

Interlake-Eastern Regional Health Authority
Community Health Assessment
2019



Interlake-Eastern
Regional Health Authority

Executive Summary	i
Introduction	ii
Acknowledgements	ii
Community Health Assessment (CHA) in Manitoba	ii
Community Health Assessment Network (CHAN)	iii
CHA Purpose and Use	iii
Community Health Assessments and the Manitoba Quality and Learning Framework (MLQF)	iii
Provincial Template for CHA Reports	v
Population Health and Health Equity	vi
First Nations People’s Health in Manitoba	ix
Data Sources and Limitations	xi
Data Presentation and Interpretation	xiv
Geographic Boundaries	xiv
Rates and Prevalence	xiv
Adjusted Rates and Crude Values	xv
Visualization of Data	xv
Graphing the two time periods:	xvii
Understanding the sliding scale:	xvii
Interpreting the Data	xviii
Zone and District Tables	xix
Disparity Measures	xix
CHAPTER 1: WHO IS INTERLAKE-EASTERN REGIONAL HEALTH AUTHORITY?	1
Tables and Figures	2
At A Glance: Who is Interlake-Eastern Regional Health Authority?	3
Why is this Chapter Important?	3
Chapter 1 Key Findings	4
Geography Boundaries	5
Programs and Services	7
Population	9
Population Pyramids	10
Birth Rate	11
Internal Migrant Mobility	13

Table of Contents

Population Density	15
Population Change over Time	16
Population Projections	17
Indigenous Population	18
Visible Minority Population	21
Language Spoken at Home	23
Knowledge of French	24
Immigrant Status in Private Households	26
Immigration by Place of Birth	27
Lone Parent Families	28
Dependency Ratio	29
CHAPTER 2: WHAT KEEPS US HEALTHY?	32
Table of Figures	35
At A Glance: What Keeps Us Healthy?	38
Why is this Chapter Important?	38
Chapter 2 Key Findings	39
What influences how healthy our population is?	40
Social Determinants of Health	42
Social Deprivation Index	42
Material Deprivation Index	44
Median Household Income—After-Tax	46
Low-income Measure – After-Tax (LIM-AT)	48
Household Food Insecurity	50
Housing Affordability	51
Educational Attainment	53
Labour Force Participation	56
Unemployment Rates	57
Industry Sectors	58
Work Stress	59
Healthy Child Development	60
Inadequate Prenatal Care	60
Preterm Birth Rate	62

Table of Contents

Small for Gestational Age (SGA)	64
Large for Gestational Age (LGA)	66
Breastfeeding Initiation	68
Proportion of Children Low-income	70
Families First – Risk Factors	72
Readiness for School Learning	74
Pediatric Dental Extractions under General Anesthesia	78
Childhood Immunization	82
Teen Pregnancy Rate	84
Teen Birth Rate	86
Personal Health Determinants	89
Quality of Life	89
Self-Rated General Health	89
Self-Rated Mental Health	90
Life Stress	91
Sense of Community Belonging	92
Changes Made to Improve Health	93
Body Mass Index (BMI)	94
Substance Use Disorders	95
Drug Methods	96
Alcohol Use	97
Tobacco Use/Smoking	99
Second-hand Smoke Exposure	100
Physical Activity – Adults	101
Participation and Activity Limitation	102
Fruit and Vegetable Consumption	103
Sleep Time	104
Driving and Safety – Cell Phone Use While Driving	105
Driving and Safety – ATV Helmet Use	106
Use of Preventive Services	108
Influenza Immunization (age 65+)	108
Pneumococcal Immunizations (age 65+)	110

Table of Contents

Colorectal Cancer Screening	112
Breast Cancer Screening	114
Cervical Cancer Screening	116
Oral Health (Dental Visits/Insurance)	118
CHAPTER 3: HOW HEALTHY ARE WE?	119
Tables and Figures	122
At A Glance: How Healthy Are We?	125
Chapter 3 Key Findings	126
Mortality	128
Life Expectancy	128
Total Mortality Rates	132
Premature Mortality Rate (PMR)	134
Infant Mortality	137
Child Mortality	138
Potential Years of Life Lost (PYLL)—All Deaths	139
Potential Years of Life Lost—Unintentional Injuries	142
Potential Years of Life Lost — Suicide	143
Potentially Avoidable Deaths	144
Unintentional Injury Causes of Death	146
Cancers	149
Cancer Incidence — All Cancers	149
Cancer Incidence—Top 4 Diagnoses	151
Cancer Mortality — All & Top 4	152
Cancer Late Stage Diagnosis	153
Cancer Survival—All & Top 4	155
Cardiovascular	159
Hypertension Prevalence	159
Ischemic Heart Disease Prevalence	161
Heart Attack Incidence Rate	163
Congestive Heart Failure Prevalence	165
Stroke Rate	167
Diabetes	170

Table of Contents

Diabetes Incidence	170
Diabetes Prevalence	172
Lower Limb Amputation Due to Diabetes	174
Diabetes Care - Eye Exams	176
Injury	180
Injury Hospitalization - Intentional	180
Injury Hospitalization - Unintentional	182
Hip Fracture Hospitalization Rate	184
Mental Illness	187
Mood & Anxiety Disorders	187
Dementia Prevalence	189
Antidepressant Prescription	191
Suicide Rates	193
Musculoskeletal	196
Arthritis Prevalence	196
Osteoporosis Prevalence	198
Renal	201
Chronic Kidney Disease Prevalence	201
End Stage Kidney Disease	202
Observed and Projected End Stage Kidney Disease	203
Respiratory	206
Total Respiratory Morbidity (TRM) Prevalence	206
Asthma Prevalence for Children	208
Asthma Care: Controller Medication Use	210
Communicable Diseases: Sexually Transmitted Infections	213
Chlamydia Rates	213
Gonorrhea Rates	214
HIV Rates	215
Syphilis Rates	216
CHAPTER 4: HOW WELL DOES OUR HEALTH SYSTEM MEET THE POPULATION'S NEEDS?	218
Tables and Figures	218
At A Glance: How Well Does Our Health System Meet the Population's Needs?	220

Chapter 4 Key Findings	221
Primary Health Care	222
Physician Use	222
Use of Physicians and Nurse Practitioners	222
Ambulatory Visits to Physicians and Nurse Practitioners	224
Location Visits to Physicians or Nurse Practitioner	227
Ambulatory Consultation	228
Majority of Care—Continuity	230
Ambulatory Care Sensitive Conditions (ACSC) Hospitalization Rates	232
Benzodiazepine Overprescribing Community-Dwelling Older Adults (75+)	234
Access to a Regular Health Care Provider	237
Type of Place for Minor Health Problem (Primary Care)	238
Reasons for No Regular Health Care Provider	240
Wait Time for Minor Health Problem	242
Coordination Between Health Professionals and Other Providers	243
Acute Care	245
Use of Hospitals	245
Inpatient Hospitalization Rate	247
Hospital Days for Acute Care	250
Where Residents Were Hospitalized: Hospital Location	253
Hospital Days for Alternate Level of Care Stays	254
Hospital Catchment: Where Patients Using RHA Hospitals Came From	256
Hospital Readmission Rates	257
Caesarean Section	259
Vaginal Birth after Caesarean Section (VBAC)	261
Canadian Patient Experience Survey—Inpatient Care	263
Home Care	266
Home Care Regional Prevalence	266
Duration of Care: How Long On Average People Receive Health Care Aid/Home Support Worker Services	268
Wait Time from Intake to First Visit	269
Personal Care Homes	270
Residents in Personal Care Homes	270

Table of Contents

Level of Care on Admission to Personal Care Homes _____	272
Median Wait Times for Personal Care Home Admission _____	273
Benzodiazepine overprescribing—Personal Care Homes (75+) _____	276
Appendices _____	278
Appendix A: Acronyms _____	278
Appendix B: Community Health Assessment Indicator Selection Process – for the 5th CHA cycle in Manitoba 2015-2019 _____	280
Endnotes _____	283

Executive Summary

This section summarizes the high-level findings from the 2019 Community Health Assessment (CHA) report for Interlake-Eastern Regional Health Authority (IERHA).

Our Residents

The unique characteristics of our region influence the factors that determine how healthy we are and have a significant impact on the need for appropriate services and programs. Population trends show the number of aging residents is growing in Interlake-Eastern. We have a larger percentage of residents ages 50-79 living in the region compared to Manitoba. As well, nearly one in three IERHA residents self-identify as Indigenous (27%), compared with the provincial average of one in five residents (18%). Our spike in population during the summer months also impacts our program and service planning.

How Healthy Are We?

Interlake-Eastern rates of many chronic diseases are higher compared to the provincial average. This includes rates for cancer, hypertension (high blood pressure), diabetes and childhood asthma.

Diabetes incidence is significantly higher than the provincial rate, with one of every ten residents diagnosed with diabetes. The management of all chronic diseases through community based programs is important in maintaining health and avoiding hospitalization. The chronic disease program, comprised of nurses and dietitians, focuses on the prevention and management of diabetes and other chronic conditions. This is an example of targeted services provided to meet the needs of residents in the region.

There was a significant decrease in the number of residents suffering from heart attack and stroke even though rates are above the provincial average. Improvement was also noted in colorectal screening rates and hip fracture hospitalization rates.

Feedback

The Canadian Patient Experience Survey – Inpatient Care tool lets hospitalized patients provide feedback regarding the care they received. Questions focus on continuity of care, partnership and participation in care by the patient and family, and physical comfort. Sixty-nine percent of Interlake-Eastern patients indicated that they had a ‘very good’ hospital stay, which was slightly higher than the provincial rate.

Disparity and Health Inequities

The region has the smallest percentage of children living in low-income families among all regions in Manitoba. However, there is significant variation between geographic zones within the region, with four of five zones having rates almost twice as high as the provincial average. Similarly, the burden of disease varies between the geographic zones and between age groupings, gender, and income ratios.

Throughout the report health inequities are highlighted where available and appropriate. Addressing inequities is a growing priority for the region, local communities, and governments at all levels.

To view the complete report visit www.ierha.ca click ‘About Us’ and then ‘Publications and Reports’ – ‘Community Health Assessment 2019’

Introduction

Acknowledgements

The team would like to express gratitude to those that have participated and contributed to the Community Health Assessment (CHA) process. The 2019 CHA process has been a true collaboration. We would like to thank all Community Health Assessment Network members from across the province, as well as staff at Manitoba Health, Seniors and Active Living for their continued support and guidance. Thanks also to all the researchers at the Manitoba Centre for Health Policy and CancerCare Manitoba for providing the data and statistical support to our health region. We are truly fortunate to have such commitment and dedication in Manitoba. If you wish to provide feedback on the report, please email: info@ierha.ca.

