facts to get peoples' attention – something they would be interested in – what's different about our neighbourhood, what do we need to find solutions for

Information to include

- Wait times at different health sites in community
- Newcomer resources in the community/health sites

Data

- How do our stats compare to other areas in the city and why would it be a priority here and not somewhere else? Why is there a difference? What is the history of that issue?
- Latest statistics from the city show huge differences within the community areas – compare Wolseley to West Broadway for example
- Income is related to health big time – we need to prioritize by neighbourhood
- Getting detailed income info at neighbourhood level would be important

Background on health indicators/issues

- Definitions of the chronic diseases and summary of findings – have definition first

Other feedback about community profiles and how to encourage/motivate action to improve health indicators/outcomes:

4. Approaches to sharing community health assessment information with the public, community groups, etc.

- How do you reach out to the community itself? How do we do outreach? Who will do the outreach?
- Mechanisms – speakers to present info
- Education and presentations to organization and could train other people
- Share other mechanisms – like having a speaker, etc. to present the CHA info to their group
- Tips for using the health care system – importance of attitude and ability to communicate – many face challenges
- As a process – organizations and clinics – health and research literacy to dig through – to dig through the CHA for stats, etc. – they could animate and bring in other community organizations -- they could be the hub for getting the info out – know partners in community to bring in
- West central community network, West Broadway network – rep from CMHA is going into different community groups to share info with staff and educate them how to handle people with serious mental health issues
- Presentations – called "ignite" – you have 5 minutes to tell your story – 20 slides that are on automatic
- Roll out so it is specific to the organization and relevant to them
- Use north end times, other community papers to get info out about the CHA
- Helpful if it's a conversation, not just a presentation
- Use of YouTube as a medium to share the info – "the story of stuff" – story of community economics
- Compact messages of 2-3 minutes
- Winnipeg clinic – info on television monitors – we could tell the story of the CHA --
- What support would different groups, etc. need in prioritizing what their community or organization needs? Help with networking, bringing together those groups – could provide examples of what other groups have done to address different health issues/challenges

River East and Transcona
Local Health Involvement Group

Community Health Assessment – Meeting #2

1. **Can you think of groups and organizations in your community who would be interested in getting information from the Community Health Assessment and how it would be useful to them?**

<u>Government departments/programs/agencies</u>
- City Library, library advisory Group
- Libraries
- Prisons, jails, remand centre
- Stresses of life – like gambling, how it impacts our health – can negatively impact our health, especially in small communities – get different org's who deal with addictions to share the info – addictions foundation, casinos, etc.
-

<u>Community Social Service Organizations</u>
- Good Neighbours Active Living Centre, Transcona Seniors, Elmwood – EKALC
- Service clubs
- Peer/support groups
- Community gardens, gardeners
- Food banks – share info and resources
- Cultural groups – share info and resources
- Social service organizations
- How can we empower organizations to tackle health issues – like low physical activity
- Daycares
- Seniors centres
- Community centres
- Programs happening at Kildonan Place mall – separate section for community groups
- Transcona Museum
- Seniors, legions – in Transcona
- Shelters
- Food banks

<u>Recreational</u>
- Recreational centres, community centres, fitness clubs – posters – information
- YM-YWCA's – for program development
- Shapes – fitness centres
- YMCA's

Health
- Senior health resource team – info on specific topics
- Groups – chronic disease
- Meal programs

Education
- Schools – high school, middle school – information on what is happening, life skills program
- Teachers – to teach about obesity, other health issues
- School divisions
- Graduate students who could then do research on different health issues, etc.

Politicians
- Politicians – city councillors – educate about the info too

Faith
- Church programs – high school, men's club, ladies' club
- Churches
- Churches have different groups – business club, women's club, etc.

Business
- Goodwill store
- Grocery stores – connect with them
- Small business
- Business improvement zones
- banks
- MPI
- Insurance companies

Other
- Senior apartments
- Haven't heard about community profiles before – and I'm active in my community
- Anyone in the community who could use the info and put it to use
- Unions – need all the info they can improve health/lives of union members
- Everyone could use this – have the widest possible distribution
- Large seniors complexes and other apartment/condo developments

2. Feedback on the community profiles (developed for health planners using 2009 community health assessment data)

A. What do you like about the community profiles?
- Good information
- Very informative
- Like the graphs

- Like tables
- Comparisons – interesting
- Summaries – at end of section
- Not just comparing household incomes
- Lots of information
- Like how indicators are laid out
- More pie charts, not just tables
- Like colour

B. Ideas for improving the community profiles – so that they are understandable and motivate community members and groups to take action and address health issues?

- Have summary/overview of information – graphs, pictures
- Be more concise, have format that people can read what they are interested in
- Have targeted bullets
- Have links to other websites for more information
- Use social media links

3. Community Profile for River East and Transcona community areas:

<u>Process for creating community profiles and other considerations</u>

- Highlight different stats that may be of interest to Winnipeggers – bring it home
- Needs to be a living document – not just a book – needs to be given to stakeholders who really could use it, need to know
- The most important part of the CHA process is to do something with this information
- Figure out who you are trying to reach and make it fit that target
- Focus group in each community area
- Tools for community facilitators
- Meeting with LHIG members and community groups – what story should we tell?

<u>Format</u>

- Indicators need to stand out more – then with info underneath it
- Make sure information is relevant to reader
- Have ideas/prompts to encourage action to improve health outcomes, address health issues
- Give me what I need to know and then put tables, etc. in the appendix – might read 5 pages but wouldn't read 10 to 15 pages
- Provide more than just statistics – give information about how to prevent different health issues and how to improve health outcomes
- Shorter, less info
- Have an executive summary
- Summaries – at end of section
- Have summary/overview of information – graphs, pictures
- Be more concise, have format that people can read what they are interested in
- Have targeted bullets

- Have links to other websites for more information
- Use social media links
- Check box format
- Ideas for next steps
- More bullets

Language – readability, style, plain language

- We skim through – needs to be formatted so you can read it
- More concise facts
- Needs to be written in consistent way – with descriptions at the beginning (for example)

Graphs, pictures, unique approaches, etc.

- Like the graphs
- Like tables
- More pie charts, not just tables
- More visual, graphics – attract younger people to read through it

Information to include

- Nutrition – diets – best approaches
- Info on what's safe to eat, not safe to eat
- Household income average
- Chronic disease info
- Like the info that is in there already – just need to figure out what to add
- Average family sizes – family composition – extended family, parents, etc.?
- Life style and environmental factors -- temperature, snowfall, snowfall removal, etc.
- Active transportation, taking the bus
- Green space, walkability
- Safety – do you feel safe in your community?
- Sidewalks – safe for scooters, wheelchairs, etc.
- Density of population – people living in big apartment complexes, etc.

Background on health indicators/issues

- Why are the different indicators getting worse, why are some getting better?
- How walking, exercise can help – tips for improving health indicators (little interesting facts)
- Present facts in a way that they can be beneficial

Other feedback about community profiles and how to encourage/motivate action to improve health indicators/outcomes:

- Need the heart of the story of our community, not just the information
- Sound advice on solutions, next steps, resources in our community
- How can we change our lifestyle, etc. knowing the facts?
- Present facts in a way that they can be beneficial
- How can we change our lifestyle, etc. knowing the facts?

- Different groups working away on different health issues – shouldn't we mobilize together to work on the issue? Like Heart and Stroke working on smoking on their own
- Could accomplish a lot more together
- All of the subsets within cancer for example – some predominantly fundraising others education, services
- Get the groups working together – put community in the driver's seat, bringing those groups to the table

4. Approaches to sharing community health assessment information with the public, community groups, etc.

- Promote community health assessment on bus shelters
- Links with Twitter
- Give small tools to people to help promote activity
- Flexible ways of messaging
- Put it on website – make it accessible to younger population
- Get it to different businesses in the community – pharmacies,
- Workplace, safety, and health – to distribute in mail outs
- Go into the Access Centres and read about what's happening in my community -- compared to the rest of the city, province, etc. --- posters – key highlights of health indicators
- Send to journalists, newspapers, etc. – follow-up interviews – community papers
- Highlight different stats that may be of interest to Winnipeggers – bring it home
- Posters that share one fact and invite people to look for more
- Advertise on buses and bus stops– one stat – go look for more
- Develop volunteer speakers bureau
- Highlight/link to Winnipeg City website
- United Way – link to the community health assessment
- Use volunteers to share the info – at booths, etc.
- Work through community facilitators in all community areas
- Community centres that have computer access – posters and then shortcuts on the computer to the community health assessment, profiles, etc.
- Children are the best way to get info out into the community – good on the technical stuff
- Health curriculum with project where you needed to look at the data
- Social media – tweeting, Facebook, Instagram – different ways of messaging, use communications' team expertise
- People who are home bound – get info out through meals on wheels, home care, public health, others who bring services to their homes
- Access health groups – relevant health indicators/chronic disease, etc.
- App on phones for the community health assessment
- Use current technology to the max
- Stresses of life – like gambling, how it impacts our health – can negatively impact our health, especially in small communities – get different org's who deal with addictions to share the info – addictions foundation, casinos, etc.

River Heights and Fort Garry
Local Health Involvement Group

Community Health Assessment – Meeting #2

1. **Can you think of groups and organizations in your community who would be interested in getting information from the Community Health Assessment and how it would be useful to them?**

Government departments/programs/agencies
- Community centres, libraries
- Government departments
- Various city departments
- Government offices
- Displays at libraries

Community Social Service Organizations
- Various agencies that deliver services
- First Nation organizations
- Seniors groups
- Youth groups
- Anyone doing proactive planning to meet peoples' needs
- Community resource centres == men's resource centre, gay and lesbian resource centre
- United Way – can pass onto agencies that they fund
- Winnipeg Poverty Reduction Group

Recreational
- Special needs groups – Special Olympics, etc.

Health
- Doctors' offices, access clinics
- Pharmacies

Education
- Schools, universities, colleges

Politicians
- City Councillors

Faith
- Faith groups, missions to help poor – would know who to target to provide assistance- help priority setting

Business

- Stores – know what to sell

2. Feedback on the community profiles (developed for health planners using 2009 community health assessment data)

A. What do you like about the community profiles?

- Liked the graphs, visual – wish there was more – would help me to see things more clearly
- Like that it references ranges, can see how community area compares to others, and how the indicator changes over time – would nice to a longer time range, identify trends
- Liked the dependency ratio
- Maps of community areas, with boundaries between identified
- Well written if you had the time to sit down and read it

B. Ideas for improving the community profiles – so that they are understandable and motivate community members and groups to take action and address health issues?

- Too wordy
- If you want someone to be able to take something from this – needs to be shorter, more concise
- Don't know if one tool will fit everyone – age, literacy, etc. differences
- Can the info be broken down to neighbourhood cluster and below?
- More pictures, graphs
- Numbers hit you in the face – especially in relationship to another community
- The info that would be supplied in the CHA – goal to motivate people, organizations to do something to improve health
- Show further detail in some indicators to understand better – like smoking rates – includes age groups – might find out something that would change your mind about the need to address it – like most of 20% of smokers are teenagers
- Explain that you can request more info on some indicators –
- Contact website has a mapping function – could link to that for each community area
- Can we identify why rates go up or down for different indicators – related to strategies, new services, etc.? Can get this from evidence.

3. Community Profile for St James/Assiniboine South community areas:

Process for creating community profiles and other considerations

- Put in memorable stories that connect to people, that shock people
- Use every opportunity to figure out what a certain group would relate to, find useful
- The info that would be supplied in the CHA – goal to motivate people, organizations to do something to improve health

Format

- If you want someone to be able to take something from this – needs to be shorter, more concise
- CONTACT website has a mapping function – could link to that for each community area

Language – readability, style, plain language

- Not too wordy
- Don't know if one tool will fit everyone – age, literacy, etc. differences

Graphs, pictures, unique approaches, etc.

- Liked the graphs, visual – wish there was more – would help me to see things more clearly
- Maps of community areas, with boundaries between identified
- More pictures, graphs

Information to include

- Can show income and age related to many of the indicators – right now – geography, income, and sometimes age
- Show numbers/indicator values in a context – over time – could include examples of ways/strategies/programs to address
- Identify resources in the community – overall – to describe the community's strengths – can include websites/links
- There have been drastic changes in health behaviours and outcomes in the past 30 years – we should celebrate that – tell that story – very positive

Data

- Like that it references ranges, can see how community area compares to others, and how the indicator changes over time – would nice to a longer time range, identify trends
- Liked the dependency ratio
- Can the information be broken down to neighbourhood cluster and below?
- Numbers hit you in the face – especially in relationship to another community

Background on health indicators/issues

- Show further detail in some indicators to understand better – like smoking rates – includes age groups – might find out something that would change your mind about the need to address it – like most of 20% of smokers are teenagers
- Explain that you can request more info on some indicators –
- Can we identify why rates go up or down for different indicators – related to strategies, new services, etc.? Can get this from evidence.