Community Health Assessment (CHA) in Manitoba

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.¹

Understanding the health needs and assets of the people that live in Interlake-Eastern Regional Health Authority is critical to effectively planning programs and services. Access to local health data supports planning for policies and programs that are responsive to communities' unique needs and will most benefit their residents.

In Manitoba, this understanding is gained through legislated CHAs. This is the 5th cycle of CHA in Manitoba. The dates of the previous CHA cycles are as follows:

- 1st CHA cycle - 1997/98
- 2nd CHA cycle - 2004
- 3rd CHA cycle - 2009
- 4th CHA cycle - 2015

Using a population health approach, CHAs provide baseline information about the health status, determinants of health, and health system utilization of community residents. The CHA also tracks health outcomes over time, identifies opportunities for health promotion and disease prevention, and describes the conditions that contribute to health disparities.

The CHA allows us to begin to understand ourselves: who we are, our strengths, our challenges, and how our health system responds to our needs. One of the strengths of the CHA is that it presents data from several time periods to reflect health trends to help identify areas needing priority action.

“Community” can refer to all persons living in a certain region, or it might refer to groups of people with common characteristics or interests, for example: women, youth, seniors, cultural groups or those living with specific health issues.

In other jurisdictions, CHA work is captured under the term “Population and Public Health Surveillance” (PPHS) which is defined as “the collection, analysis, interpretation, and dissemination of data about demography, socio-economic status, health status and chronic diseases as well as their protective and risk factors”.ⁱⁱ

Community Health Assessment Network (CHAN)

CHAN enables a coordinated approach to province-wide comparability on health issues within health regions, while recognizing and respecting the diversity among them. The Community Health Assessment Network (CHAN) is a provincially coordinated, collaborative group comprised of representatives from:

- Manitoba Health Seniors and Active Living
- Department of Education (Healthy Child MB)
- Manitoba Centre for Health Policy (MCHP)
- George & Fay Yee Centre for Healthcare Innovation
- Service Delivery Organizations:
 - Shared Health/Soins communs (SH)
 - CancerCare Manitoba (CCMB)
 - Addictions Foundation of Manitoba
 - Interlake-Eastern Regional Health Authority
 - Northern Health Region
 - Prairie Mountain Health
 - Southern Health-Santé Sud
 - Winnipeg Regional Health Authority



CHAN workshop in Winnipeg, Autumn 2018

CHA Purpose and Use

CHAs present local data and local interpretation of that data, foster community engagement, and highlight community strengths and areas for improvement. This information enables the community-wide establishment of health priorities and facilitates collaborative action planning directed at improving community health status and quality of life.

Community Health Assessments and the Manitoba Quality and Learning Framework (MLQF)

Manitoba is taking bold steps to improve access to care, quality of services, and patient outcomes. Clinical leaders and health system experts from across the province are working on a provincial approach to the planning and delivery of better health care for Manitobans. This work is supported by clinical data and evidence, including the information presented in Manitoba’s Community Health Assessments (CHA).

As the Provincial Clinical and Preventive Services Plan guides and supports decisions about human resources, investment, and clinical services, the valuable information we gather in the CHAs will help ensure clinical experts have a real understanding of our population.

Ensuring positive patient outcome experiences is a focus and responsibility of every member of our health system. Efforts to improve quality and safety are ongoing and will be guided going forward by a new Manitoba Quality and Learning Framework that presents a common vision and approach to quality, patient safety, and accreditation.

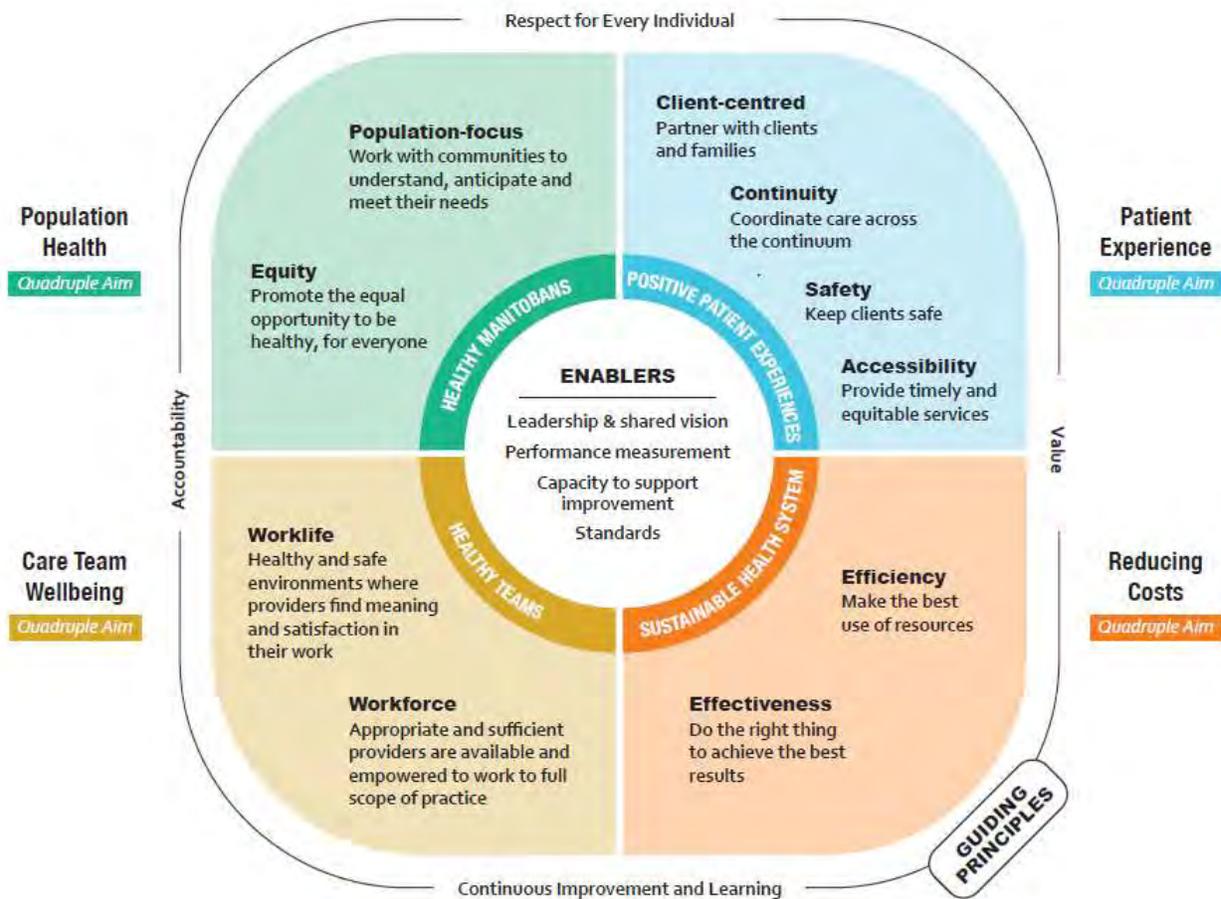
The Framework describes the Principles and Enablers of quality health care and defines the overarching goals of our system in alignment with the Institute for Healthcare Improvement's Quadruple Aim. These four areas – Healthy Manitobans, Positive Patient Experience, Sustainable Health System and Healthy Teams – allow service delivery organizations, patients, and providers to share a common understanding of our goals.

These common goals also ensure that we are able to closely monitor progress and success by aligning the indicators included in Community Health Assessments (population health, equity, continuity of care, accessibility) with the overarching goals of the health system. Health authorities will be able to use CHA data and the Framework together to set priorities and monitor quality performance all within a culture of continuous improvement and learning.

The Framework is intended for use across the health system by funders, policy makers, leaders, direct service providers, and patients. It applies across the continuum of care and is focused on improved provincial outcomes but it is also adaptable to local needs and experiences.

For more information on the Manitoba Quality and Learning Framework, please visit <https://sharedhealthmb.ca/>

The Manitoba Quality and Learning Framework (MQLF)



Provincial Template for CHA Reports

There are five regional health authorities (RHAs) in Manitoba, and all RHAs have collaborated to produce CHA reports using a common template to allow for easier comparison of population health indicators across the province. While regional CHA reports will have a similar look, the content reflects findings unique to each health region. New to CHA reports are story boxes called “A Closer Look” which provide additional regional context.



Population Health and Health Equity

To tell the story of the health and well-being of any community or population, we do so by making comparisons. We ask ourselves how that population has stayed the same over time and how it is changing. We compare the population in our health region to that of other health regions in the province; in one district (or community area) to the neighboring one. We ask ourselves why one population is healthier than another.

Many terms are used to describe differences in health among population groups including “disparities”, “inequalities”, and “inequities”. Even when intending to describe ideas that mean something quite different, these terms are sometimes used interchangeably. It is important to be clear what we mean when we use these terms.

What does it mean?

While **health disparities** and **health inequalities** can both be used to describe measurable differences in health status among population groups, the term health inequities should be interpreted differently.

Health inequities are *unfair* and *modifiable* because the underlying causes are largely social and economic in nature. The interventions needed go beyond health care services and supporting healthy behaviours, to the types of public policies, programs and services a society chooses. For example, decades ago, the poverty rates amongst older adults in Canada was substantially reduced by introducing a universal public pension program. Language surrounding health inequities will hopefully lead us to talk about why these differences exist and what kind of changes are likely to get at the root causes to make the biggest difference in narrowing persisting gaps among population groups.ⁱⁱⁱ Conceptual differences are illustrated below.^{iv}

“Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”
(Braveman, P. et al 2017)



Measuring and reporting on health inequalities has grown with each cycle of CHA. We have expanded the measurement of health inequalities when available and appropriate. In doing so, we will advance discussions and action around health equity — a growing priority for health systems and governments at all levels in Canada and internationally. This aligns with Manitoba’s **Chief Provincial Public Health Officer Position Statement on Health Equity**,^v which discusses the importance of working to improve health equity as a key way to improve overall population health and as a health goal in and of itself.

“Social determinants of health are unequally distributed among population groups in our society” and these are influenced by “unequal and unfair social relations such as colonialism, discrimination, racism and gender inequity” as well as “structural drivers such as social policies and programs, economic arrangements and politics.”^{vi} The Chief’s position statement also recognizes that the health care system and its services influence only about 25 percent of overall health outcomes, while up to 60 percent of a population’s health status is influenced by the social determinants of health and the structural drivers.^{vii}

To provide a comprehensive picture of the health of the people living in our communities, information regarding the social determinants of health, health status measures by health region, and health status changes over time is presented throughout this report.