Other feedback about community profiles and how to encourage/motivate action to improve health indicators/outcomes:

- Poster with a picture of each community – with some stat's put in places all around community area – health issues/indicators that are significant – then provide link to report

4. **Approaches to sharing community health assessment information with the public, community groups, etc.**

- Social media – YouTube videos, Facebook, twitter – tweet out certain stats
- Advertisements on TV – use the media to get information out
- Mail outs
- Community presentations
- Radio – like “My Right Care” ad’s
- Bus ad’s, side and inside, park benches
- Health magazine
- The more people that get to see this info the better
- Need to convince people that health equity should happen
- Probably only about 5000 people who would want and use this info
- Put in memorable stories that connect to people, that shock people
- Use every opportunity to figure out what a certain group would relate to, find useful
- Poster with a picture of each community – with some stat’s put in places all around community area – health issues/indicators that are significant – then provide link to report
- Every city Councilor , every MLA, etc. should receive info about their communities
- Use public health nurses to get the info out – would know who to target certain info – getting it to where it needs to go – schools – info on child health issues, seniors groups – info on seniors, mental health issues, etc.
- Pharmacies
- Displays at libraries
- Newsletters
- Giant billboard
- Community papers – like Herald, the Lance, Metro
- Public TV – like
- SHAW TV

Seven Oaks and Inkster
Local Health Involvement Group

Community Health Assessment – Meeting Two

1. **Can you think of groups and organizations in your community who would be interested in getting information from the Community Health Assessment and how it would be useful to them?**

<u>Government departments/programs/agencies</u>
- Police

<u>Community Social Service Organizations</u>
- MB Child Care Association
- Daycares – build programs around the info
- Immigrant settlement services
- Manitoba Association of Seniors Centres
- Seniors centres – need to be aware of diet
- Cultural Associations – knowing more, makes you re-think your diet, other ways of doing things
- Community agencies – like women's resource centres
- Neighbourhood Resource Centres
- Food banks

<u>Recreational</u>
- Community centres – build programs around the info
- Weston Community Centre
- YMCA's
- Gym's, fitness centres

<u>Health</u>
- Seven Oaks Wellness Centre – workshops, planning services and education programs, share info with members
- Personal care homes
- Doctors' offices
- Mental health facilities, organizations
- Access centres
- Middlechurch Home
- Health services – like ambulance, paramedics – planning, get to know their community better – know what to expect

Education
- Adult education centres – educating students – including in curriculum, workshops – will see big picture of health issues in their community
- Schools
- Universities, colleges – RRC

Politicians
- City hall, Councillors, other politicians

Faith
- Churches – different groups may be interested
- Salvation Army – community programs and sites

Business
- Stores – grocery – can respond to nutritional needs identified – "healthy choices"
- Home builders – family size how it impacts housing needs
- Malls
- Pharmacies
- Big corporations – who do charity work – can target different health issues, to get community behind them
- Wellness programs at corporations, business, large employers

Other
- Local radio stations

2. Feedback on the community profiles (developed for health planners using 2009 community health assessment data)

A. What do you like about the community profiles?
- Like the way it's organized – with demographics and geography to begin – smart way to open it up
- Like how data is presented – different types of graphs – appeal to broad range
- It is clear – data is presented – by age groups, how things progress/don't progress over time
- How they compare with the element of time – to see patterns
- Like the summaries for each section -- with definitions, and how it affected a particular area
- Breakdown of demographics – bullets, descriptors, explanations – see trends, foresight
- For health planning – it's very helpful – for example, need for chronic disease coordination because diabetes rate is so high
- Helpful for schools too – esp. mental health data
- Language is fairly straight forward, not too complicated
- Having colour – makes it more appealing to look at

B. Ideas for improving the community profiles – so that they are understandable and motivate community members and groups to take action and address health issues?

- Data on demographics – missing one age group (5-9)
- Open up with executive summary for each of the 4 indicators
- Low literacy – no graphs – pictures and illustrations to draw attention, short summaries in plain language
- Cue to look for more info on WRHA website
- Divide up – doctors' offices – pull out info that would be most important to them
- Child centres – children's health, etc. families
- Make available in different languages
- What is the goal in sharing the information – and then figure out what info they need – data or data and resources?
- Recommendations and conclusions from the stats
- Question the stats on languages spoken
- Important to be able to provide feedback on the stats as they come out
- Include ethnicity in the profile
- Wondering about indicators for mental health/mood disorders – prescriptions, description, etc. – will the data be credible, usable?

3. Community Profile for Seven Oaks and Inkster community areas:

<u>Process for creating community profiles and other considerations</u>

- Divide up – doctors' offices – pull out info that would be most important to them
- Child centres – children's health, etc. families
- Targeted approach to content and format for different groups
- What is the goal in sharing the information – and then figure out what info they need – data or data and resources?
- Important to be able to provide feedback on the stats as they come out

<u>Format</u>

- Like the way it's organized – with demographics and geography to begin – smart way to open it up
- Like the summaries for each section -- with definitions, and how it affected a particular area
- Open up with exec summary for each of the 4 indicators

Cue to look for more info on WRHA website

<u>Language – readability, style, plain language</u>

- Language is fairly straight forward, not too complicated
- Too wordy for most organizations to work through
- Low literacy – no graphs – pictures and illustrations to draw attention, short summaries in plain language
- Make available in different languages

Graphs, pictures, unique approaches, etc.

- Breakdown of demographics – bullets, descriptors, explanations – see trends, foresight
- Having colour – makes it more appealing to look at
- Recommendations and conclusions from the stats
- Mapping out community resources – recreation, health, education,
- Use info graphics – Pinterest
- Set up Pinterest – with the CHA info and tools

Information to include

- Income levels
- High school graduation rate – education levels
- Map out cultural/ethnic/newcomer groups
- Include ethnicity in the profile

Data

- Like how data is presented – different types of graphs – appeal to broad range
- It is clear – data is presented – by age groups, how things progress/don't progress over time
- Data on demographics – missing one age group (5-9)
- Question the stats on languages spoken
- Wondering about indicators for mental health/mood disorders – prescriptions, description, etc. – will the data be credible, usable?

Background on health indicators/issues

- How they compare with the element of time – to see patterns
- Information about children's health issues
- Strengths in the community, threats to the community, what can the community do to curb the threats?

Other feedback about community profiles and how to encourage/motivate action to improve health indicators/outcomes:

- Animated section for kids – to share the information – get high school or college kids to work on as part of their programs

4. Approaches to sharing community health assessment information with the public, community groups, etc.

- Use social media – use twitter – send out different facts, CHA out, etc. – to get a conversation going
- Use Facebook – side column – put advertisement there about CHA
- Interesting facts -- share
- Website – scroll down and click on data you're interested in
- Video, YouTube
- Animated section for kids – to share the information – get high school or college kids to work on as part of their programs

- Use summer students/interns to work on tools, etc.
- Community newspapers – North End times, lance, etc.
- Seniors Scope
- Cultural newspapers – Filipino community has 4!
- Mass media – get it in the news – radio, newspapers, etc.
- Give the info to teachers to include in their discussions with classes – math, social studies, health/physical education, language arts, etc.
- Coffee Time
- Breakfast television
- Community kitchens
- Info to seniors centres- might be different – should speak to rep's from different org's to get their input

St Boniface and St Vital
Local Health Involvement Group

Community Health Assessment – Meeting Two

1. **Can you think of groups and organizations in your community who would be interested in getting information from the Community Health Assessment and how it would be useful to them?**

Government departments/programs/agencies
- City planners
- All 3 levels of government

Community Social Service Organizations
- Org's that work with youth at risk – data to plan
- Seniors resource Groups
- United Way
- Winnipeg Foundation
- Child Care Associations, day cares
- Food Matters Manitoba – and other organizations that address food security issues, distribution
- Food banks

Recreational
- YM-YWCA's, YMHA's
- Sport Manitoba
- Community centres

Health
- Addictions association
- Mental health association
- Other RHA's
- Doctors Manitoba
- Health in Common
- Active living coalition for older adults

Education
- Schools – socio-economic, health of children (age-specific) – help focus on priorities,
- Universities

Faith
- Churches

Business

- Insurance companies
- Employers
- Companies – large and small
- Grocery stores, pharmacies
- Advertising companies
- Financial institutions

Other

- Unions – look at diff indicators – like smoking, high blood pressure, issues impacting health of workers to help with planning to address, etc.
- Media

2. Feedback on the community profiles (developed for health planners using 2009 community health assessment data)

A What do you like about the community profiles?

- Point form summary – is good
- Chronic diseases at a glance
- Having the previous years' data
- Population pyramids
- Excellent information

B Ideas for improving the community profiles – so that they are understandable and motivate community members and groups to take action and address health issues?

- Explanations need to be more simple – understandable
- Summarized at a glance – simple bullets – highlight significant stats
- Accessible on-line – to choose the info that you'd like to look at – i.e. you're interested in stats on teen pregnancy
- Relate stats to potential actions
- Info is complex – can't be too short
- Summary of chronic illness is good
- Identify where things are getting worse
- Some data tables to refer to
- Give us ideas if the changes are significant or not
- Pictures/visuals
- Too many tables
- Data on how much money is spent on different issues – table to show over time
- Some comparative info to compare to other areas of the city
- Visualization and simple - changes over time (only a couple of indicators) and compare to other areas
- Info graphics – use to put in community paper – highlight most significant issues – where things are improving or getting significantly worse - link to more data

- Equity
- Mental health
- Teen pregnancy
- Stories in there
- Simple pictures
- What is our goal in sharing this info – then work back from there
- Works to send clear message over and over again
- Would want to tailor info to suit needs of different groups – Knowledge Translation strategies that would be important to different groups
- If there's not follow-up, support, money, etc. – groups might not do anything with this – they have their own priorities, etc.

3. Community Profile for St Boniface and St Vital community areas:

<u>Process for creating community profiles and other considerations</u>

- Need the head line to get the media attention to tell the story and then engage the public and community groups
- Accessible on-line – to choose the info that you'd like to look at – i.e. you're interested in stats on teen pregnancy
- What is our goal in sharing this info – then work back from there
- Works to send clear message over and over again
- Would want to tailor info to suit needs of different groups – Knowledge Translation strategies that would be important to different groups
- If there's no follow-up, support, money, etc. – groups might not do anything with this – they have their own priorities, etc.

<u>Format</u>

- Summary – what is the most important thing to know about health in my community? Affects the most number of people? Significant and dramatic change in an indicator?
- Point form summary – is good
- Summarized at a glance – simple bullets – highlight significant stats
- Info is complex – can't be too short
- Summary of chronic illness is good
- Stories in there

<u>Language – readability, style, plain language</u>

- Explanations need to be more simple – understandable

<u>Graphs, pictures, unique approaches, etc.</u>

- Some data tables to refer to
- Pictures/visuals

- Not too many tables
- Visualization and simple - changes over time (only a couple of indicators) and compare to other areas
- Info graphics – use to put in community paper – highlight most significant issues – where things are improving or getting significantly worse - link to more data
- Simple pictures

Information to include

- Give us ideas if the changes are significant or not
- Demographics - -who lives in our community?
- Getting trends over time – as far back as possible
- Local health matters –
- Section on mental health – anxiety rates having been increasing over time, for example
- Some comparative info to compare to other areas of the city
- Equity
- Mental health
- Teen pregnancy

Data

- Having the previous years' data
- Population pyramids
- Tables – good visual
- Organize data so that it identifies trends going up /going down –
- Data on how much money is spent on different issues – table to show over time

Background on health indicators/issues

- Identify where things are getting worse
- Chronic diseases at a glance
- Indicators – data and provide ideas for how to address – i.e. lack of physical activity and standing work stations/tread mills, etc.
- Stories about what happened after last CHA, how new programs impacted health outcomes, etc.
- Relate stats to potential actions
- Chronic diseases overview
- Definitions

Other feedback about community profiles and how to encourage/motivate action to improve health indicators/outcomes:

- Trends – indicators that are changing in a significant way
- Melding info from the annual report – budget, programs to address, and changes in health indicators

4. **Approaches to sharing community health assessment information with the public, community groups, etc.**

- Have people present info to targeted groups (work with the group to identify info that would be useful, have someone from the group present/co-present)
- We need to set the tone or the government will set it for us
- Series in local papers highlighting one indicator at a time – expanding on it, telling the story
- Stories – like what teen challenge does
- Like "60 Second Driver" – approach – catches attention, where to go, identifies success, etc.
- Social media
- Time release of info with things like "heart month", as different initiatives roll out – work place wellness initiative about to roll out
- Bus advertising – inside the bus
- Mentors within groups to share info, train others
- Messaging for kids – teach them young, get them engaged
- Festival, river walk – where lots of people come out – present the info in some creative way
- Contests, get people engaged, involved
- Health expo
- Walkathon, bike a thon, etc.
- Summaries in community papers
- Posters

St James-Assiniboia and Assiniboine South
Local Health Involvement Group

Community Health Assessment – Meeting Two

1. **Can you think of groups and organizations in your community who would be interested in getting information from the Community Health Assessment and how it would be useful to them?**

Government departments/programs/agencies
- City of Winnipeg – for planning recreation, etc.
- Health planning – doc's, public health nurses, clinics,
- City police – better understanding of how indicators impact different areas of the city could help with planning – ambulance, fire, etc. emergency responders
- Allied health professions
- Libraries
- MB housing
- 17Wing

Community Social Service Organizations
- Seniors groups – for planning
- Women's shelters, Siloam mission
- Aboriginal org's
- Social activists/org's – get in front of community and have message to deliver
- Those who provide services to different groups
- Community Economic Development network – org that trains entrepreneurs
- SEED Winnipeg
- Kiwanis, Kinsmen, Lion's – community clubs
- Family resource centres
- Red Cross
- Adult day centres – planning where to locate facilities, programs
- Salvation Army
- United Way
- Seniors resource Groups

Recreational

Health
- Labs – meeting needs of clients
- Helping organizations – health-related – like Heart and Stroke, Lung Association
- St John's Ambulance

Education
- School divisions – decisions re: curriculum, dietary planning
- Post-secondary – colleges, universities – planning for training needs in the future
- University students – for projects, thesis
- Students union
- School boards

Politicians
- Politicians – who represent the areas

Faith
- Churches, religious org's

Business
- Businesses – chamber of commerce, etc.