How are health inequalities measured?

To strengthen the measurement of health inequalities between subpopulations, Manitoba participated in a collaborative pan-Canadian expert working group to inform work by Statistics Canada and the Canadian Institute for Health Information (CIHI). The goal was to develop common equity characteristics for disaggregating health indicators. This collaborative national work resulted in

recommended definitions for six equity characteristics for measuring health inequalities: age, sex, gender, income, education, and geographic location.^{viii}

This CHA report supports measuring health inequalities by:

- Stratifying data by geographic location
- Stratification of select indicators by age groupings and sex
- Geographic disparity ratios
- Income disparity ratios
- Presenting data graphs and tables in a new way to help identify disparities or health gaps

System Responsibility

CHAs provide a better understanding of what contributes to health inequities and what we need to address in order to advance health equity for our population.

As identified for the third round of CHA in 2015, the evidence informs an approach to interventions to achieve more equitable population health outcomes, which address equitable access in three main areas. These include **equity of access** to:

Health Care Services

This is the responsibility of health and social service agencies, their boards, and the various levels of government that provide funding, oversight, planning, and policy support. One example is providing services universally to the whole population and supplementing them with “targeted” services for population groups experiencing persistently poorer health and social outcomes.

Social Determinants of Health

This is the responsibility of all levels of government and the organizations to which they further delegate responsibilities, commission work, and distribute funds that affect all sectors of society. Examples include approaches such as healthy community planning, inter-sectoral action on health, healthy public policy, health in all policies, health as a human right, and health among sustainable development goals.

Community Participation

An important consideration includes collaboration with populations in vulnerable situations, which are more likely to experience health inequities, to inform priorities, directions, and decisions. This includes making space for community voices at the tables where decisions are made..

The notion of equitable access is based on the pioneering work done by Dahlgren and Whitehead and international works related to the right to health to which Canada has made commitments to via international covenants, treaties and declarations.^{ixx}

Health regions and the province overall strive to maintain and improve the health of the entire population. To this end, we are involved in population health planning which must address what contributes to those socially and economically influenced health differences among population

groups. Future planning efforts must take these health equity gaps into consideration to improve overall population health outcomes and would benefit from applying an equity analysis to all phases of planning and implementation. Further resources are available in the appendix.

Actions to mitigate health inequities among population groups are an important component of improving the overall health of all Manitobans. Health inequities are evident among several population groups including newcomers and refugees, visible minorities, persons with disabilities, and people living in poverty or other types of economic or social marginalization. There is strong evidence that Indigenous peoples of Manitoba experience persistent health disparities resulting from historic and current traumatic experiences related to colonization and racism. Indigenous peoples are also most affected by health inequities. A recent report, ***The Health Status of and Access to Healthcare by Registered First Nations Peoples in Manitoba***, is noted below.

First Nations People's Health in Manitoba

The Manitoba Centre for Health Policy (MCHP) and the First Nations Health and Social Secretariat of Manitoba (FNHSSM) partnered to develop a comprehensive report, entitled ***The Health Status of and Access to Healthcare by Registered First Nations Peoples in Manitoba***, looking at health and health-care use patterns of First Nations people living in Manitoba. Comparisons were made between First Nations and all other Manitobans, between on and off reserve First Nations, and regional comparisons by health regions and by Tribal Council Areas. This report will “contribute to building a dialogue that supports strategies for increased access to equitable healthcare, improving programs that support First Nations health and wellness, and supporting policy change and development”.^{xi} It is an update to the MCHP report referred to as the 2002 First Nations Atlas.

There is a widening and unequal gap between First Nations people's health and other Manitobans.

“To understand why First Nations’ health is worse than other Manitobans, we need to first acknowledge the history of colonization and the horrendous effects it had (and continues to have) on the First Nations (peoples and their) ways of life. As part of an effort to ‘civilize’ First Nation people, many children were forcibly removed from their families and communities and placed in residential schools. In being made to adopt the European way of life, they lost much of their language, their culture, and their connection to the families and communities. The trauma from this experience is still being felt today as the pain of this loss is passed down through generations.”

The Truth and Reconciliation Commission (TRC) of Canada's Call to Actions, especially number 19, was the impetus for this study: “to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.”^{xii}

While the majority of the data available was based on illness and not wellness, the report did highlight community strengths and resilience in results from the Manitoba First Nations Regional Health Survey (RHS). Compared to all other Manitobans, some of the key findings included:

- Mortality indicators are significantly worse among First Nations peoples
- Cancer screening rates are significantly lower among First Nations peoples
- Incidence of cervical and colorectal cancer are significantly higher among First Nations peoples
- Poorer mental health is seen among First Nations peoples
- First Nations peoples have substance use disorder rates three times higher
- Rates of suicide and suicide attempts are five to six times higher among First Nations peoples
- Poor health and lower physician service use indicate barriers to First Nations peoples accessing care
- First Nations peoples have more hospital use across all indicators
- There is a dramatically higher rate of opioid dispensations for First Nations peoples
- First Nations communities highlight the importance of traditional healers
- 45 percent of RHS respondents reported they have safe drinking water on reserve
- 59 percent of RHS respondents reported their houses on reserves require repair
- One in four families living on reserve include a survivor of residential schools

The health status gap between First Nations and all other Manitobans has widened since 2002. Researchers have urged five actions to create change and improve health of the individuals, families, and communities:^{xiii}

1. Annual reporting on progress in addressing gaps in health and access to healthcare;
2. Development of strategic initiatives for equitable access to intervention and prevention measures (including addressing racism in the health system through mandatory cultural safety training for all staff, hiring of First Nations providers and new human resource policies for safe reporting of racist incidents);
3. Development of short- and long-term plans for the training and hiring of First Nations health-care professionals;
4. Further development of research partnerships among MCHP, Manitoba Health, Seniors and Active Living (MHSAL), FNHSSM and Manitoba First Nations;
5. Setting First Nations on the path to borderless health-care delivery by improving access to primary care healthcare that is designated and delivered through First Nations-led partnerships.

Although the health profile of First Nations peoples is not summarized in the CHA report, we invite you to read *The Health Status of and Access to Healthcare by Registered First Nations Peoples in*

Manitoba. You will find the full report at:

http://umanitoba.ca/faculties/health_sciences/medicine/units/chs/departmental_units/mchp/Landin-g-FNAtlas.html

Data Sources and Limitations

Data Sources

The information for this report includes multiple sources of data to provide an in-depth look into the health of our population. These are referenced throughout the document in the figures and tables and include:

Administrative Health and Surveillance Data

These data measure health status and health services utilization in the province and health regions. The majority of the administrative health and surveillance data are provided by the Manitoba Centre for Health Policy (MCHP) or Manitoba Health, Seniors and Active Living, Information Management and Analytics Branch (MHSAL IMA).

MCHP data are obtained from the Population Research Data Repository, a comprehensive collection of administrative, registry, survey, and other data about residents of Manitoba. The data come from a variety of government department administrative datasets. For more detailed information about the repository, visit the MCHP [website](#). Data presented in this report are primarily from published reports, including: [The 2019 RHA Indicators Atlas](#) and [Mental Illness Among Adult Manitobans](#). However, home care data from the MCHP are unpublished work commissioned by MHSAL.

Canadian Community Health Survey (CCHS)

CCHS is a national cross-sectional self-reported survey on residents' health status, health determinants, and health care utilization. CCHS is designed to collect health data at the provincial and health region levels. Respondents who participated in the CCHS were selected to be representative of the provincial population and to provide reliable estimates at the health region level. It is typically collected by Statistics Canada every other year. The Manitoba sample size is 5,183 respondents. The data are weighted for representativeness and standardized to take into account certain demographic differences across health regions (e.g., age and sex), which can allow for more accurate comparisons between health regions in the province.

2016 Census

The 2016 Census data are used to describe population and community characteristics. The Census data provide high-quality information for communities across the province and are used to support planning for employment, education, and health care services. It is typically collected by Statistics Canada every five years.

To ensure confidentiality, Statistics Canada randomly rounds the values, including totals, either up or down to a multiple of '5' or '10.' As a result, when these data are summed or grouped, the total value may not match the individual values since totals and sub-totals are independently rounded. Similarly, percentages, which are calculated on rounded data, may not necessarily add up to 100 percent.

Healthy Child Manitoba

Data on the Early Development Instrument (EDI) and Family First risk factors are provided by the Healthy Child Manitoba Office. For more details about the EDI program in Manitoba and other provincial reports on child health, please visit: <http://www.gov.mb.ca/healthychild/edi/>.

CancerCare Manitoba

Cancer screening, incidence and mortality data are provided by CancerCare Manitoba from the Manitoba Cancer Registry, Screening Programs and Radiation Oncology Program. Please visit <https://www.cancercare.mb.ca/About-Us/corporate-publications>.

Canadian Patient Experiences Survey – Inpatient Care (CPES-IC)

The 2017/18 Canadian Patient Experiences Survey is a standardized survey patients use to provide feedback about the quality of care they received during their most recent stay in a Canadian acute care hospital. It was created by the Canadian Institute for Health Information (CIHI) and has been endorsed by Accreditation Canada to meet the accreditation requirements for in-patient experience surveying. The results of the survey were analyzed by the Information Management and Analytics Branch of MHSAL. The CPES-IC has been collected across all regional health authorities in Manitoba since 2017.

Data Limitations

We acknowledge that there are limitations that should be taken into consideration when interpreting the data presented in this report. A challenge of drafting large population surveillance reports using multiple data sources is the availability of the most up-to-date data. The most current data available have been used for this report; however, for some indicators (e.g., dementia prevalence, mood and anxiety disorders) the most recent data can be several years old.

Although many of the indicators are representative of the population, the information in this report may not reflect the health status and needs of Indigenous peoples living in Manitoba due to data limitations. For more information on the Health Status of First Nations people in Manitoba, please see the previous section (First Nations People's Health in Manitoba).

Some indicators (e.g., cancer-related) are not available at the zone or district level. For some indicators, statistical testing was not available to test the differences compared to the Manitoba average (e.g., Census) or the changes over time (e.g., Canadian Community Health Survey). Although differences may be noted, the statistical significance of these differences should not be inferred. Similarly, statistically significant differences were not tested across RHAs, zones, and districts.

Administrative Health and Surveillance Data

The majority of the administrative health and surveillance data (e.g., provided by the Manitoba Centre for Health Policy or MHSAL IMA) relies on medical claims data. Some health providers (e.g., physicians, nurse practitioners) working in rural areas are covered under alternate payment methods (e.g., salaried) and they submit claims (shadow billings) for administrative purposes only. This may result in under-reported health services in those areas. This is particularly true for many Northern districts because much of the primary care for residents in some communities is provided by nurses and not coded into medical claims data.

In addition, some useful demographic factors such as race and ethnicity are not captured in the administrative health data repository; we also cannot assess the differences of health status and health care utilizations across these groups.

Canadian Community Health Survey (CCHS)

Due to the self-reported nature of the CCHS, recall and self-serving biases may have particular effects on certain survey questions. For example, respondents were asked about events (e.g., physical activity, fruit and vegetable consumption) occurring during the last month and their ability to remember accurately may affect the data. In addition, respondents may choose to alter their responses in a more positive light to questions that may be perceived as more sensitive (e.g., alcohol consumption).

Respondents who participated in the CCHS were selected to be representative of the provincial population and to provide reliable estimates at the health region level. However, due to the small number of respondents, caution is needed when interpreting some response categories and smaller geographic areas.

Since 2015, considerable changes were made to the CCHS (e.g., sample selection procedures, content, etc.). Therefore, the 2015-2016 data cannot be combined with previous cycles to examine data at smaller area levels (e.g., community areas, zones, and districts). For certain indicators deemed important to report, data used in previous cycles of the CCHS were not available this cycle.

Although the CCHS survey is representative of 98 percent of the total population, it is missing information from the other two percent of the population (e.g., the homeless, persons living on-reserve and other Indigenous settlements, full-time members of the Canadian Armed Forces, the institutionalized population, and children aged 12 to 17 years old living in foster care). These groups may differ in risk for a wide range of health issues and may have different health service needs.

Census Data

In 2011, Statistics Canada's mandatory long-form census was abolished and replaced with a voluntary National Household Survey (NHS). The response rate to the NHS was much lower than the mandatory long-form census. Therefore, comparisons between the 2016 census data, presented in this report, and the previous 2011 NHS cannot be made, as well as trends since 2011 cannot be noted.

Data Presentation and Interpretation

Most indicators in this report are presented using a population-based approach. This means that the rates or prevalence shown are based upon virtually every person living in Manitoba and excludes only those in federal penitentiaries, members of the Canadian Armed Forces, and the Royal Canadian Mounted Police (RCMP).

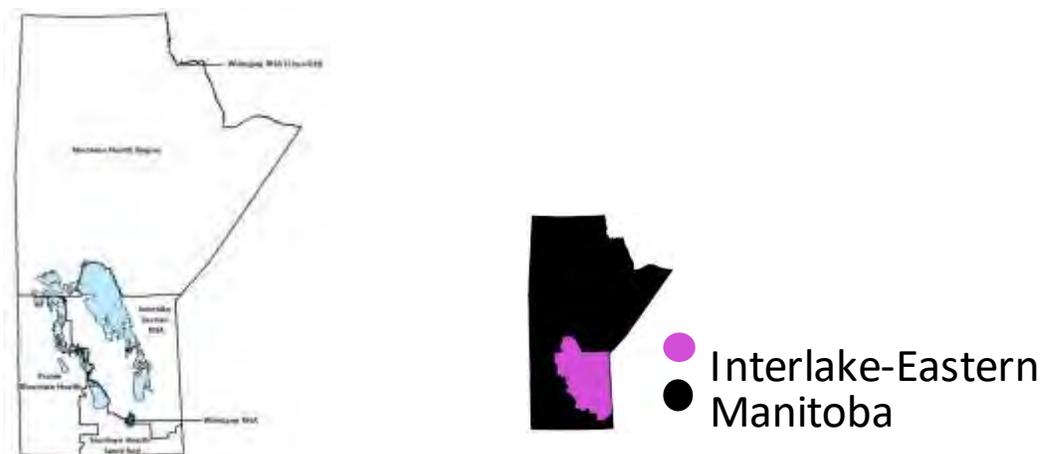
The indicators in this report are based upon where people live, not where they received services, with a few exceptions. For example, a person living in the Interlake-Eastern Regional Health Authority may be hospitalized in Winnipeg but the hospitalization is attributed back to the rate for Interlake-Eastern Regional Health Authority. Thus, the results show the health and health-care use patterns of the population living in the Interlake-Eastern Regional Health Authority, no matter where they receive their care.

In all cases, the latest available information is presented. Visual representations of data have been labeled and ordered in a consistent fashion throughout the report with sources clearly defined.

In this report where the term 'Indigenous' is used, it is referring to only those residents who have self-identified as being First Nations, Métis or Inuit. When 'Interlake-Eastern Regional Health Authority' is used alone it refers to all residents of the health region, including those identifying as First Nations, Métis or Inuit.

Geographic Boundaries

In the majority of cases, the quantitative data are presented for the five regional health authorities of Manitoba.



Rates and Prevalence

In the majority of visual representations, data are presented as a rate or prevalence. Prevalence refers to the proportion of the population that has a certain condition, either at a given point in time (point prevalence) or over a period of time (period prevalence). It is an indication of how common the

condition is, and therefore, has implications for the provision of services. Most indicators in this report use the concept of period prevalence over a one-, three-, or five-year period. When a difference is not described as ‘significant’, the rate should be considered similar to the provincial average and/or the previous time period.

In contrast, a rate refers to a change in state over time and is used to express the frequency of events during a given period. Many health-related events can happen to a given person more than once. For example, the physician visit rate shows how often residents visit physicians each year. Where an indicator covers a period longer than one year, the rate is annualized— that is, given as an annual average.

Adjusted Rates and Crude Values

The indicator tables and figures in this report are labeled as ‘age and sex adjusted’ rates when results have been statistically adjusted to account for the different age and sex composition of the populations living in different areas. This adjustment allows for fair comparisons among areas with different population characteristics. Adjusted rates show what that area’s rate would have been if the area’s population had the same age and sex composition as the Manitoba population.

In some cases, ‘crude values’ are presented in order to indicate the actual number of events that occurred (e.g., residents living with a particular condition) within the health region and to represent the possible burden of illness to Interlake-Eastern Regional Health Authority in particular.

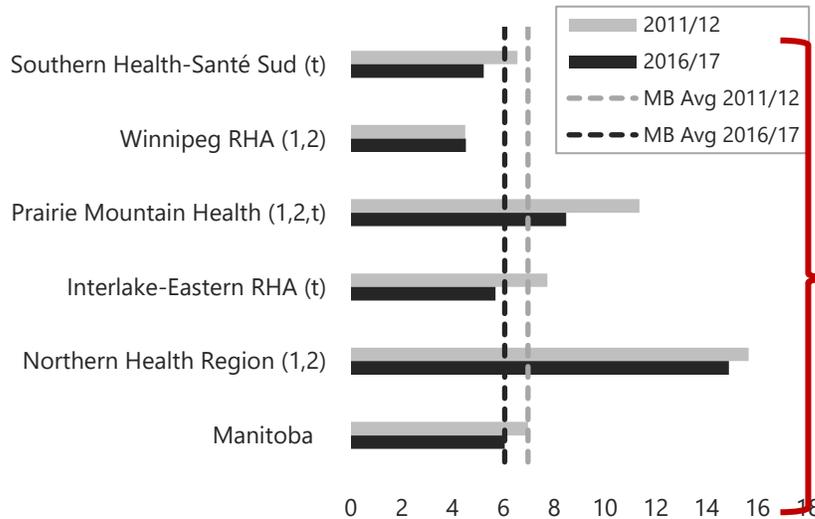
When reading this report, if the narrative referring to an indicator suggests that a difference is ‘significant’ then you know the difference is considered statistically significant (p -value < .05) and not likely to be an annual or period fluctuation or due to chance. When a difference is not described as ‘significant’, the rate should be considered similar to the provincial average. Statistical significance was only tested for the difference compared to the provincial average and/or changes over time. There were no statistical tests completed for differences between regions, zones, and districts.

Visualization of Data

The 2019 CHA introduces a new method of visualizing data to describe regional differences and changes over time. It captures all the components of the previously used Manitoba Centre for Health Policy multiple year bar charts (on the next page) but in a more condensed format. The regions are ordered from lowest to highest (based on T2 for tables).

The ORIGINAL bar graph from MCHP:

Hospitalization Rate Ambulatory Care Sensitive Conditions by RHA, 2016/17 (T2) and 2011/12 (T1)
Age- and sex-adjusted per 1,000 residents aged 0-74



In the CHA Reports, the bar charts here are collapsed and visualized below.

For each time period, the range in values (lowest to highest) are shown on either end

The regions are ordered from lowest to highest (based on T2)

**T2 = recent time period
T1 = earlier time period**

Data tables with actual

- 1 indicates area's rate was statistically different from Manitoba average in first time period
- 2 indicates area's rate was statistically different from Manitoba average in second time period
- t indicates change over time was statistically significant for that area
- s indicates data suppressed due to small numbers

MCHP RHA Indicators Atlas 2019

The NEW look in CHA reports:

Hospitalization Rate Ambulatory Care Sensitive Conditions by RHA, 2016/17 (T2) and 2011/12 (T1)
Age- and sex-adjusted per 1,000 residents aged 0-74



H/L Significantly higher or lower than the MB average for that time period.
+/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	IERHA	MB	PMH	NRHA
T2 COUNT	3,467	1,010	861	8,023	1,522	995
T2 RATE	4.5 L	5.2 -	5.7 -	6.1	8.5 H-	14.9 H
T1 RATE	4.5 L	6.6	7.7	7.0	11.4 H	15.7 H

Source: MCHP RHA Indicators Atlas 2019

Graphing the two time periods:

- The line bars are stacked one on top of the other with the most recent time period on top and the earlier time period below.
- The earlier or first time period is labeled “T1” and the second or more recent time period is labeled “T2”. These labels are positioned at the extreme left end of the line bars.

Understanding the sliding scale:

Identifying regional data

- Bars on the sliding scale correspond to the regional values in the MCHP bar chart. To easily identify regional position, each RHA and Manitoba have been assigned specific colours.

The range of values

- The T2 bar reflects only the range in values from the lowest regional value (WRHA 4.5) to the highest (14.9 NRHA). The horizontal bar does not show the entire scale from 0.
- The T1 bar reflects the data in the earlier time period (or in some cases, the only time period available). In the example above, the lowest value is the same for both time periods (WRHA 4.5) but the highest value extends the scale to the right (NRHA 15.7). The scale has been extended to reflect the full range of values for both time periods.
- The bookends (lowest and highest values) easily identify whether values have increased, decreased, or remained similar across the province. This is a quick way to see whether the regional disparity has widened or narrowed.