Other
- Journalists, media
- Fundraisers
- Housing planners

2. Feedback on the community profiles (developed for health planners using 2009 community health assessment data)

A. What do you like about the community profiles?
- Graphs, pictures – give picture of where things are at
- Comparison to other areas in the city
- Narrative is good – balance to the graphs – provides context
- Balance society's want for short sound bite versus good information that takes longer to read
- Summaries are really helpful

B. Ideas for improving the community profiles – so that they are understandable and motivate community members and groups to take action and address health issues?
- Limitation – data seems old – can we get better data? It is reliable – yes? Can we get more recent data?
- Needs to be written in plain language so everyone can understand
- Need to consider range in terms of capacity of org's that will receive
- Always offer "more info" – click on here to get more
- What is the priority? The most significant issue? Signal what some of those priorities might be
- Executive summary to highlight what is included, what the priorities are

- Need to consider and engage for community knowledge of the issue too
- Needs to be print friendly in PDF format – not too many colours – test to make sure you can read it –
- Have links to different parts of the report
- Chunk the info – into sections – so you can go to those sections you are interested
- Quotes
- Point form
- Info to pull out to use in other formats, like newsletters
- Beta test or have focus groups of non-health care professionals review and provide feedback
- Written in active voice so that it is engaging – get a good writer – MB Centre for Health Policy – writing is excellent
- Storytelling
- Different languages
- Different way to package material for different cultural groups?
- Include a story-based summary document that could be translated into different languages
- Fictitious family – to tell story about health indicators
- Pictorial
- Pictograms, info graphics

3. Community Profile for St James/Assiniboine South community areas:

<u>Process for creating community profiles and other considerations</u>

- Need to consider and engage for community knowledge of the issue too
- Needs to be print friendly in PDF format – not too many colours – test to make sure you can read it –
- Beta test or have focus groups of non-health care professionals review and provide feedback

<u>Format</u>

- Summaries are really helpful
- Always offer “more info” – click on here to get more
- What is the priority? The most significant issue? Signal what some of those priorities might be
- Executive summary to highlight what is included, what the priorities are
- Have links to different parts of the report
- Chunk the info – into sections – so you can go to those sections you are interested
- Quotes
- Point form
- Info to pull out to use in other formats, like newsletters
- Different way to package material for different cultural groups?
- Story-based summary document include - -that could be translated into different languages

Language – readability, style, plain language

- Narrative is good – balance to the graphs – provides context
- Balance society's want for short sound bite versus good information that takes longer to read
- Needs to be written in plain language so everyone can understand
- Need to consider range in terms of capacity of organizations that will receive
- Written in active voice so that it is engaging – get a good writer – MB Centre for Health Policy – writing is excellent
- Storytelling
- Different languages

Graphs, pictures, unique approaches, etc.

- Graphs, pictures – give picture of where things are at
- Fictitious family – to tell story about health indicators
- Pictorial
- Pictograms, info graphics

Information to include

- Comparison to other areas in the city

Data

- Limitation – data seems old – can we get better data? It is reliable – yes? Can we get more recent data?

Background on health indicators/issues

Other feedback about community profiles and how to encourage/motivate action to improve health indicators/outcomes:

- Different way to generate awareness – Russia – 30 squats to get a free bus pass – video showing people – subway stairs versus escalator

4. Approaches to sharing community health assessment information with the public, community groups, etc.

- Provide data to educational institutions – create dialogue for what data means – and then engage to develop tools to share
- Need communication strategy to design tools and communication support – health care providers aren't communications experts
- Use "vines" – 6 second videos to share info – for youth
- YouTube, Facebook, social media
- Power points with speaking notes to present info
- Have speakers' bureau to go to different groups to share info

- Have volunteers/staff write articles for community newspapers – engage community papers to write about this
- Focus should be on community groups, etc. trying to plan programs and meet needs
- Public needs to know so that they will support those groups
- Get to the community facilitators to share the info with groups in their community areas
- Networking – to share the info – a hub from members out to many more organizations – include tips for getting the information out into the community through your own connections
- Meeting notes – power point outline
- Profile community health assessment in Saturday paper – compare community areas

Appendix A

Community Health Assessment in Winnipeg
-- A BACKGROUNDER --

What is COMMUNITY HEALTH ASSESSMENT (CHA)?

CHA is a legislated process in Manitoba undertaken to identify the strengths and needs of different communities (like Winnipeg's community areas).

A Community Health Assessment (CHA):

- is a tool for health planning
- enables the community-wide establishment of health priorities
- facilitates collaborative action planning
  and is directed at improving community health status and quality of life.

HOW does one identify the strengths & needs of the community?

We collect, analyze and present information so that the health of the community can be understood and improved. Having a CHA also means that health and community services can be planned using evidence.

First, we decide what information is needed (indicator selection) in partnership with the larger community, then we gather and analyze this information and finally, we produce a report of these indicators every 5 years for the Winnipeg health region.

Identifying what indicators we need to produce a meaningful CHA

Manitoba is fortunate in that we can measure many aspects of a neighborhood's health and health status. In order to organize and then select these measures, a provincial committee set up to select indicators, using a framework proposed by the Canadian Institute for Health Information (CIHI) and informed by Statistics Canada.

The indicators are first grouped in four 'domains' or areas:

Domain #1	Health Status	Well-being, health conditions, human function, death
Domain #2	Non-medical Determinants of Health	Health behaviours, living & working conditions, personal resources, environmental factors
Domain #3	Health System Quality	Access to procedures & services, delivery of services that are appropriate, effective & safe
Domain #4	Community & Health System Characteristics	Demographics, system capacity…these indicators provide 'context'

In order to agree on what indicators to measure we use the following criteria[1] to decide:

Is the indicator:

[1] A standard, rule, or test on which a judgment or decision can be based

Important & Relevant?	• Reasonably reflect of efforts to reduce health risks & improve health status & health systems? • Understandable, relevant & useful for health planning?
Valid?	• Actually measure what it is claiming to measure?
Possible to measure?	• Currently able to be 'collected' and reported on? • Support meaningful comparison over time and place (e.g., 2001-2006 vs. 2007-2012 & among neighborhood areas in Winnipeg)?
Meaningful?	• A phenomenon that the health care system can change? • Sensitive & reflective of changes in the phenomena that it is intended to measure?
Can something be done?	• Support evidence to motivate change? …is it amenable to action?

During our session we will be drawing on the document: "Core & Optional Indicators for CHA 2014" (attached). It is a summary of the 2014 Core/Optional Indicators which passed provincial criteria for inclusion in the 2014 CHA. There are 80 Core Indicators (those the WRHA MUST report on) and another 67 Optional Indicators.

WHAT is your role in CHA as a LHIG member?

We would like to know <u>what you think is important</u> for your community to know and perhaps, act upon. We will be asking you to divide into groups of 3; we will give you a set of THREE (3) criteria in order to discuss 5 CHA indicators from your community area. Finally, we will get you to 'score' the indicators. By scoring you will be judging how important they might be for your community. The three (3) criteria are:

Magnitude	How many persons do you think the problem affects?
Consequences	Seriousness: What is the degree of disability or premature death that occurs because of the problem? Are there economic or social burdens to the community?
Feasibility	Is the problem amenable to interventions available in the community?

At the end of the meeting, we'd like your input into the 67 Optional Indicators. Again, in the same groups, we will ask you to number your top FIVE selections for indicators you'd like to know more about, in each of the 4 domains. At our next meeting, we will have the results of your choices to share.

Appendix B

Feedback on Community Health Assessment Community Profiles

LHIG members were asked to review and provide feedback on the existing community profiles. These were developed for health staff and health organizations to use for planning purposes using information from the 2006 Community Health Assessment. (The profiles can be found in Appendix E)

What LHIG members liked

- Like the range of current estimates (high and Low) – compare to other community areas
- Know that it is hard to put in simple/plain language and be statistically accurate – most people would find the current language difficult to understand
- Definitions of the chronic diseases and summary of findings – have definition first
- Very informative
- Comparisons – interesting
- Summaries – at end of section
- Not just comparing household incomes
- Like how indicators are laid out
- Liked the graphs, visual – wish there was more – would help me to see things more clearly
- Like that it references ranges, can see how community area compares to others, and how the indicator changes over time – would nice to a longer time range, identify trends
- Liked the dependency ratio
- Maps of community areas, with boundaries between identified
- Well written if you had the time to sit down and read it
- Like the way it's organized – with demographics and geography to begin – smart way to open it up
- It is clear – data is presented – by age groups, how things progress/don't progress over time
- Breakdown of demographics – bullets, descriptors, explanations – see trends, foresight
- For health planning – it's very helpful – for example, need for chronic disease coordination because diabetes rate is so high
- Language is fairly straight forward, not too complicated
- Having colour – makes it more appealing to look at
- Point form summary – is good
- Chronic diseases at a glance
- Having the previous years' data
- Population pyramids
- Graphs, pictures – give picture of where things are at
- Comparison to other areas in the city
- Narrative is good – balance to the graphs – provides context
- Balance society's want for short sound bites versus good information that takes longer
- Summaries are really helpful

Ideas for improving the community profiles

- Would be good to have different organizations reflect on data and help us to understand what that really means, the context for a health indicator, change, etc.
- Consider what information community groups will want, connect to
- Each area will have their own issues to work on
- Works to send clear message over and over again
- Would want to tailor info to suit needs of different groups – Knowledge Translation strategies that would be important to different groups
- If there's not follow-up, support, money, etc. – groups might not do anything with this – they have their own priorities, etc.
- Need to consider and engage for community knowledge of the issue too
- Beta test or have focus groups of non-health care professionals to review and provide feedback
- Like the way it's organized – with demographics and geography to begin – smart way to open it up
- What is the priority? The most significant issue? Signal what some of those priorities might be
- Executive summary to highlight what is included, what the priorities are
- Chunk the info – into sections – so you can go to those sections you are interested
- Statistical "snapshot"
- Animate it, be strategic – need to engage, make it exciting – use significant facts to get peoples' attention – something they would be interested in – what's different about our neighbourhood, what do we need to find solutions for (DT/PTD)
- Have summary/overview of information – graphs, pictures
- Be more concise, have format that people can read what they are interested in
- Have targeted bullets
- Make it more visual, graphics
- Info graphics – use to put in community paper – highlight most significant issues – where things are improving or getting significantly worse - link to more data
- Some data tables to refer to
- Pictograms, info graphics
- Maps of community areas, with boundaries between identified
- Low literacy – no graphs – pictures and illustrations to draw attention, short summaries in plain language
- Make available in different languages
- Explanations need to be more simple – understandable
- Needs to be written in plain language so everyone can understand
- Need to consider range in terms of capacity of org's that will receive
- Written in active voice so that it is engaging – get a good writer – MB Centre for Health Policy – writing is excellent
- Storytelling
- Different way to package material for different cultural groups?
- Story-based summary document include - -that could be translated into different languages

- Numbers hit you in the face – especially in relationship to another community RH/FG
- Can we identify why rates go up or down for different indicators – related to strategies, new services, etc.? Can get this from evidence.
- Give us ideas if the changes are significant or not
- Identify where things are getting worse
- Summarized at a glance – simple bullets – highlight significant stats
- Contact website has a mapping function – could link to that for each community area
- Have links to other websites for more information
- Use social media links
- Show further detail in some indicators to understand better – like smoking rates – includes age groups – might find out something that would change your mind about the need to address it – like most of 20% of smokers are teenagers
- Explain that you can request more info on some indicators –
- Cue to look for more info on WRHA website
- Accessible on-line – to choose the info that you'd like to look at – i.e. you're interested in stats on teen pregnancy
- Always offer "more info" – click on here to get more
- Have links (from the community profiles) to different parts of the entire Community Health Assessment Report

Appendix C

COMMUNITY HEALTH ASSESSMENT (2014): CORE & OPTIONAL INDICATORS

Domain 1: Health Status [CORE]

INDICATOR	DEFINITION
Preterm Birth Rate	The number of live born infants prior to 37 weeks gestation expressed as a proportion of all live births.
Small for Gestational Age	Rates for SGA are calculated by taking all live–born small for preterm, small for term and small for postterm births and dividing by the total number of live–born deliveries. To provide an indication of the size of these babies, in 2001/02 - 2005/06, the average birth weight for Manitoba newborns was 7.6 pounds and for SGA was 5.8 pounds.
Large for Gestational Age (LGA)	Rates for LGA used large for preterm, large for term and large for postterm births in the numerator and total liveborn deliveries in the denominator. To provide an indication of the size of these babies, in 2001/02 - 2005/06, the average birth weight for Manitoba newborns was 7.6 pounds and for LGA was 9.3 pounds.
Total Respiratory Morbidity Prevalence	The percentage of persons having at least one physician visit or hospitalization for a respiratory disease within a two-year period
Cancer Incidence	Age standardized rate and crude rate of new sites of cancer (malignant neoplasms) per 100,000 population: for all cancers, and new sites for top 4 causes per region.
Diabetes Incidence	The number of new cases of diabetes detected in the population (not including gestational diabetes) during a fiscal year (April 1 to March 31).
Diabetes Prevalence	The number of individuals aged 19 and over who have been diagnosed by a health professional as having diabetes. Data derived from a population based database of individuals diagnosed with diabetes, expressed as a rate per 10,000 population.
Lower Limb Amputation due to Diabetes	The percentage of residents with diabetes (age 19+) who had lower limb amputation (below or including the knee) in a 5 year period.
Hypertension prevalence	The percentage of persons aged 25 or older who had at least one physician visit for hypertension in a three-year period.