Statistical significance (statistical significance of $p < .05$)

- Significant differences from the Manitoba average are shown below the RHA marker as either H (higher) or L (lower). This replaces MCHP’s symbols “1” or “2” for indicating statistical differences from the Manitoba average by time period.
- Significant changes over time are shown above the RHA marker as + (increasing) or - (decreasing). This replaces MCHP’s symbols “t” for indicating if the change over time was statistically significant for that area.

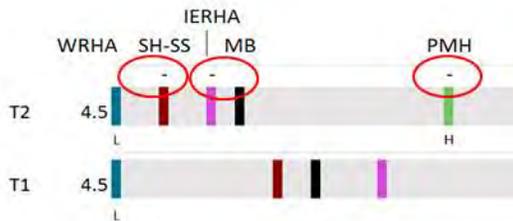
Data table below sliding scales

- A data table follows each set of line bars showing the actual values for every health region.
- T2 COUNT reflects the crude count for only the recent time period (e.g., residents, hospitalizations, visits, etc.)
- T2 RATE presents the regional data reflected in T2 sliding scale
- T1 RATE presents the regional data reflected in T1 sliding scale
- Statistically significant notations as described above
- Values are ordered from left to right, lowest to highest ambulatory care sensitive conditions (ACS) according to the T2 rate

Interpreting the Data

Significant increases or decreases (statistical significance of $p < .05$) in a health region's value over time (from T1 to T2) are notated by either a + (increase) or - (decrease) above the RHA marker on the T2 bar and repeated in the accompanying table.

Southern Health Santé Sud, Interlake-Eastern RHA and Prairie Mountain Health have all shown a significant decrease in hospitalizations for Ambulatory Care Sensitive (ACS) conditions between T1 and T2.



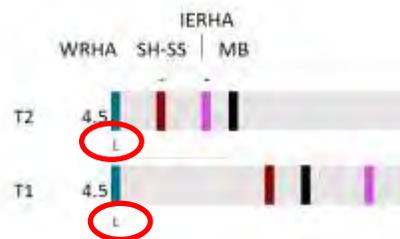
Values that are significantly different from the Manitoba average for that time period are notated by either an H (higher) or L (lower) underneath the

RHA marker on both the T1 and T2 bars and repeated in the accompanying table.



Prairie Mountain Health and Northern RHA have significantly higher rates of hospitalization for ACS conditions than the province as a whole in both time periods.

Winnipeg RHA has significantly lower rates of hospitalization for ACS conditions than the province as a whole in both time periods.



	PMH	
	1,522	
	8.5	H-
	11.4	H

Prairie Mountain Health had an ACSC rate of 11.4/1,000 in the first time period (2011/12) which was significantly higher than the provincial average of 7.0/1,000. This value has decreased significantly to 8.5/1,000 in the second time period (2016/17) but remains significantly higher than the T2 provincial average of 6.1/1,000. Within each group, the population is divided into five groups of approximately equal population according to

the average household income (as determined by the Census small dissemination area) called income quintiles. Manitobans are split into urban and rural with urban being just the cities of Winnipeg and Brandon and rural being everyone else. In the current report, any income information is reported provincially but for rural quintiles only, which includes all of Interlake-Eastern RHA, including Selkirk.

Zone and District Tables

Whenever available and appropriate, zone and district level data are presented in tables.

- When two time periods are available, the counts and rates or percentages of the most recent time period (labeled T2) are presented first, followed by the rates or percentages of the earlier time period (labeled T1).
- The zones are ordered by premature mortality rate from best to worse from left to right in the first row, followed by the second row (e.g., for Interlake-Eastern Regional Health Authority these are ordered South Zone, East Zone, West Zone, Selkirk Zone, North Zone, Northern Remote Zone).
- The district order varies between tables as they are ordered from best to worse, when appropriate.

Disparity Measures

There are two disparity measures shown in the report: income disparity and geographic disparity.

Income disparity is provided at a provincial level and is represented by the following visual for

Inadequate Prenatal Care:



Manitobans are split into urban and rural with urban being just the city of Brandon and rural being all other health regions.

Within each group, the population is divided into five groups of approximately equal population, according to the average household income (as determined by the Census small dissemination area).

- The disparity measure is reported only where there is a statistically significant linear trend between income and the indicator results, and the nature of the increases or decreases are stepwise.
- The disparity is the relative difference between those in the highest income quintile and those in the lowest income quintile.

Understanding the income disparity information:

- The example above indicates that in urban settings, in the second time period (T2), the lowest income residents are 3.1 times as likely to receive inadequate prenatal care as those in the highest income quintile. The gap between the income levels has shrunk markedly over time.

- In a rural setting, the lowest income residents are 4.2 times as likely to receive inadequate prenatal care as those in the highest income quintile. The gap between the income levels has increased slightly over time.
- The direction of change is indicated by the arrows and the colour indicates whether the gap is narrowing (green) or widening (red).

Geographic disparity is shown at a regional level and is represented in the district table by the following visual sample.



The disparity is measured between the district with the best value for the indicator and the district with the worst value. In this example, the district with the lower value is actually better, but in other indicators the reverse may be true.

Understanding the geographic disparity information:

- In the example above, the disparity measure in T1 indicates that the district with the highest value is 7.21 times more likely to receive 'inadequate care' than the district with the lowest value. Similarly, the T2 reflects that the district with the highest value is 8.13 times more likely to receive 'inadequate care' than the district with the lowest value.
- Note that the districts with the highest and lowest values may vary from T1 to T2.
- The red or green highlighted value indicates the change between the two time periods. The arrow pointing up or down and the red or green font colour indicate that the disparity or gap has widened or narrowed over time.

CHAPTER 1: WHO IS INTERLAKE-EASTERN REGIONAL HEALTH AUTHORITY?



Table of Contents

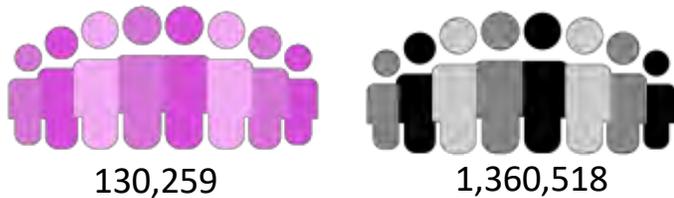
CHAPTER 1: WHO IS INTERLAKE-EASTERN REGIONAL HEALTH AUTHORITY?	1
Tables and Figures	2
At A Glance: Who is Interlake-Eastern Regional Health Authority?	3
Why is this Chapter Important?	3
Chapter 1 Key Findings	4
Geography Boundaries	5
Programs and Services	7
Population	9
Population Pyramids	10
Birth Rate	11
Internal Migrant Mobility	13
Population Density	15
Population Change over Time	16
Population Projections	17
Indigenous Population	18
Visible Minority Population	21
Language Spoken at Home	23
Knowledge of French	24
Immigrant Status in Private Households	26
Immigration by Place of Birth	27
Lone Parent Families	28
Dependency Ratio	29

Tables and Figures

Figure 1.1. Map of Interlake-Eastern Regional Health Authority (IERHA)	5
Table 1.1. Interlake-Eastern List of Communities by Zone and District	6
Figure 1.2. Interlake-Eastern Zone and District Map	6
Table 1.2. IERHA Population by Zone & District Findings, 2018	9
Figure 1.3. Population —Provincial Findings	10
Figure 1.4. Birth Rate by RHA, 2011/12 (T1) and 2016/17 (T2).....	11
Table 1.3. Birth Rate — IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2).....	12
Figure 1.5. Provincial and RHA 5-Year Internal Migration Mobility	13
Table 1.4. Internal Migrant Mobility - IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)	14
Figure 1.6. Population Density —Provincial Findings	15
Figure 1.7. Population Change Over Time - IERHA 2013 to 2018	16
Figure 1.8. Population Projections —Provincial Findings 2017 to 2030	17
Figure 1.9. Indigenous Population by RHA	18
Table 1.5. Indigenous Population — IERHA Zone & District Findings.....	19
Figure 1.10. Visible Minority Population by RHA.....	21
Table 1.6. Visible Minority Population — IERHA Zone & District Findings	22
Table 1.7. Language Spoken at Home — Provincial & IERHA Findings	23
Table 1.8. Knowledge of Francophone Language – IERHA Zone Findings	24
Table 1.9. Immigrant Status in Private Households — IERHA Zone Findings.....	26
Table 1.10. Immigration by Place of Birth — Provincial Findings	27
Figure 1.11. Lone Parent Families, Manitoba and RHAs, 2016.....	28
Table 1.11. Lone Parent Families — IERHA Zone Findings.....	28
Figure 1.12. Dependency Ratio, by MB and RHA, 2013 (T1) and 2018 (T2)	29
Table 1.12. Dependency Ratio — Provincial Findings.....	29
Table 1.13. Dependency Ratio — IERHA Zone & District Findings, 2018.....	30

At A Glance: Who is Interlake-Eastern Regional Health Authority?

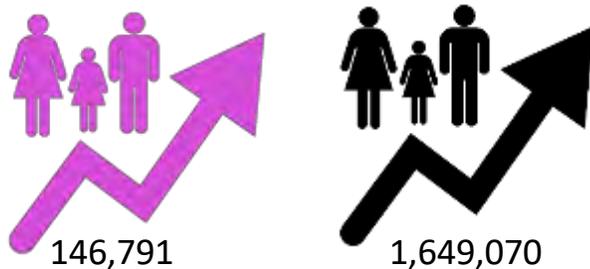
2018 Population



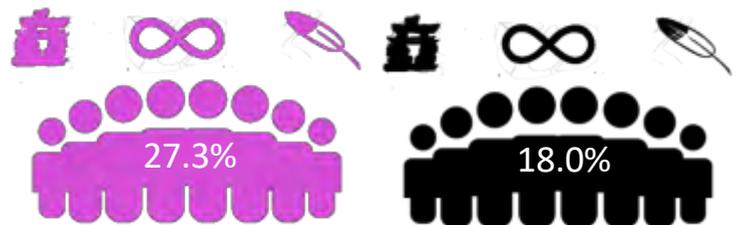
Birth Rate per 1,000 Females



Population Projection by 2030



Indigenous Population



Why is this Chapter Important?

- This chapter outlines the geography of the region as well as demographic features of our population. The unique characteristics of our region influence the factors that determine how healthy we are and have a significant affect on the need for appropriate services and programs.
- The information in this chapter is foundational to forecast future issues that will require dedicated strategies in both the short and long-term.
- Population health surveillance is essential to health-care planning and resource allocation to ensure we develop equitable and sustainable programs and services.