Domain 1: Health Status [CORE]

INDICATOR	DEFINITION
Acute Myocardial Infarction (AMI) Incidence Rates	The annual rate of hospitalization (3 or more days) or death due to AMI per 1,000 residents age 40 or older, over a five year period.
Ischemic Heart Disease (IHD) Treatment Prevalence	The treatment prevalence rate of IHD (restriction to flow to coronary arteries) in residents age 19 or older, defined by a combination of data in physician visits, hospitalizations, and prescription drugs, over a 3 year period.
Stroke Incidence Rates	The annual rate of hospitalization or death due to stroke, in a five year period, per 1,000 residents age 40 or older**.**
Injury Hospitalization Rates	Number of Manitoba residents who stayed in hospital at least one day with a primary diagnosis of injury or poisoning. (CIHI 1.1 Age-standardized rate of acute care hospitalization due to injury resulting from the transfer of energy (excluding poisoning and other non-traumatic injuries), per 100,000 population.)
Injury Causes of Hospitalization	The top 5 causes of hospitalization due to injury, reported as a percentage of all injuries, by regional area (South, Mid, North, Brandon, Winnipeg most healthy, Winnipeg average health, Winnipeg least healthy, Manitoba).
Hip Fracture Incidence Rate	The age adjusted annual hospitalization rates for hip fracture per 1,000 residents age 40 or older, during a 5 year period.
Prevalence of Mood & Anxiety Disorders	Percent (%) of residents aged 10 years and older with mood & anxiety disorders
Prevalence of Substance Abuse	Percent (%) of residents aged 10 years and older with substance abuse.
Prevalence of Dementia	Percent (%) of residents aged 55 years and older with Dementia.
STI: Chlamydia	Number of cases of the notifiably sexually transmitted infection (STI) Chlamydia trachomatis per population per year.
STI: Gonorrhea	Number of cases of the notifiably sexually transmitted infection (STI) Gonorrhea per population per year.

Domain 1: Health Status [CORE]

INDICATOR	DEFINITION
Self-rated Health	Percent (%) of the population age 12 & over who report that their health is excellent, very good, good, or fair/poor.
SF36 - Physical Functioning Scale	Percent (%) of the population age 12 and over with a score of 100% on the Physical Functioning scale of the SF36.
SF36 - General Mental Health Scale	The general mental health scale is a derived measure from the SF-36 questionnaire, addressing overall mental health on a scale of 0 to 100 (higher is better)
Infant Mortality	(a) Ratio of deaths among infants under 1 year old to the number of live births, for a given period of time (excludes stillbirths and infants less than 500 grams or 22 weeks of gestation).
Child Mortality	Ratio of deaths among children aged 1 to 19 years to the total number of children aged 1 to 19, for a given period of time.
Top 5 Cancer Mortalities	Number of deaths for the top 4 and all other causes of cancer deaths per year, by RHA.
Unintentional Injury Deaths	Age adjusted rate of death from unintentional injuries per 100,000 population. Unintentional ("accidental") injuries include injuries due to causes such as motor vehicle collisions, falls, drowning, burns and poisoning, but not medical misadventures/complication, homicide.
Suicide Rates	The annual rate of deaths due to suicide, per 1,000 residents aged 10 and older. The data are by calendar year rather than fiscal year. Suicide is the act of intentionally killing oneself through self-inflicted injury (e.g. cutting or poisoning).
Life Expectancy	The number of years a person would be expected to live, starting from birth (for life expectancy at birth), on the basis of the mortality statistics for a given observation period, typically a calendar year. Report by age and sex.
Top 10 causes of Mortality	Percentage of deaths represented by the ten most prevalent causes.
Premature Mortality Rates	Annual number of deaths occurring before the age of 75 per 1,000 population for individuals under age 75, which is adjusted to a reference (or standard) population of individuals under 75 years of age.

Domain 1: Health Status [CORE]

INDICATOR	DEFINITION
Top 10 causes of premature mortality	Crude annual proportion (%) of premature deaths for the 10 most prevalent ICD-9 and ICD-10 code groupings for cause of death, for aggregate areas: South and Brandon, Winnipeg, Mid, North, Manitoba, Public Trustee.
Potential Years of Life Lost (PYLL) - all deaths	Potential years of life lost (PYLL) is the number of years of life "lost" by sex, when a person dies "prematurely" before age 75. A person dying at age 25, for example, has lost 50 years of life.

Domain 2: Determinants of Health [CORE]

INDICATOR	DEFINITION
Body Mass Index - Obesity prevalence	Proportion of the population aged 18 and older, reported by three Body Mass Index groupings: underweight/normal, overweight, and obese. BMI is calculated as follows: weight in kilograms divided by height in meters squared. The index is 30 or higher (obese).
Nutrition: Fruit and Vegetable Consumption	The proportion of the population aged 12 and over who reported that they consumed on average 5 or more servings of fruit and vegetables per day.
Frequency of Binge Drinking	The percentage (%) of the population aged 12 and over who are current drinkers and who reported drinking 5 or more drinks on at least one occasion in the past 12 months.
Smoking	The percentage (%) of the population aged 12 and over who reported being either a current smoker (daily or occasional) or a former smoker (former, former daily, former occasional) or a non-smoker (never smoked).
Total Physical Activity Levels (Work + Leisure + Travel)	An index was created to calculate total energy expenditure levels for respondents aged 15 to 75, based on physical activity undertaken during both work-time and leisure-time activities in the previous three months. The proportion of respondents that were active, moderately active, or inactive, is shown.
Breastfeeding Practices (initiation)	Proportion of women who deliver in hospital & initiate breastfeeding (either breast only or breast and bottle) while in hospital.
Childhood Immunization Rates: age 1, 2, 7, 11, 17	Crude proportion of children who had complete immunization schedules for DaPtp/HiB, Diphtheria, Acellular Pertussis, Tetanus, Polio, Haemophilus influenza B immunization rates, as of their first, second and seventh birthdays, respectively.
Adult Influenza Immunization Rates	Percent (%) of the population aged 65 years & older (including those in PCH), who were immunized for influenza (received a flu shot).
Breast Cancer Screening (Mammogram)	Rate per 1,000 women in Manitoba aged 50 to 69, receiving at least one mammogram in two years, screened by RHA of residence.
Cervical Cancer Screening (PAP)	Rate per 1,000 women in Manitoba age 18 to 69 with one or more PAP smears in a 3 year time period, by RHA of residence.
Low Income Cut Off (LICO) - After Tax	Refers to the proportion of an economic family or an unattached individual 15 years of age and over in relation to Statistics Canada's low income cut-offs (LICOs).
Median income of Individuals & Households	Median individual income is calculated using the total income (pre-tax, post-transfer) for persons aged 15 and over who reported income in the Census of Canada. Median household income is calculated for all household units in the Census of Canada, whether or not they reported income.
Labor Force Participation Rate	The percentage of the population aged 15 years and over, who were in the labour force in the week prior to the Census of Canada.

Domain 2: Determinants of Health [CORE]

INDICATOR	DEFINITION
Unemployment Rates	The labor force aged 15 and over who did not have a job during the reference week.
Education Level	Highest level of schooling attainment (less than high school, high school, trades, college, university).
Housing Affordability	The percentage of the population who reported spending 30% or more of total household income on shelter costs from the Census of Canada. Shelter expenses include payments for electricity, oil, gas, coal, wood or other fuels, water and other municipal services, monthly mortgage payments, property taxes, condominium fees and rent. Band housing on First Nations reserves was not included in this calculation.
Adolescent / Teenage Pregnancy Rates	The number of pregnancies per 1,000 females aged 15 through 19. Pregnancies include live births, stillbirths, abortions and ectopic pregnancies.
Teen Birth Rates	Percent (%) of females aged 13-14, 15-17, 18-19 years who gave birth.
Families First Program Risk Factors (6 indicators)	The Families First Program provides prevalence rates of risk factors for poor child outcomes based on risk factor percentages (%) of the regional post partum population screened for enrollment in the Families First Program.
Inadequate Prenatal Care	An index-based measure (R-GINDEX) of the adequacy of prenatal care by healthcare providers. Three birth-related outcomes are required to calculate R-GINDEX: a) the gestational age of the infant; b) the trimester during which prenatal care began; & c) the total number of prenatal visits during pregnancy.
Early Development Instrument (EDI) - readiness for school	The percentage of children 'not ready' for school and 'very ready for school. The average EDI scores, provided at the provincial, regional and district level, in each of the 5 areas of development: -physical health and well-being -social competence -emotional maturity -language and cognitive skillls -communication skills and general knowledge.

Domain 3: Health System Quality [CORE]

INDICATOR	DEFINITION
In & Out Flow of RHA Inpatients	The in and out flow of the RHA residents measures: -Catchment: Where RHA hospital inpatients came from based on hospital separations, and -Location: Where RHA residents went for hospital separations.
Use of Physicians	This is the percentage of area residents who had at least one ambulatory visit to a physician (including GP/FPs and specialists) per area per fiscal year.
Ambulatory Visit Rate	The annual rate of ambulatory visits to all physicians, per resident.
Ambulatory Consultation Rates	This is the age-adjusted average number of ambulatory consultations (first referrals) per resident to all physicians in a fiscal year. Consultations are a subset of ambulatory visits: they occur when one physician refers a patient to another physician.
Continuity of Care	The percentage (%) of residents receiving more than 50% of their ambulatory visits from the same physician within a two year period.
Where RHA Residents went for visits to GP/FPs	Location of visits to General Practitioners and Family Practitioners, by percent (%) of residents in district, % elsewhere in RHA, % to other regions, and % to Winnipeg and Brandon.
Have a family doc or are looking for a family doc	From CCHS questionnaire: "Have family doctor" or "Don't have a family doctor but are looking for family doctor".
Anti Depressant Follow Up	The crude percentage of patients with a new prescription for antidepressants and a diagnosis of depression within two weeks of each other, who then had three subsequent ambulatory visits within four months of the prescription being filled.
Asthma Care: Controller Medication	The crude percentage of asthmatics (defined as those with a repeat prescription for Beta 2-agonists) who filled at least one prescription for medications (inhaled steroids) recommended for long-term control of asthma in a fiscal year.
Diabetes care: eye exams	The percentage of diabetics age 20 to 79 that had an eye exam in a fiscal year.
Potentially inappropriate prescribing benzodiazepines for older adults	The crude percentage of seniors age 75 and older who have had at least two prescriptions, or a greater than 30 day supply of benzodiazepines in a fiscal year, for: -community dwelling seniors -PCH residents
Ambulatory Care Sensitive Conditions	The acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, for the population under age 75 years.
Dental extractions	The rate of hospital-based dental extractions for children 0 to 5 years of age.

Domain 4: Community & Health System Characteristics [CORE]

INDICATOR	DEFINITION
Population Attributes - Population	The number of people living in a geographic area by age and sex.
Population Projections	Population projections have been prepared for the RHAs. The base populations for these projections are the June 1, 1998 Health registration counts for the 11 RHAs by sex and single years of age (to 90 years and over). The projection period is to extend to June 1, 2025 covering a 27-year period (until 2036).
Aboriginal Population	Aboriginal people living in a geographic area. Aboriginal people are those persons who reported identifying with at least one Aboriginal group (e.g. North American Indian, Métis or Inuit and/or those who reported being a Treaty Indian or a Registered Indian as defined by the Indian Act and/or those who were members of an Indian Band or First Nation).
Lone-parent families	The percentage (%) of lone-parent families among all census families living in private households. By sex.
Physician Visit Rates by Top 10 Causes	The average annual number of ambulatory visits to all physicians by category of illness, ranking the causes by relative frequency of visits.
Total Hospital Separation Rates	The rate of hospitalizations per 1,000 area residents, counting cases for which a hospital abstract is created (all inpatient cases plus day surgery cases). Multiple admissions of the same person are counted as separate events.
Separations by Cause (or causes of hospitalization)	Based on hospital discharge data, the crude percentages of hospitalizations in acute care hospitals per year, with a breakdown by cause.
Hospital Days Used: -For Short Stays:	The rate of all hospital days used per 1,000 area residents:for short stays of less than 14 days
Hospital Days Used: -For Long Stays	The rate of all hospital days used per 1,000 area residents for long stays of 14 days or longer.
Home Care Prevalence	"Units of Home Care" by service type.

Domain 4: Community & Health System Characteristics [CORE]

INDICATOR	DEFINITION
PCH Utilization: Level of Care on Admission	The distribution of new cases being admitted to provincial Personal Care Homes (PCHs) in a fiscal year, by level of care (1 to 4) at admission. Level 1 represents the lowest level of need, and Level 4 represents the highest.
Residents in PCH by RHA	The annual percentage of residents aged 75 and older who were living in a provincial PCH for at least one day over a given period, by region of residence prior to PCH admission.
Re-admission rate (general)	The risk-adjusted rate of unplanned readmission following discharge for hospital admission. A case is counted as a readmission if it is for a relevant diagnosis and occurs within 28 days after the index AMI episode of care. An episode of care refers to all contiguous in-patient hospitalizations and same-day surgery visits.

Appendix D

WHAT WOULD YOU LIKE TO KNOW MORE ABOUT?

LHIG
Date:

Choose and then **RANK** from #1 (most important) to #5 (least important) from each of the lists **FIVE** (5) **optional** indicators for the 2014 Community Health Assessment that you think your community would like to know more about.

DOMAIN #1: HEALTH STATUS

#1 to #5	INDICATOR	DEFINITION
	Health Utility Index	A generic health status index, developed at McMaster University's Centre for Health Economics and Policy Analysis, which measures health status and health-related quality of life as one number.
	Deprivation Index*	The Deprivation Index is not considered to be a complete description of poverty, but a way of recognizing common symptoms of poverty. It includes multiple elements of poverty, including deprivation that leads to social isolation, issues of economic security, and the ability to make changes in your life.
	Low Birth Weight	The percentage of live infants born weighing less than 2500 grams to the number of births (birth weight known and greater than 500 grams).
	Arthritis Prevalence	The percentage of residents aged 19 or older diagnosed with arthritis (osteo or rheumatoid) using a combination of data in physician visits, hospitalizations, and prescription drugs.
	Osteoporosis	The percentage of residents aged 50 or older diagnosed with osteoporosis.
	Asthma Prevalence	The number of individuals who had been diagnosed by a health professional as having asthma within a 2 year window, expressed as a rate per 1000.
	STI: HIV	Number of new laboratory-confirmed infections with HIV per 1,000 per population per year.
	Activity Limitation	Population aged 12 and over (for the data from CCHS & NPHS) who report having a disability or being limited in certain activities on a continuing basis (at least 6 months) because of a physical condition, mental condition, or health problem.
	Top 5 Causes of Child Mortality	The top 5 causes of deaths among children age 1 to 19 years.
	Injury Mortality Rates	The number of deaths due to injury per 1,000 residents per year, based on Vital Statistics death codes.
	Potential Years of Life Lost (PYLL) - **cancer deaths**	Potential years of life lost (PYLL) for all malignant neoplasms, is the number of years of life "lost" when a person dies "prematurely" from malignant neoplasms before age 75.
	Potential Years of Life Lost (PYLL) - all **Circulatory Disease Deaths**	Potential years of life lost (PYLL) for all circulatory disease deaths, is the number of years of life "lost" when a person dies "prematurely" from circulatory disease before age 75.
	Potential Years of Life Lost (PYLL) - all **Respiratory Disease Deaths**	Potential years of life lost (PYLL) for all respiratory disease deaths, is the number of years of life "lost" when a person dies "prematurely" from any respiratory disease before age 75.
	Potential Years of Life Lost (PYLL) – **unintentional injury deaths**	Potential years of life lost (PYLL) for all unintentional injuries, is the number of years of life "lost" when a person dies "prematurely" from unintentional injuries before age 75.
	Potential Years of Life Lost (PYLL) - **suicide**	Potential years of life lost (PYLL) due to suicides, is the number of years of life "lost" when a person dies "prematurely" from suicide, before age 75.

DOMAIN #2: NON-MEDICAL DETERMINANTS OF HEALTH

#1 to #5	INDICATOR	DEFINITION
	Adult Pneumococcal Immunization	Cumulative percentage (%) of the regional population aged 65 years and older, who were immunized for pneumococcal disease.
	Reproductive Health 15 to 19 years: Sexual activity, condom use, birth control pill use	(a) Proportion of teens 15 to 19 who responded on CCHS that they were/had been sexually active, and average age of first sexual intercourse. (b) For sexually active teens, the average age of first sexual intercourse. (c) Percent of sexually active teens who reported using condom on last encounter. (d) Percent of sexually active 15 to 19 year old females who reported use of birth control pill as usual method of contraception.
	Colorectal cancer screening	
	Socio-economic Factor Index (SEFI) Score	The percent (%) of residents within geographic areas (RHAs, WCAs) who are: lone-parent families, unemployed, have greater than high school education, females who are participating in labor force (components of the Social Economic Factor Index (SEFI).
	Average Household Income	The weighted mean total household income (pre-tax, post transfer) of individuals 15 years of age and over who reported income.
	Occupation	Refers to the kind of work persons aged 15 years and over (excluding institutional residents) were doing during the reference week, as determined by their kind of work and the description of the most important duties in their job, as reported in the Census of Canada. If the person did not have a job during the week prior to enumeration, the data related to the job of longest duration since Jan. 1, 2005. Persons with 2 or more jobs were to report the information for the job at which they worked the most hours.
	Percentage of Population Scoring High on Work Stress Scale	The annual percentage (prevalence) of the working population (age 15 to 74) who scored "None"/"Low" or "Medium" or "High" on the Work Stress scale. This indicator is derived from the CCHS survey, and reflects a respondent's perceptions of work, including job security, social support, monotony, physical effort required, and the extent of participation in decision-making.
	Youth Unemployment	The labor force aged 15 to 24 who did not have a job during the reference week. The labor force consists of people who are currently employed and people who are unemployed but were available to work in the reference week and had looked for work in the past 4 weeks.
	High School Completion	The percent (%) of grade 9 students who graduated from high school within the next 6 years.
	Screening For and Use of Families First Program	The percentages (%) of the regional post partum population screened for enrollment in the Families First Program, and the percentage (%) screened positive that actually enrolled.
	Life Stress	Level of chronic life stress reported by the population aged 15 and over, based on their responses to a series of 17 questions about their personal situation.
	Licensed child care spaces	The rate of licensed child care spaces per 1,000 children ages 0 to 12 years by area.
	General information on kindergarten children from "EDI" results*	(a) Number of EDI participating children with ESL / FSL (b) Number of EDI participating children with special needs (c) Number of EDI participating children who require further assessment concerning possible special needs
	Second-hand Smoke Exposure	Proportion of the non-smoking Canadian population aged 12 and older, exposed to environmental tobacco smoke at home on most days.

**EDI= Early Development Instrument*

Appendix E

A Profile of the Health of the Downtown Community

The Winnipeg Health Region's Community Health Assessment (CHA) 2009/2010 reports on 107 indicators of the region's health status, determinants of health and well-being, health system performance and demographics (http://www.wrha.mb.ca/research/cha2009/index.php). As Arlene Wilgosh, WRHA's CEO stated in its release in Fall 2010:

> *The Community Health Assessment (CHA) serves as an important information resource for the many organizations and programs associated with health, wellness and community development. It plays a key role in helping us engage with the public in a shared effort to improve the health for everyone in the Winnipeg Health Region.*
>
> *The CHA provides a snapshot in time of where we need to go. Our community facilitators, as well as numerous community stakeholders, use this information as part of their ongoing public engagement and community development activities. By sharing and using this information, they are better able to determine strategies and priorities aimed at building stronger communities.*

Downtown Community Area has actively solicited the WRHA, through its Research & Evaluation Unit, to provide community level analysis on four key groups of indicators that inform on the community's health:

1. Demographics & Geography
2. Chronic disease
3. Mental health disease
4. Health risk factors

These four (4) indicators should contribute to our understanding of the strengths and challenges faced by the Downtown community and assist in informing its decision-makers of solutions and directions. However, indicators such as these cannot tell us how to set priorities or where to focus our attention. Rather, it is a starting point, like a pencil sketch outline, from which we can invite community conversations and identify issues that need further exploration to fill in more of the picture.

Helping you to Read the Report

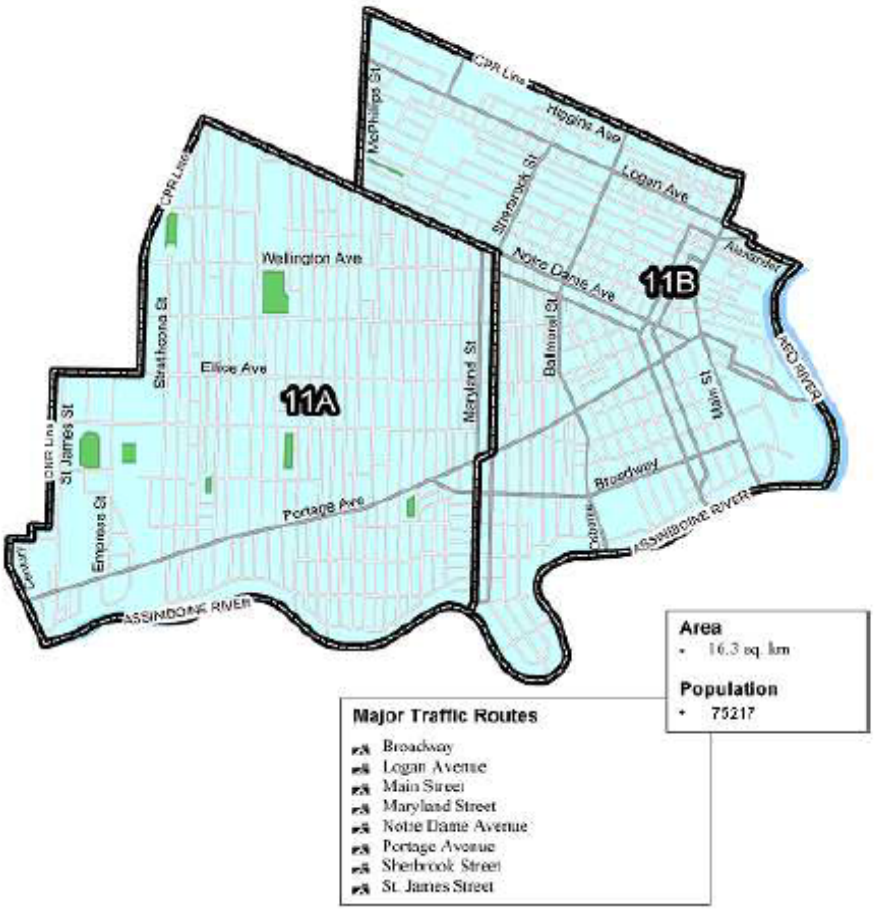
Each of the four (4) indicator sections starts with an overall statement and definitions of the indicators included in it. Next, we include a brief ***summary*** of indicator values in point form. However, no attempt has been made to provide detailed explanations of the observed patterns. We finish each section with two tables. The first is an ***"AT A GLANCE table"*** which summarizes, in tabular form, current and past indicator values (age- and sex-standardized to the Manitoba population, where possible) for the section's indicators. Included in the table is the "Range of Current Estimates" for each indicator which reports high and low values that define the range of the indicator's values across WHR Community Areas (CAs). The second table summarizes the current and past indicator values **by neighbourhood cluster**; this table uses crude or actual rates (i.e., they are not adjusted for the underlying Manitoba age- and sex-distribution) and also includes the "Range of Current Estimates" (also stated as crude or actual rates).

Where possible, two time-periods for each indicator are included. The time-periods stated for each indicator vary depending on the indicator and the data available to measure it. For example, these could be periods of one year as in the demographics section (census years 2001 & 2006) or five years in the case of the "Ischemic Heart Disease" indicator (FY 1996/97-2000/01). Where multi-year time periods appear, the numbers presented are cumulative numbers for the specified time period. Most core indicators are based on data to 31 March 2006. However, for this summary, we have added Stats Can estimates of the population of the Downtown area to 2012.

Where available, the statistical significance of the change between the two time periods is reported behind each indicator label as a ***'t'*** and is based on an age- and sex- adjusted rate. Two other labels of statistical significance are attached: ***'1'*** 'indicates that in the first time period, Downtown's rate was statistically different from the Manitoba average at that time; ***'2'*** indicates that in the second time period, the area's rate was statistically different from the Manitoba average at that time.

NOTE: The data included in this profile come from a number of sources. As a result, the ranges of dates used vary from 1996-2000 to 2007-2012.

Downtown Geography & Population (Demographics)



Source: Manitoba Health Population Health Registry File, June 2006.

1A. Geography

Downtown is one of twelve community areas (CAs) within the Winnipeg Health Region and is 16.3 square kilometers in size. Maryland St and Notre Dame Ave separate the two neighborhood clusters of Downtown West and Downtown East. The Downtown CA is further bounded by the Assiniboine River and Red River on the South and East. These rivers border the Downtown CA from River Heights and St. Boniface CAs respectively. The CPR Line and McPhillips St. define the Downtown CA on the West and the North borders. The major traffic routes through the area are Broadway, Logan Ave., Main St., Maryland St., Notre Dame Ave., Portage Ave., Sherbrook St., and St.James St.

1B. Demographics

Detailed population characteristics of the Downtown CA are found in this section. These data are from the Winnipeg Regional Health Authority's Community Health Assessment 2009/10, Manitoba Health's Population Health Registry, and Manitoba Health's Population Report (2012).

The demographic indicators described are:

Population Number of people living in Downtown by age and sex as of June 1, 2007 and 2012 (based on records of residents registered with Manitoba Health)

Population distribution by sex Downtown resident counts & percentages by age group & sex as of June 1, 2007 and 2012.

Population density Number of people per square kilometre in Downtown. This indicator is calculated by dividing the Downtown population by its land area (63.3 sq km)

Percentage age distribution Overall, Downtown CA's age distribution is categorized as children (0-4 year), youth (10-14 and 15-19 years), adults (20-24, 25-44, 45-64 years), seniors (65-74, 75+ years). This is further broken down by sex and shown in population pyramids: the actual number of males and females in each five–year age category (males on the right, females on the left).