Chapter 1 Key Findings

Population:

- Interlake-Eastern's population is 130,259; increased by 2.83% since the 2014 Community Health Assessment

Demographics:

- 31 Municipalities
- 17 First Nations Communities
- 24 Métis Communities

Birth Rate:

- Birth rates have decreased slightly over time
- Female residents in Northern Remote Zone have a birth rate three times higher than female residents in Selkirk Zone

Internal Migration:

- 16.8% of Interlake-Eastern's residents have relocated or moved within Canada in the past five years

Population Projections:

- Interlake-Eastern's population is projected to increase 13% by 2030

Indigenous Population

- Nearly one in three residents self-identify as Indigenous

Immigrant Status in Private Households:

- 5% of all private households include a person with immigrant status

Lone Parent Families:

- Nearly 15% of all private households are made up of lone parent families



Geography Boundaries

At 61,000 square kilometres, Interlake-Eastern RHA represents approximately one-tenth of Manitoba's area. The Interlake-Eastern region is a geographical area that extends east to the Ontario border, north to the 53rd parallel, and west to Lake Manitoba. There are 31 rural municipalities, 17 First Nation communities, 24 Métis communities and a large area that is defined as unorganized territories, which tends to be largely unpopulated.

The region includes a wide variety of geographical features such as natural lakes, forests, agricultural lands, parklands, beaches, and marshlands. The population more than doubles in the summer with vacationers and cottage owners enjoying properties along Lake Winnipeg and Lake Manitoba as well as the Birds Hill, Hecla/Grindstone, Whiteshell, Nopiming and Atikaki Provincial Parks and resort communities.

Figure 1.1. Map of Interlake-Eastern Regional Health Authority (IERHA)



Who is Interlake-Eastern Regional Health Authority?

The region has been divided into six zones (Selkirk, South, North, East, West, Northern Remote) and 15 districts (see **Table 1.1.** and **Figure 1.2.**). These zones and districts were organized to facilitate and coordinate the planning and provision of health services in the region.

Table 1.1. Interlake-Eastern List of Communities by Zone and District

South Zone
Stonewall/Teulon
Winnipeg Beach/St. Andrews
St. Clements
Springfield

East Zone
Beausejour
Pinawa/Lac du Bonnet
Whiteshell

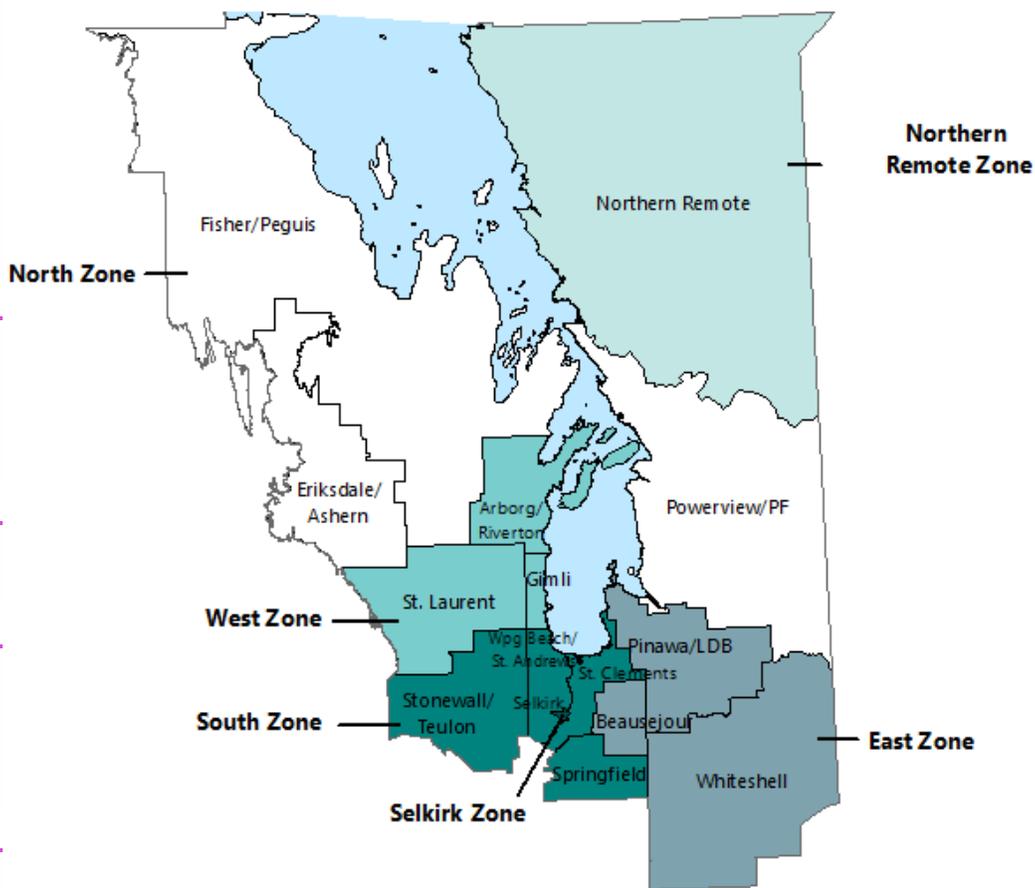
West Zone
Gimli
Arborg/Riverton
St. Laurent

Selkirk Zone
Selkirk

North Zone
Powerview/Pine Falls
Fisher/Peguis
Eriksdale/Ashern

Northern Remote
Northern Remote

Figure 1.2. Interlake-Eastern Zone and District Map



Programs and Services

In collaboration with communities and partners, Interlake-Eastern Regional Health Authority endeavors to provide access to appropriate services in the appropriate setting as demonstrated by the many programs and services delivered in the region. We strive to deliver a seamless continuum of care that supports our clients at every stage of their lives.



Access to a wide range of Programs & Services:

- **CancerCare/Cancer Navigation Services**
- **Dietary Services**
- **Elderly Persons Housing**
- **Emergency Medical Services (ambulance)**
- **Home Care**
 - Treatment clinics
 - Services to seniors
 - Adult day programs
 - Community resource councils
 - Congregate meal program
 - Meals on wheels
 - Personal care at home
 - Respite care
 - Supports for seniors in group living
- **Medical Clinics**
- **Medical Officer of Health**
- **Mental Health**
 - Adult community mental health
 - Brief treatment services
 - Centralized intake services
 - Child & adolescent community mental health services
 - Crisis services: crisis stabilization unit & mobile crisis services for adult and youth
 - Intensive case management services
 - Psychiatry consultation services
 - Psychology consultation services
 - Rapid access to brief treatment
 - Rapid access to addictions medicine clinic (Selkirk)
 - Mental health services for the elderly shared mental health care
- **Palliative Care/End of Life**
- **Pharmacy**
- **Primary Health Care**
 - Chronic disease education
 - Family doctor finder
 - Medical clinics
 - Mobile clinic
 - My health teams
 - Nurse practitioners
 - Primary health care centres
 - QuickCare clinic
 - Teen clinics
- **Public Health - Healthy Living**
 - FASD services & key worker program
 - Healthy living services
 - Get better together
 - Healthy together now grants
 - Local health promotion
 - Mobile wellness
 - Fit kids healthy kids
 - Craving change
 - Health equity and community capacity building
 - Healthy living grants
- **Public Health - Nursing Services**
 - Families first
 - Healthy baby
 - Communicable disease prevention & control
 - Early childhood development & parenting
 - Harm reduction and supply distribution
 - Immunizations/child health clinic
 - Travel health clinic
 - Prenatal, postpartum & breastfeeding support
 - Reproductive health
 - School health
 - Uris-unified referral intake system
- **Allied Health**
 - Audiology
 - Clinical Dietitians
 - Occupational therapy
 - Physiotherapy
 - Rehabilitation
 - Speech language therapy
 - Spiritual health care
- **Other services**
 - Indigenous health
 - Communications and public relations
 - Disaster management
 - Facilities management
 - Finance
 - French language services
 - Human resources
 - Information & communication technology (ICT)
 - Quality, risk and patient safety
 - Support services
 - Telehealth

Who is Interlake-Eastern Regional Health Authority?

Facility-Based Services

- Acute care
 - Cancer care/cancer navigation services
 - Emergency care
 - Rehabilitation
 - Hemodialysis
 - Medical care
 - Obstetrical care
 - Outpatient services
 - Respiratory services
 - Surgery/surgical care
- Affiliate Health Corporations

- Community-Owned Not for Profit
- Lab & Imaging Services
 - Cardiac stress testing
 - Computed tomography (CT scans)
 - Electrocardiogram (EKG)
 - Fluoroscopy
 - Laboratory
 - Magnetic resonance imaging (MRI)
 - Ultrasound
 - X-ray
- Personal Care Homes

To learn more about the Care in your Community and Hospital, please visit the Interlake-Eastern Regional Health Authority webpage:
<http://www.ierha.ca>



Population

Definition

The total number of residents living within a geographic area over a one-year time period based on a resident's current address on their Manitoba Health Card, which is updated on June 1st of every year.

Regional Key Findings

- According to Manitoba Health, the 2018 Interlake-Eastern population was 130,259 residents which is higher than what was reported in the 2014 Community Health Assessment, when the population totaled 126,674.
- The South Zone makes up the largest percentage of residents within Interlake-Eastern at 46%, while Northern Remote makes up the smallest percentage of the population.