Percentage population change States how Downtown CA population numbers have changed over time. The Downtown population on December 31, 2001 is compared with that on December 31, 2006 and December 31, 2007 with that of December 31, 2012.

Child to elderly (dependency) ratio Defined as the ratio of the combined child population (aged 0 to 14 years) and elderly population (aged 65 years and older) to the working age population (aged 15 to 64 years). A region's dependency ratio is a reasonable measure of the likely demands on its health services since those residents under the age 15 and over the age of 64 are more likely to require health services. Children and the elderly are also more likely to be socially and/or economically dependent on those of working age. This ratio is usually presented as the number of dependents for every 100 people in the working age population.

Percentage of lone-parent families The percentage (%) of lone-parent families among all census families living in private households. A census family refers to married or common-law couple or lone parent with at least one never-married son or daughter living in the same household.

Aboriginal People Aboriginal status is a social determinant of health (e.g., rates of infant mortality, smoking and chronic disease are significantly higher among Aboriginal peoples). Knowing the proportion of people in a geographic area who are Aboriginal can help with health planning. Aboriginal peoples are those persons who report identifying with at least one Aboriginal group (e.g., North American Indian, Metis or Inuit and/or those who reported being a Treaty Indian or a Registered Indian as defined by the Indian Act and/or those who were members of an Indian Band or First Nation).

Most frequent language spoken at home The language spoken most often or on a regular basis at home is recorded as part of the Statistics Canada Census. This indicator describes the language spoken most often or on a regular basis at home by individuals at the time of the census (2001, 2006).

A Summary of Downtown CA's Demographics

As of June 1, 2012, the population of the Downtown CA was estimated to be 80,702 which accounts for 11.2% of the population in the Winnipeg Health region (723,491).

From the Manitoba Health Population Report (2012):

- The total population in Downtown **increased** by 7.3% from June 1, 2007 to June 1, 2012;
- The ratio of male to female in the population was 1.04;
- Compared to other CAs, Downtown CA has a higher proportion of children and youth (25.1%) and a mid-range proportion of seniors aged 65 and over (11.2%); the largest age group is 25-44 years old (31.7%);[1]

From Stats Canada (Census Report, 2006):

- Seventeen (17.0%) percent of Downtown CA residents were aboriginal in 2006;
- Most people (89.6%) indicate that English is the most frequent language spoken at home, and 0.1% of the population speaks French at home;
- The dependency ratio (children & elderly to working age population ratio) was 44.0% or approximately 44 dependent persons per 100 residents in 2006

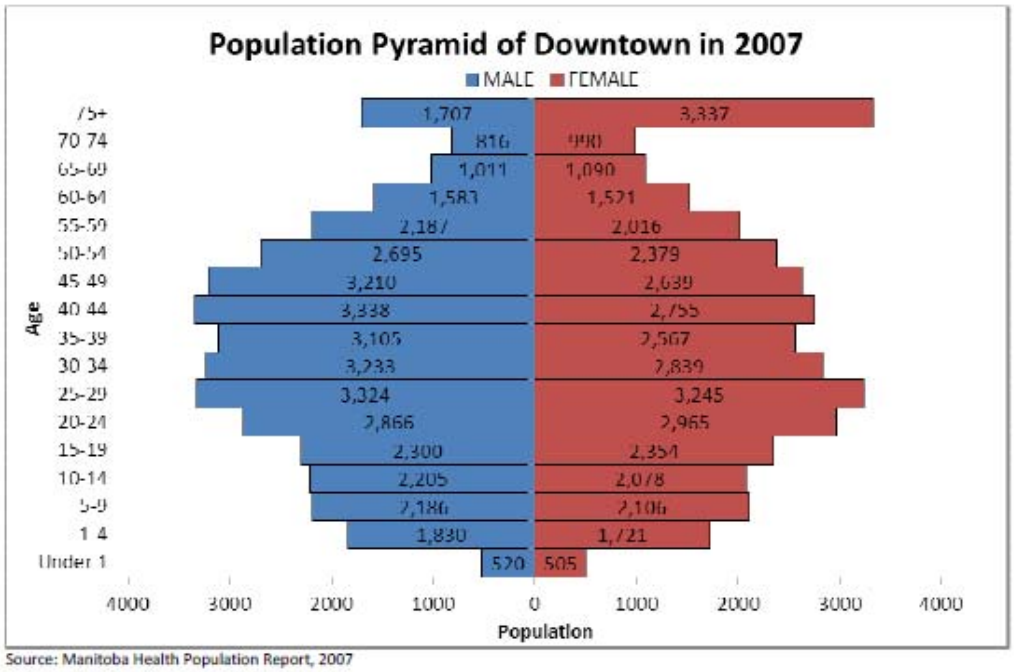
[1] NOTE: actual numbers in the age categories are not known until the next census numbers are available; only percentage estimates were available at the time this report was written.

Downtown CA DEMOGRAPHIC Characteristics *AT A GLANCE*

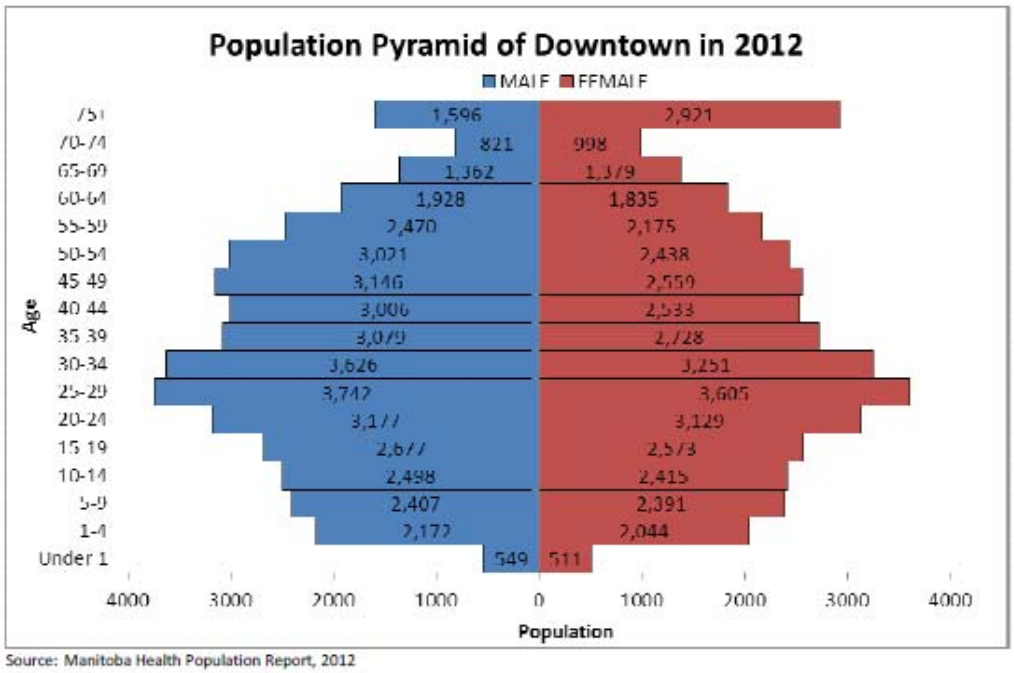
		Current Rate	Previous Rate	Range of Current Estimates (low CA* – high CA*)
MANITOBA POPULATION REPORT:				
Population		**2012**	**2007**	
		80,702	75,223	35,211 – 96,748
Population Distribution by Sex		**2012**	**2007**	
	Male	41,217	37,107	16,912 - 47,045
	Female	39,485	38,116	16,842 - 49,703
Population Density (residents/sq.km)		**2012**	**2007**	
		4951.0	4614.9	460.4 – 4614.9
Percentage Age Distribution	**Children**	**2012**	**2007**	
	0-4 years	5276 (6.5%)	4576 (6.1%)	4.4% - 8.3%
	5-9 years	4798 (5.9%)	4292 (5.7%)	4.2% - 7.4%
	Youth			
	10-14 years	4913 (6.1%)	4283 (5.7%)	4.3% - 7.3%
	15-19 years	5250 (6.5%)	4654 (6.2%)	4.9% - 8.1%
	Adults			
	20-24 years	6246 (7.7%)	5831 (7.8%)	6.6% - 8.7%
	25-44 years	25570 (31.7%)	24406 (32.4%)	22.3% - 32.2%
	45-64 years	19572 (24.3%)	18230 (24.2%)	24.2% - 30.3%
	Seniors			
	65-74 years	4560 (5.7%)	3907 (5.2%)	4.7% - 10.1%
	75+ years	4517 (5.6%)	5044 (6.7%)	4.0% - 9.9%
Percentage Population Change		**Between 2007-2012**	**Between 2001-2006**	
	% Change Total Population	7.3%	16%	-- 3.5% to 18.6%
CENSUS DATA (N/A FOR 2011):				
Dependency Ratio (Child & Elderly to Working Age Ratio)		**2006**	**2001**	
		44.0%	50.6%	43.5%-54.1%
Percentage of Lone-Parent Families		**2006**	**2001**	
	Female	83%	87%	81% - 87%
	Male	17%	14%	13% - 19%
Aboriginal Peoples Living in a Geographic Area		**2006**	**2001**	
		17%	17%	4%-29%
Most Frequent Language Spoken at Home		**2006**	**2001**	
	English only	89.6%	89.7%	69.3 -93.7%
	Both English & French	8.1%	8.0%	4.7 - 28.8%
	Not English or French	2.1%	2.2%	0.3 - 2.1%
	French only	0.1%	0.1%	0.0 - 1.2%

*CA=Community Areas; N/A=Data not available

Data source: 1. Manitoba Health Population Health Registry File, June 2006; 2. Manitoba Health Population Report, June 2007 & 2012 (source: Stats Can estimates); 3. WRHA CHA 2009/10; 4.City of Winnipeg Census Data 2001 and 2006



Source: Manitoba Health Population Report, 2007



Source: Manitoba Health Population Report, 2012

2. Chronic Diseases

Chronic diseases are the leading causes of death and disability among Canadians. This section presents several indicators of chronic disease. Treatment prevalence and incidence of chronic diseases were examined. For many chronic conditions there is no easy way to find out how many people have been diagnosed with the condition, so we use administrative databases to look at how many people are treated for the conditions as an approximation for a confirmed diagnosis. In this section, we use ***treatment prevalence*** to approximate the prevalence of diabetes, hypertension, ischemic heart disease, arthritis, osteoporosis, respiratory diseases, and asthma. Since treated strokes are discrete events, their treatment prevalence approximates the incidence of treated strokes.

The chronic disease indicators described include the following. They are roughly grouped around diabetes and cardiovascular disease, musculoskeletal disease and respiratory disease:

Diabetes prevalence is the proportion of Downtown CA residents age 19 or older who received treatment for diabetes within a 3-year period as identified by at least two physician visits or one hospitalization with a diagnosis of diabetes, or one or more prescriptions for medications used to treat diabetes during that time. Diabetes is a metabolic disorder characterized by the presence of hyperglycemia (high blood sugar) due to defective insulin secretion, defective insulin action or both.

Hypertension (high blood pressure) prevalence is the proportion of Downtown residents age 19 or older who received treatment for hypertension in a 1-year period as identified by either at least one physician visit or one hospitalization with a diagnosis of hypertension or two or more prescriptions for high blood pressure medicines during that time. High blood pressure can strain the heart, damage arteries and the kidneys and increase the risk for ischemic heart disease and stroke.

Ischemic heart disease prevalence is a group of cardiac disorders resulting from insufficient supply of oxygenated blood to the heart usually caused by narrowed or occluded coronary arteries. This indicator is defined as the proportion of Downtown CA residents age 19 or older who received treatment for IHD (including myocardial infarction, angina and other coronary heart diseases) in a 5-year period as identified by either at least two physician visits or one hospitalization with a diagnosis of IHD, or at least one physician visit for IHD and two or more prescriptions for IHD medications during that time period.

Stroke incidence A stroke is a circulatory event that results in rapid loss of brain function(s) due to a disturbance in the blood supply to the brain. Strokes are a significant cause of death and disability. This indicator is defined as the rate of hospitalizations or deaths due to stroke per 1000 residents age 40 or older.

Arthritis prevalence is the proportion of Downtown CA residents age 19 or older who received treatment for rheumatoid or osteoarthritis in a 2-year period as identified by either at least two physician visits or one hospitalization for arthritis or one physician visit and two or more prescriptions for certain prescription medications used to treat arthritis during that time period.

Osteoporosis prevalence is the proportion of Downtown residents age 50 or older who received treatment for osteoporosis in a 3-year period as identified by either at least one physician visit for:

osteoporosis, hip, spine, upper arm or wrist fracture or one or more prescriptions for medications to treat osteoporosis during that time period.

Total respiratory morbidity is measured as the proportion of residents (all ages) who received treatment for any of the following diseases (identified by at least one physician visit or hospitalization) in two, 1-year time periods (2000/01 and 2005/06): asthma, acute bronchitis, chronic bronchitis, bronchitis not specified as acute or chronic, emphysema or chronic airway obstruction.

Asthma (all ages) prevalence is the proportion of individuals resident in Downtown CA who received treatment from a health professional for asthma within a 2-year window is reported. Age-adjusted percentages of asthma in the WHR are reported for each year for a total of 5-years (2002/03 to 2006/07).

Asthma (child) prevalence is the proportion of Downtown children aged 5 to 19 who received treatment for asthma for two, 2-year periods (1999/2000-2000/01 and 2004/05-2005/06).