Table 1.2. IERHA Population by Zone & District Findings, 2018

	Population	Percentage of IERHA		Population	Percentage of IERHA
Manitoba	1,360,518		IERHA	130,259	
South Zone	59,842	46%	North Zone	20,044	15%
Stonewall/Teulon	19,291	15%	Powerview/Pine Falls	6,295	5%
Winnipeg Beach/St. Andrews	16,754	13%	Fisher/Peguis	7,071	5%
St. Clements	8,857	7%	Eriksdale/Ashern	6,678	5%
Springfield	14,940	11%			
East Zone	20,548	16%	Northern Remote	4,098	3%
Beausejour	9,554	7%	Northern Remote	4,098	3%
Pinawa/Lac du Bonnet	8,070	6%			
Whiteshell	2,924	2%			
West Zone	15,280	12%			
Gimli	6,118	5%			
Arborg/Riverton	5,015	4%			
St. Laurent	4,147	3%			
Selkirk Zone	10,447	8%			
Selkirk	10,447	8%			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: Manitoba Health, Information Management Analytics (IMA) 2019

Population Pyramids

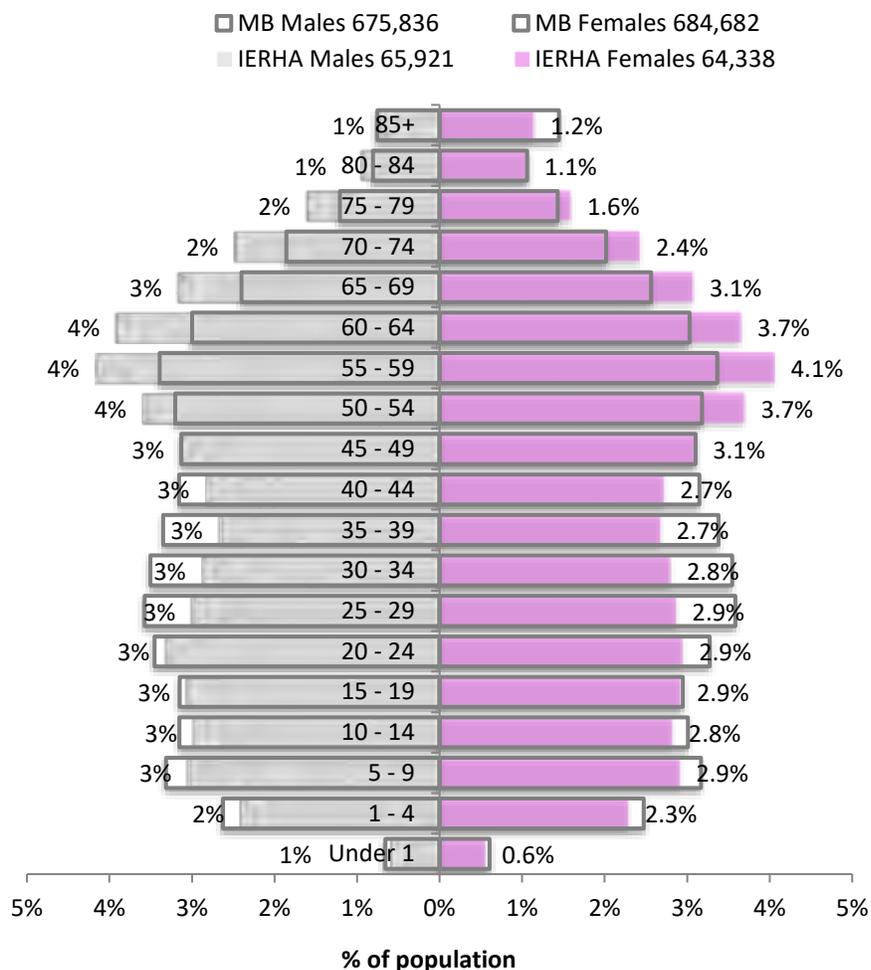
Definition

The age and sex distribution of a population living in a geographic area for a one-year time period.

Regional Key Findings

- Interlake-Eastern has a very similar profile (pyramid shape) to Manitoba overall, but appears to be slightly older (**Figure 1.3.**).
- Starting at age 50-54 up until 75-79, Interlake-Eastern has a larger percentage of residents living within those age categories compared to Manitoba.
- Interlake-Eastern has a smaller proportion of both middle age and young children when compared to provincial population data.

Figure 1.3. Population — Provincial Findings



Source: Manitoba Health, IMA 2019

Birth Rate

Definition

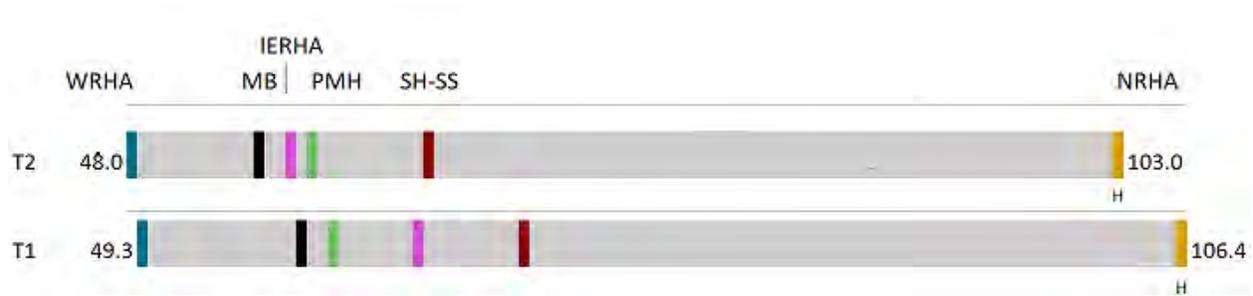
The rate of live births per 1,000 females aged 15 to 45, for a one-year time period.

Provincial Key Findings

- The annual birth rate in Manitoba decreased slightly, from 58.1 to 55.5 live births per 1,000 females.
- Northern RHA has a birth rate significantly higher than the Manitoba average.
- Between 2011 to 2017 all regions have experienced slight decreases in birth rates.

Figure 1.4. Birth Rate by RHA, 2011/12 (T1) and 2016/17 (T2)

Age adjusted rate of live births per 1,000 females aged 15-45



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	IERHA	PMH	SH-SS	NRHA	
T2 COUNT	8,021	16,027	1,360	2,080	2,882	1,669	
T2 RATE	48.0	55.5	57.4	58.8	65.1	103.0	H
T1 RATE	49.3	58.1	64.3	59.6	70.2	106.4	H

Source: MCHP RHA Indicators Atlas 2019

Who is Interlake-Eastern Regional Health Authority?

Regional Key Findings

- Interlake-Eastern had 1,360 live births over a one-year time period, a rate of 57.4 live births per 1,000 female residents.
- All six zones experienced a decrease in live birth rates over time.
- Although rates have decreased across the region, both North and Northern Remote Zone continue to have live birth rates significantly higher than Manitoba.
- Female residents in Northern Remote Zone have a birth rate three times higher than female residents in Selkirk. Over time the disparity in live birth rates has slightly increased between districts.

Table 1.3. Birth Rate — IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1
	Count	Rate	Rate
Manitoba	16,027	55.5	58.1

	T2		T1
	Count	Rate	Rate
IERHA	1,360	57.4	64.4

South Zone	519	47.6	-	51.4
Springfield	146	50.8		54.5
Stonewall/Teulon	188	49.7		52.9
St. Clements	62	45.4		52.3
Wpg Beach/St. Andrews	123	44.8		45.4

North Zone	320	91.3	H	94.2	H
Fisher/Peguis	142	117.2	H	109.8	
Powerview/Pine Falls	90	76.9		90.0	
Eriksdale/Ashern	88	76.2		82.0	

East Zone	171	50.0	-	69.4
Whiteshell	40	66.6		70.2
Beausejour	95	49.5		69.1
Pinawa/Lac du Bonnet	36	39.0		70.3

Northern Remote	102	128.2	H	134.3	H
Northern Remote	102	128.2	H	134.3	H

West Zone	155	63.1	-	66.9
St. Laurent	46	70.0		63.0
Arborg/Riverton	63	61.3		72.5
Gimli	46	61.2		61.9

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	3.0
	T2 Disparity	3.3
	Change	0.3↑
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

Selkirk Zone	93	43.0	-	48.9
Selkirk	93	43.0		48.9

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Internal Migrant Mobility

Definition

The percentage of the population that is currently living in a different city, town, township, village, or Indian Reserve within Canada compared to five years earlier.

Provincial Key Findings

- The provincial 5-year mobility rate has decreased slightly from the 2011 Census where 10.5% of Manitobans had moved compared to 10.1% in the 2016 Census.
- The rate of 5-year mobility is highest in Southern Health-Santé Sud where close to a fifth of all residents have moved in a five-year time period.
- Winnipeg RHA has the lowest mobility at only 5.4%.

Figure 1.5. Provincial and RHA 5-Year Internal Migration Mobility



	WRHA	MB	NRHA	PMH	IERHA	SH-SS
T1 COUNT	36,160	117,145	6,625	22,735	19,435	32,190
T1 PERCENT	5.4%	10.1%	10.4%	15.4%	16.8%	19.1%

Source: Statistics Canada Census: 2016

Who is Interlake-Eastern Regional Health Authority?

Regional Key Findings

- Interlake-Eastern has the second highest percentage of internal mobility among all RHAs.
- 16.8% of residents within Interlake-Eastern are living in a different city, town, township, village, or Indian Reserve compared to five years earlier.
- Internal migrant mobility at the zone level ranges from as high as 20% of residents (East Zone) to a low of 9% (Northern Remote).
- There appears to be higher migrant mobility in southern areas of Interlake-Eastern compared to the north.

Table 1.4. Internal Migrant Mobility - IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)

	Total mobility status 5 years ago	Internal migrants	%		Total mobility status 5 years ago	Internal migrants	%
Manitoba	1,161,235	117,145	10.1%	IERHA	121,610	19,435	16.8%
South Zone	54,195	9,660	18%	North Zone	15,560	1,635	11%
Stonewall/Teulon	16,110	2,820	18%	Powerview/Pine Falls	4,610	335	11%
Winnipeg Beach/St. Andrews	13,170	2,145	16%	Fisher/Peguis	5,715	665	12%
St. Clements	10,815	1,980	18%	Eriksdale/Ashern	5,235	635	12%
Springfield	14,100	2,715	19%				
East Zone	19,595	3,980	20%	Northern Remote	3,210	280	9%
Beausejour	7,740	1,580	20%	Northern Remote	3,210	280	9%
Pinawa/Lac du Bonnet	8,680	1,850	21%				
Whiteshell	3,175	550	17%				
West Zone	14,210	2,280	16%				
Gimli	5,820	1,240	16%				
Arborg/Riverton	4,200	530	13%				
St. Laurent	4,190	510	12%				
Selkirk Zone	8,975	1,600	18%				
Selkirk	8,975	1,600	18%				

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: Statistics Canada Census: 2016