A Summary of Chronic Diseases in Downtown CA

Based on administrative data, in Downtown CA, the treatment prevalence of diabetes, hypertension, and osteoporosis significantly increased, whereas stroke incidence and total respiratory morbidity significantly decreased over time.* The current prevalence rates of most chronic diseases were lower than the Winnipeg's rate.

- Diabetes prevalence increased by 25.0% over the two time periods (1998-2001 and 2003-2006) in Downtown CA; the increase was also significant in the two neighbourhood clusters (NCs) over time.
- Hypertension prevalence increased significantly (12.4%) in Downtown CA and its two NCs over the two time periods reported on 2000/01 and 2005/06.
- Ischemic heart disease prevalence decreased by 10.8% between the two time periods (1996/97-2000/01 and 2001/02-2005/06); the decrease was significant over time for Downtown East NC.
- The stroke incidence decreased significantly by 32.6% between the two time periods (1996/97-2000/01 and 2001/02-2005/06) in Downtown CA; the decrease was significant for both Downtown East and West (NC) over time.
- Arthritis prevalence decreased by 3.9% over two time periods (1999/00-2000/01 and 2004/05-2005-06). The decrease was significant for Downtown West NC at 5.6%.
- Osteoporosis prevalence significantly increased by 19.4% in Downtown over two time periods (1998/99-2000/01 and 2003/04-2005/06).
- Total respiratory morbidity decreased by 8.1% in Downtown CA, and the decrease was significant over time.
- The prevalence of asthma in children remained stable for two 2-year periods (1999/2000-2000/01 and 2004/05-2005/06), with a non-significant increase of 1.7%.

* percentage change is based on crude rates vs. the adjusted rates reported.

Downtown CA CHRONIC DISEASES *AT A GLANCE*

		Current Rate*	Previous Rate*	Range of Current Estimates (low CA** – high CA**)
Diabetes (1,2,t)		10.3% 2003/04-2005/06	8.2% 1998/99-2000/01	Assiniboine South 5.9%- Point Douglas 11.3%
Hypertension (t)		23.3% 2005/6	20.3% 2000/01	Assiniboine South 21.3%- Inkster 26.1%
Ischemic Heart Disease (IHD) (t)		8.3% 2001/02-2005/06	9.0% 1996/97-2000/01	Ft. Garry 7.8%- Point Douglas 10.0%
Stroke Incidence (t)		2.9/1000 2001/02-2005/06	4.0/1000 1996/97-2000/01	St. Boniface 2.1/1000 – River East 3.2/1000
Arthritis (1,2,t)		22.4% 2004/05-2005/06	23.1% 1999/00-2000/01	Ft. Garry 18.0%- Point Douglas 24.9%
Osteoporosis (t)		12.8% 2003/04-2005/06	10.4% 1998/99-2000/01	Inkster 10.0%- Assiniboine & St. James - Assiniboia 14.3%
Total Respiratory Morbidity (t)		13.5% 2005/06	14.6% 2000/01	Ft. Garry 10.8%- Point Douglas 17.5%
Asthma (All Ages) Age standardized cases per 1000 residents	Male	74	73	Transcona 64- Inskter 90
	Female	86 2006/07	84 2002/03	St. Vital 72- Point Douglas 106
Asthma (CHILD) (2)		15.8% 2004/05-2005/06	15.2% 1999/00-2000/01	Transcona & St.Boniface 14.6% Inskter 19.0%

Source: WRHA CHA, 2009/10

*All rates are age- and sex-adjusted to the Manitoba population in the 1st time period of the rate/event calculation, where possible. However, percentage change calculations from one time period to the next time period are based on crude rates.

**CA=Community Areas

'1' indicates that in the first time period, the area's rate was statistically different from the MB average at that time.
'2' indicates that in the second time period, the area's rate was statistically different from the MB average at that time
't' indicates for that area, the change in rates from time 1 to time 2 was significant

Downtown Neighborhoods: CHRONIC DISEASES *AT A GLANCE*

Diabetes

Crude percent of residents aged 19+ for diabetes

	Cases	Current % 2003/04-2005/06	Cases	Previous % 1998/99-2000/01	Range of Current Estimates (low NC *– high NC*)
Downtown W (t)	2407	8.5	1910	6.7	River East N 4.9-
Downtown E (1,2,t)	2674	10.2	2052	8.3	Point Douglas S 13.0

Hypertension

Crude percent of residents aged 19+ treated for high blood pressure

	Cases	Current % 2005/06	Cases	Previous % 2000/01	Range of Current Estimates (low NC* – high NC*)
Downtown W (t)	5934	20.8	5315	18.6	River East N 20.0-
Downtown E (t)	5303	20.1	4546	17.8	River East W 29.0

Ischemic Heart Disease

Crude percent of residents aged 19+ treated for ischemic heart disease

	Cases	Current % 2001/02-2005/06	Cases	Previous % 1996/97-2000/01	Range of Current Estimates (low NC *– high NC*)
Downtown W	2013	7.1	2158	7.6	Inkster W 4.5-
Downtown E (t)	2006	7.5	2162	8.8	St James-Assiniboia E 11.8

Stroke Incidence

Crude annual rate of death or hospitalization for stroke, per 1000 residents aged 40+

	Current Rate 2001/02-2005/06	Previous Rate 1996/97-2000/01	Range of Current Estimates (low NC* – high NC*)
Downtown W (t)	2.5/1000	4.2/1000	St. Boniface E 1.2-
Downtown E (t)	3.4/1000	4.5/1000	Point Douglas S 4.7

Source: WRHA CHA, 2009/10

*NC=Neighborhood Clusters

'1' indicates that in the first time period, the area's rate was statistically different from the MB average at that time.
'2' indicates that in the second time period, the area's rate was statistically different from the MB average at that time
't' indicates for that area, the change in rates from time 1 to time 2 was significant

Arthritis

Crude percent of residents aged 19+ treated for arthritis

	Cases	Current % 2004/05-2005/06	Cases	Previous % 1999/00-2000/01	Range of Current Estimates (low NC *– high NC*)
Downtown W (t)	5546	19.5	5902	20.6	Inkster W 16.3-
Downtown E (1,2)	6067	22.9	6016	23.6	Point Douglas S 29.7

Osteoporosis

Crude percent of residents aged 19+ treated for osteoporosis

	Cases	Current % 2003/04-2005/06	Cases	Previous % 1998/99-2000/01	Range of Current Estimates (low NC* – high NC*)
Downtown W	1217	12.4	945	10.0	Inkster W 6.9- St.-
Downtown E (t)	1227	14.1	1022	12.3	James Assiniboia E 17.5

Total Respiratory Morbidity

Crude percent of residents (all ages) treated for respiratory disease

	Cases	Current % 2004/05-2005/06	Cases	Previous % 1999/00-2000/01	Range of Current Estimates (low NC *– high NC*)
Downtown W (1,2,t)	4727	12.6	5349	13.9	River East N 8.9-
Downtown E (1,2,t)	4826	13.9	5068	15.0	Point Douglas S 19.7

Child Asthma

Crude percent of children aged 5-19 diagnosed with asthma

	Cases	Current % 2004/05-2005/06	Cases	Previous % 1999/00-2000/01	Range of Current Estimates (low NC* – high NC*)
Downtown W (1,2)	2013	16.0	1195	16.1	St. Boniface E 14.4-
Downtown E	2006	15.8	731	15.0	Inkster E 19.4

WRHA CHA, 2009/10

*NC=Neighborhood Clusters

'1' indicates that in the first time period, the area's rate was statistically different from the MB average at that time.
'2' indicates that in the second time period, the area's rate was statistically different from the MB average at that time
't' indicates for that area, the change in rates from time 1 to time 2 was significant

3. Mental Health Disorders

This section presents several indicators focused on the **treatment prevalence of certain mental illnesses** in the Downtown CA. By "treatment prevalence" we mean that only those persons who have received certain types of health services or treatment for the disorder (by visiting a doctor, being admitted to a hospital and/or having a prescription dispensed) are counted in our rates, but those who may have undetected disorders, disorders that do not require frequent medical care, and those not receiving the care they may need for their condition are not counted.

This must be kept in mind when treatment prevalence rates are interpreted—rates that change may mean that the disease is actually getting more or less common, or it may mean that more or less people are getting diagnosed or receiving care. For example, an increase in the treatment prevalence for anxiety disorders could mean that more people are anxious or that more people are having their anxiety diagnosed and treated appropriately. We just do not know based on these rates.

Please note that the comparison of these mental illness prevalence indicators to results of other studies is challenging because of differences in data sources and definitions used.

The indicators for mental health disorders include:

Mood disorders and/or use of antidepressants/mood stabilizers is an indicator that refers to all Downtown residents age 10 or older who have been treated for a large number of mental illnesses including depressive and bipolar disorders, affective psychoses, neurotic depression, adjustment reaction and/or anxiety disorders (when combined with a dispensed prescription for antidepressants or mood stabilizers). Consequently, this indicator does not correspond to any single, clinically-defined mental illness, and should be interpreted with caution.

Anxiety disorders is based on counting among Downtown CA residents age 10 or older, hospitalizations and physician visits for a number of conditions including anxiety states, phobic disorders and obsessive-compulsive disorders.

Substance abuse is defined as the proportion of Downtown CA's residents age 10 or older who were treated for alcoholic or drug psychoses, alcohol or drug dependence or nondependent abuse of drugs.

Personality disorders is an indicator based on a diagnosis of any personality disorder as identified in hospital or physician claims in residents age 10 or older. The treatment prevalence of personality disorders has remained stable over time

Schizophrenia is based on a diagnosis of schizophrenia as identified in hospital or physician claims. The treatment prevalence in the WHR (2001-2006,) was 1.20%. Records going back 12 years were examined to ensure inclusion of residents diagnosed earlier but who may not have had the diagnosis attributed to recent hospitalizations or physician visits.

One or more of the mental disorderslisted above (cumulative mental illness) combines the occurrence of many mental illnesses in one person and provides an overall description of the prevalence of mental illness; it accounts for the considerable co-occurrence among mental illnesses. Five mental illness diagnoses are included in its calculation: depression, anxiety, substance abuse, personality disorders or schizophrenia.

Dementia (in persons aged 55 and over) is not a mental illness but was included in this section for convenience. Dementia refers to a group of illnesses characterized by progressive decline in several mental functions including memory, learning, and communication. Therefore, the definition of dementia in Downtown residents 55 years of age and older involves many diagnostic codes included in hospital and physician visit data.

A Summary of Mental Health Disorders in Downtown

The data show that the treatment prevalence of mood disorder, anxiety, cumulative mental disorders and dementia increased significantly over time. The treatment prevalence of substance abuse decreased significantly over time. In addition, the prevalence rate of dementia was higher than Winnipeg's prevalence rate.

- The prevalence of mood disorders increased significantly in all CAs and Winnipeg overall; Downtown had a significant rate increase of 14.1% over the two time periods (1996/97-2000/01 and 2001/02-2005/06).
- The prevalence of anxiety disorders increased significantly in all CAs and Winnipeg overall; Downtown experienced 24.1% increase over the two time periods (1996/97-2000/01 and 2001/02-2005/06). Both NCs experienced significant increases at 21.6% and 25.0% for Downtown West and East respectively.
- The prevalence of substance abuse remained stable with a non-significant increase of 6.8% over the two time periods (1996/97-2000/01 and 2001/02-2005/06).
- The prevalence rates of personality disorder and schizophrenia remained stable in Downtown and its neighborhood clusters over the two time periods.
- Cumulative mental illness showed a significant increase (10.9%) over time.
- Dementia prevalence (in those aged 55 or more) increased significantly in the Downtown community area (14.6%) and Downtown West (NC) over time (26.0%).

Downtown CA MENTAL HEALTH DISORDERS *AT A GLANCE*

	Current Rate*	Previous Rate*	Range of Current Estimates (low CA **– high CA**)
Mood disorders and/or use of antidepressants/ mood stabilizers (2,t)	20.3% 2001/02-2005/06	17.6% 1996/97-2000/01	Inkster 15.8% - Point Douglas 22.5%
Anxiety Disorders (1,2,t)	9.5% 2001/02-2005/06	7.6% 1996/97-2000/01	Fort Garry 6.8% – Transcona 11.2%
Substance Abuse (1,2)	8.0% 2001/02-2005/06	7.7% 1996/97-2000/01	Fort Garry 2.6 – Point Douglas 9.1%
Personality Disorder (1,2)	1.8% 2001/02-2005/06	1.6% 1996/97-2000/01	Inkster 0.66%- Downtown 1.77%
Schizophrenia (1,2)	2.7% 2001/02-2005/06	2.5% 1996/97-2000/01	Transcona 0.69 – Downtown 2.65%
One or more Mental Disorders (cumulative mental illness) (1,2,t)	27.8% 2001/02-2005/06	25.0% 1996/97-2000/01	Fort Garry 20.9% – Point Douglas 29.8%
Dementia (age 55 +) (1,2,t)	12.5% 2001/02-2005/06	11.2% 1996/97-2000/01	Inkster 9.68%- Point Douglas 12.9%

Source: WRHA CHA, 2009/10

*All rates are age- and sex-adjusted to the Manitoba population in the 1st time period of the rate/event calculation
**CA=Community Areas

'1' indicates that in the first time period, the area's rate was statistically different from the MB average at that time.
'2' indicates that in the second time period, the area's rate was statistically different from the MB average at that time
't' indicates for that area, the change in rates from time 1 to time 2 was significant

Downtown Neighborhoods: MENTAL HEALTH DISORDERS *AT A GLANCE*

Mood Disorder and/or Use of Antidepressants/Mood Stabilizers

Crude percent of residents aged 10+ for depression

	Cases	Current % 2001/02-2005/06	Cases	Previous % 1996/97-2000/01	Range of Current Estimates (low NC* – high NC*)
Downtown W (t)	6761	18.7	5837	16.4	Point Douglas S 24.8-
Downtown E (1,2,t)	7788	22.2	6221	19.6	Inkster W 13.7

Anxiety Disorders

Crude percent of residents aged 10+ for Anxiety Disorders

	Cases	Current % 2001/02-2005/06	Cases	Previous % 1996/97-2000/01	Range of Current Estimates (low NC *– high NC*)
Downtown W (t)	3003	8.3	2432	6.8	Fort Garry N 6.5-
Downtown E (1,2,t)	3749	10.7	2716	8.5	Transcona 11.0

Substance Abuse

Crude percent of residents aged 10+ treated for substance abuse

	Cases	Current % 2001/02-2005/06	Cases	Previous % 1996/97-2000/01	Range of Current Estimates (low NC* – high NC*)
Downtown W	2255	6.3	2093	5.9	Fort Garry N 2.5 -
Downtown E (1,2)	3676	10.5	3158	9.9	Point Douglas S 14.2

Personality Disorder

Crude percent of residents aged 10+ for personality disorder

	Case	Current % 2001/02-2005/06	Cases	Previous % 1996/97-2000/01	Range of Current Estimates (low NC* – high NC*)
Downtown W (1,2)	466	1.3	454	1.3	Inkster W 0.3-
Downtown E (1,2)	869	2.5	677	2.1	Downtown E & River Heights E 2.5

Source: WRHA CHA, 2009/10

*NC=Neighborhood Clusters

'1' indicates that in the first time period, the area's rate was statistically different from the MB average at that time.
'2' indicates that in the second time period, the area's rate was statistically different from the MB average at that time
't' indicates for that area, the change in rates from time 1 to time 2 was significant

Schizophrenia

Crude percent of residents aged 10+ treated for schizophrenia

	Cases	Current % 2001/02-2005/06	Cases	Previous % 1996/97-2000/01	Range of Current Estimates (low NC* – high NC*)
Downtown W (1,2)	716	2.0	640	1.8	River East N 0.4-
Downtown E (1,2)	1256	3.6	1080	3.4	Downtown E 3.6

One or More Mental Disorders (Cumulative Mental Illness)

Crude percent of residents aged 10+ treated for cumulative mental illness

	Cases	Current % 2001/02-2005/06	Cases	Previous % 1996/97-2000/01	Range of Current Estimates (low NC *– high NC*)
Downtown W (t)	9137	25.3	7998	22.5	Inkster W 19.9-
Downtown E (1,2)	10830	30.9	9025	28.4	Point Douglas S 34.4

Dementia (age 55+)

Crude percent of residents aged 55+ for dementia

	Cases	Current % 2001/02-2005/06	Cases	Previous % 1996/97-2000/01	Range of Current Estimates (low NC* – high NC*)
Downtown W (t)	942	12.2	753	9.7	Inkster W 3.7-
Downtown E (1,2)	1072	14.9	1019	14.1	Point Douglas S 23.1

Source: WRHA CHA, 2009/10

*NC=Neighborhood Clusters

'1' indicates that in the first time period, the area's rate was statistically different from the MB average at that time.
'2' indicates that in the second time period, the area's rate was statistically different from the MB average at that time
't' indicates for that area, the change in rates from time 1 to time 2 was significant

4. Health Risk Factors

This section examines a small number of indicators (3) related to the risk of acquiring chronic diseases; they are indicators of smoking, body weight and physical activity. A description of each indicator can be found below.

Our source of these data is the Canadian Community Health Survey (CCHS) administered to a random sample of Manitobans in 2001, 2003 and 2005. The CCHS provides cross-sectional estimates of health determinants such as life-style risk factors. However, these data are collected by telephone interview and answers can be affected by personal bias and recall error. To overcome sample size issues (and especially to allow for community area (CA) descriptions like those for Downtown), data from several years of CCHS administration are combined. As a result, changes over time could not be analyzed and a single (multi-year) time period is reported here. Additionally, by combining the cycles, some of the data contributing to the proportions described are nearly a decade old and may no longer reflect current behaviours. More information on the CCHS can be found on the Statistics Canada website in particular details on the CCHS sampling methodology and its limitations : www.statcan.gc.ca/imdb-bmdi/3226-eng.htm

Three health risk factors are reported in this section:

Smoking We report on the proportion (%) of respondents to the CCHS (2001, 2003, 2005) aged 12 and over who reported being either a current, former or non-smoker. Responses to several questions are grouped accordingly: 'Current Smoker' (includes daily smoker, occasional daily smoker who previously was a daily smoker and always an occasional smoker), 'Former Smoker' (includes former daily smoker and former occasional smoker), and 'Non–smoker' (never smoked).

Total activity level (work + leisure + travel) Physical activity improves health and well-being. It reduces stress, improves cardiovascular functioning, has a positive effect on mood, energy levels and academic performance and helps achieve and maintain a healthy body weight. Research shows that physical inactivity can also contribute to chronic disease, disability and premature death. An index approximating total physical activity was created from responses to various CCHS questions in order to calculate total energy expenditure levels for respondents aged 15–75 years. It is based on physical activity undertaken during both work–time and leisure–time in the respondents' previous three months and is measured in average kilocalories per kilogram body weight per day (kcal/kg/d). Respondents were grouped into three categories: active (≥3 kcal/kg/d), moderate (1.5 to <3 kcal/kg/d), or inactive <1.5 kcal/kg/d) based on current energy expenditure conventions.

Body mass index (BMI) is a measure used to classify and compare individuals according to their height and weight. It is calculated as weight (in kilograms) divided by height (in metres) squared. BMIs that are too high or too low are associated with a variety of health risks. BMI for respondents to the CCHS aged 18 years and over was calculated from self-reported height and weight and presented in standard categories as follows: underweight or normal (BMI less than 25), overweight (BMI 25-29) and obese (BMI 30+). In Winnipeg, 47.4% of respondents fall into the "underweight/normal" category (Manitoba 44.2%) which means that the majority of Winnipeg adults are not in the normal BMI category.

A Summary of Health Risk Factors in Downtown

Smoking tobacco has a number of negative health effects in people of all ages, and remains a leading cause of preventable death. Total activity level improves cardiovascular functioning and also has a positive effect on mood, energy helping to achieve a healthy body weight. BMIs that are too high or too low are associated with a variety of health risks.

- According to the Canadian Community Health Survey (CCHS) 2001-2005, a 26.1% sample of Downtown respondents have indicated that they were current smokers (Winnipeg 22.1%).
- According to CCHS (2001-2005), approximately 31.0% of Downtown respondents fall into an "active" physical activity category (Winnipeg 25.3%). This is statistically comparable (p>0.05) to the Manitoba average of 29.5%.
- Approximately 16.5% of Downtown respondents (all CCHS waves) were categorized as "obese".

Downtown CA HEALTH RISK FACTORS *AT A GLANCE*

	Current smoker	Former Smoker	Non-smoker
Smoking (CCHS 2001-2005)	26.1%	**30.2%**	43.6%
	Active (≥3kcal/kg/d)	**Moderate (1.5 to < 3 kcal/kg/d)**	**Inactive (<1.5 kcal/kg/d)**
Total Activity Level (Work+Leisure +Travel) (CCHS 2001-2005)	31.0%	29.2%	39.8%
	% Normal + Underweight	**% Overweight +**	**% Obese**
Body Mass Index (BMI) Age-adjusted (males and females combined, aged 18 and older)	**53.7%**	29.8%	16.5%

Source: 1) WRHA CHA, 2009/10;
2) Manitoba Centre for Health Policy, 2011

***Bold** indicates that rate was statistically different from the Manitoba average (p<.05)

Downtown Neighborhoods: HEALTH RISK FACTORS *AT A GLANCE*

Smoking

	Current Smoker	Former Smoker	Non-Smoker
Downtown W	23.3%	29.5%	47.2%
Downtown E	**33.7%**	29.3%	37.1%

Total Activity Level (Work+ Leisure+Travel)

	Active	Moderate	Inactive
Downtown W	31.5%	*27.1%*	41.4%
Downtown E	35.4%	30.8%	33.8%

Body Mass Index (BMI)

	Underweight + Normal	Overweight	Obese
Downtown W	55.6%	*28.9%*	15.5%
Downtown E	52.6%	33.1%	14.3%

Source: WRHA CHA, 2009/10

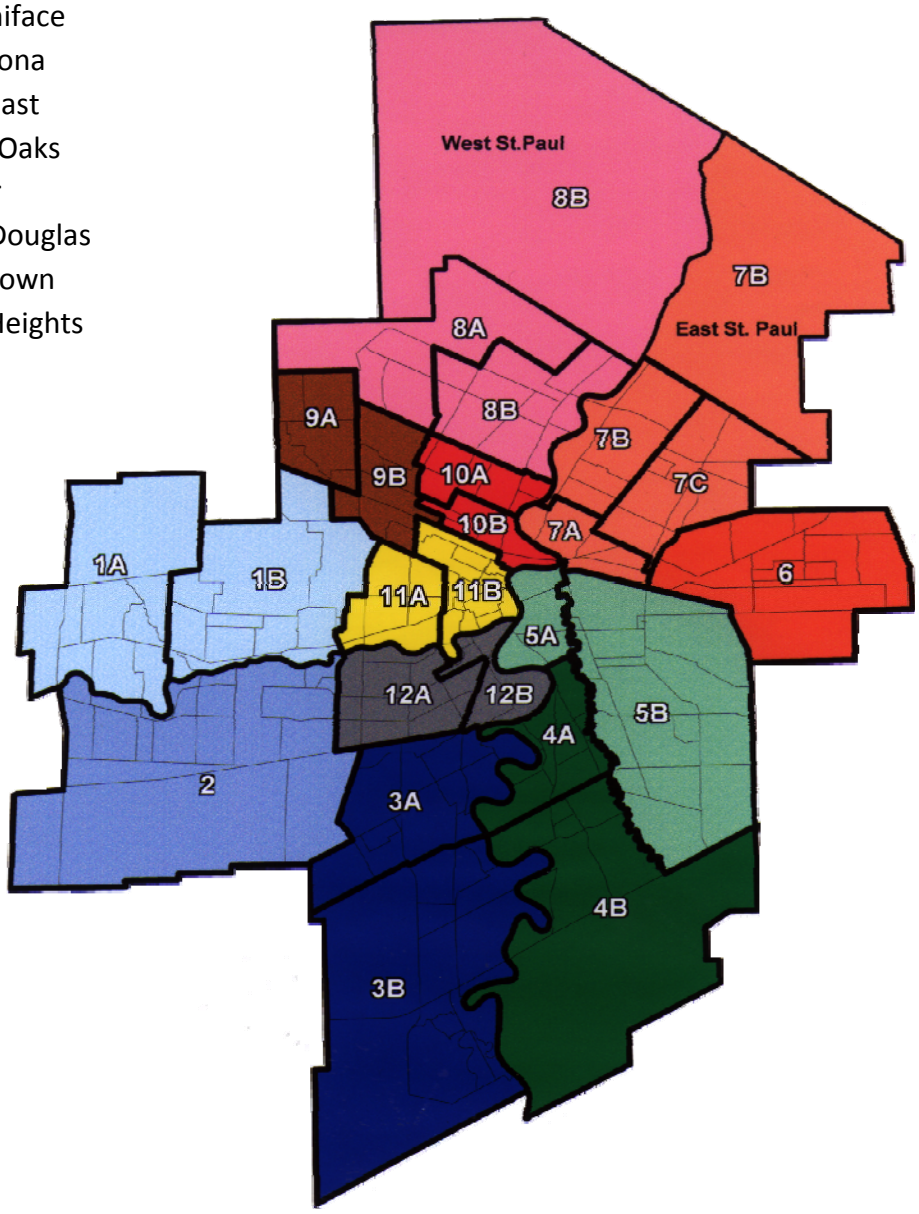
*NC=Neighborhood Clusters

Bold-indicates area's rate was statistically different from Manitoba average.
Italics-indicates a warning-the area's rate is highly variable and should be interpreted with caution.

Appendix F

Map of the Community Areas in the Winnipeg Health Region

1 St. James – Assiniboia
2 Assiniboine South
3 Fort Garry
4 St. Vital
5 St. Boniface
6 Transcona
7 River East
8 Seven Oaks
9 Inkster
10 Point Douglas
11 Downtown
12 River Heights



Appendix G

Acknowledgements
Members of the Local Health Involvement Groups
Board Liaisons to the Groups
Support Staff for Groups

Members of Local Health Involvement Groups
2013-2014

Downtown/Point Douglas Group

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Shirley Murray
Elsie Nabroski
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St. James-Assiniboia/Assiniboine South Group

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Angela Keno
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Bruce Thompson and Jeff Cook	River Heights/Fort Garry
Stuart Greenfield and Elaine Bishop	Seven Oaks/Inkster
Josée Lemoine and Rob Santos	St. Boniface/St. Vital
Joanne Biggs and Jean Friesen	St. James-Assiniboia/Assiniboine South

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Susan Stratford	St. Boniface/St. Vital
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