Population Density

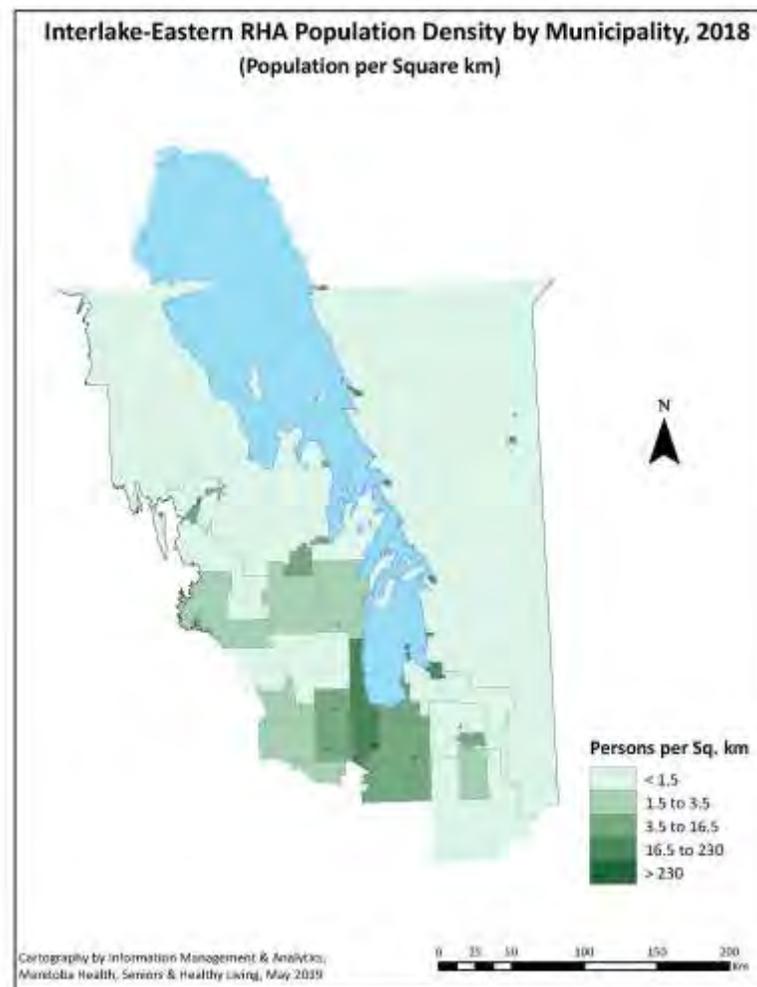
Definition

The number of people per-square kilometre based on the population divided by the total land area for a one-year time period.

Regional Key Findings

- Interlake-Eastern's total population density is 1.67 people per square kilometre based on 2018 population data.
- Density ranges from less than 1.5 residents to greater than 230 residents per square kilometre across the region.
- **Figure 1.6.** indicates a lower population density in both the mid and northern areas of Interlake-Eastern. The most densely populated areas boarder the perimeter of Winnipeg as well as both Lake Winnipeg and Lake Manitoba shorelines.

Figure 1.6. Population Density —Provincial Findings



Source: Manitoba Health, IMA 2019

Population Change over Time

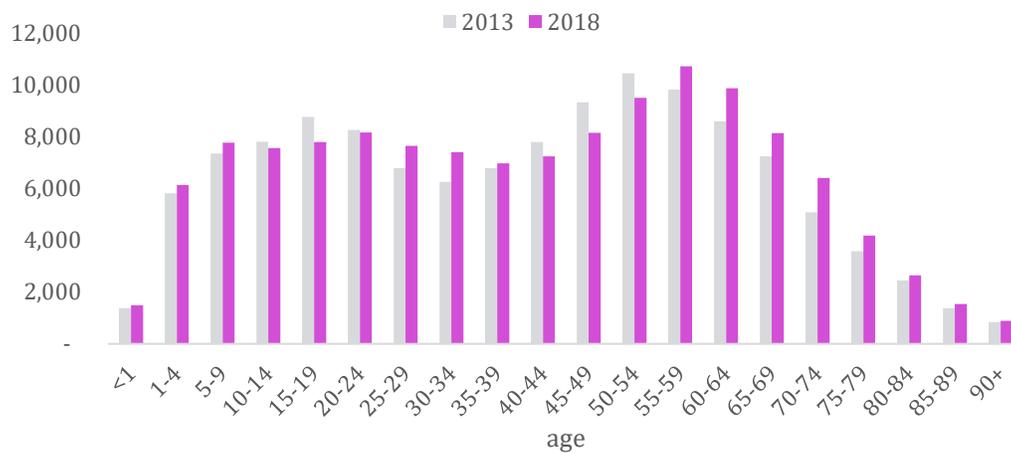
Definition

The change in the number of people who live in a defined area over a five-year time period.

Regional Key Findings

- Interlake-Eastern's population has increased by 4,414 residents over the five-year time period, which represents a 3.5% increase.
- The most noticeable changes over the five-year time period are the decrease in residents between ages 40-44, 45-49 and 50-54 years of age and an increase in people aged 55 and older.

Figure 1.7. Population Change Over Time - IERHA 2013 to 2018



Source: Manitoba Health, IMA 2019

Population Projections

Definition

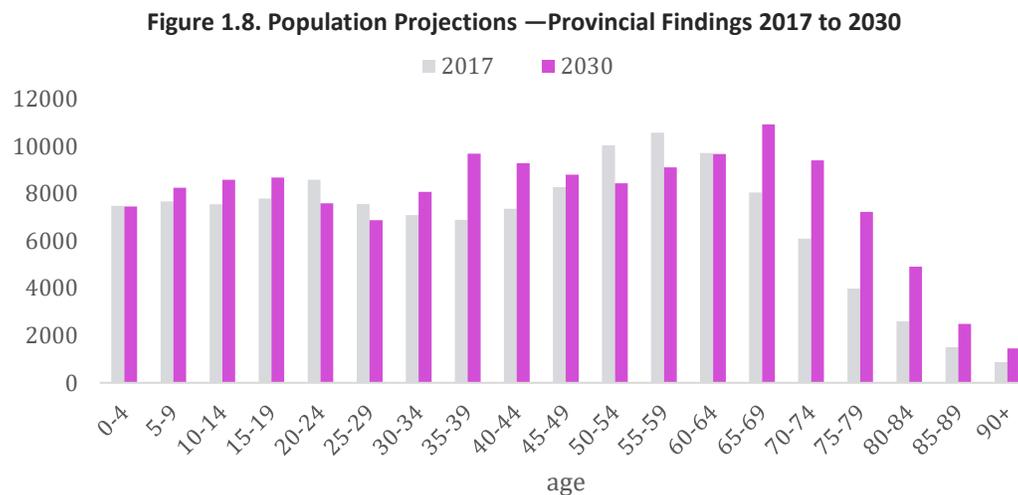
An estimate of population growth expected by 2030, based on medium forecasts of birth, death and migration rates.

Provincial Key Findings

- Manitoba's total population in 2017 was 1,360,518.
- Manitoba's projected population total will be 1,649,070 by 2030, a 21% increase over a 13-year time period.

Regional Key Findings

- According to population projections to 2030, the region is projected to have a population of 146,791, which represents a 13% increase.
- **Figure 1.8.** breaks down the population into five-year age categories. The most noticeable change among Interlake-Eastern will be the significantly higher counts of residents in the 65 and older age groupings.



Source: Manitoba Health, IMA 2019

Indigenous Population

Definition

An estimate of the Indigenous population based on self-reported 'Aboriginal identity' which includes persons who are First Nations (North American Indian), Métis or Inuk (Inuit) and/or those who are Registered or Treaty Indians (that is, registered under the Indian Act of Canada), and/or those who have membership in a First Nation or Indian band.

Provincial Key Findings

- Approximately one out of five Manitoba residents self-identify with an 'Aboriginal identity'.
- Indigenous populations vary across all RHAs in Manitoba, with Winnipeg RHA having the smallest percentage and Northern RHA having the highest.

Figure 1.9. Indigenous Population by RHA



	WRHA	SH-SS	PMH	MB	IERHA	NRHA
T1 PERCENT	12.2%	13.4%	17.5%	18.0%	27.3%	72.6%

Source: Statistics Canada Census 2016

Who is Interlake-Eastern Regional Health Authority?

Regional Key Findings

- According to the 2011 Census, a total of 29,335 residents self-identified as Indigenous, which represented 24.7% of all Interlake-Eastern residents and, over the past five years, that percentage has increased to 27.3%.
- Indigenous populations vary among Interlake-Eastern zones from as low as 14% (South Zone) to as high as 98% (Northern Remote).
- The North Zone was found to have the largest population of residents self-identifying as Indigenous, totaling 12,160 residents.

Table 1.5. Indigenous Population — IERHA Zone & District Findings

	Total #	Count	%
Manitoba	1,240,700	223,310	18%
IERHA	122,875	33,520	27%
South Zone	57,125	8,090	14%
Stonewall/Teulon	17,080	2,590	15.2%
Winnipeg Beach/St. Andrews	13,680	1,950	14.3%
St. Clements	11,340	2,145	18.9%
Springfield	15,025	1,405	9.4%
North Zone	17,050	12,160	71%
Powerview/Pine Falls	5,010	3,995	79.7%
Fisher/Peguis	6,265	4,890	78.1%
Eriksdale/Ashern	5,775	3,275	56.7%
East Zone	20,490	3,400	17%
Beausejour	8,235	1,185	14.3%
Pinawa/Lac du Bonnet	8,950	1,830	20.4%
Whiteshell	3,310	385	11.6%
West Zone	14,970	2,900	19%
Gimli	6,035	640	10.6%
Arborg/Riverton	4,585	755	16.5%
St. Laurent	4,350	1,505	34.6%
Selkirk Zone	9,535	3,320	35%
Selkirk	9,535	3,320	35%
Northern Remote	3,710	3,650	98%
Northern Remote	3,710	3,650	98%

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: Statistics Canada Census 2016

CLOSER LOOK... REACHING OUT

Nurse Practitioner (NP) Clinics

Nurse practitioner Jesse Lamoureux (back row, third from left) who practices in Pine Falls also works with community health nurses and on-site staff at Black River First Nation Health Centre weekly to deliver primary health care to the community. He also works with two community health nurses to introduce more youth health services at Black River Anishinabe School.



The care team at Pine Falls Primary Health Care Centre. At back, from left to right, Peggy McMullen, Dr. Prasanga Ketawala, Jesse Lamoureux, Paula Seguin, Judy Boisjoli, Kim Green and, at front, Dr. Ahmed Rateb.

Visible Minority Population

Definition

An estimate of the visible minority population, defined as persons other than Indigenous people, who are non-Caucasian in race or non-white in colour.

Provincial Key Findings

- Approximately one out five Manitoba residents self-identify as a visible minority.
- Visible minority populations vary across all RHAs in Manitoba, with Interlake-Eastern having the lowest population and Winnipeg RHA having the highest.

Figure 1.10. Visible Minority Population by RHA



	IERHA	NRHA	SH-SS	PMH	MB	WRHA
T1 PERCENT	1.8%	3.2%	3.6%	7.4%	17.5%	27.5%

Source: Statistics Canada Census 2016

Who is Interlake-Eastern Regional Health Authority?

Regional Key Findings

- In the 2016 Census, a total of 2,185 Interlake-Eastern residents self-identified as a visible minority.
- Visible minority populations are relatively stable and consistent among all zones, with Selkirk having the highest percentage.

Table 1.6. Visible Minority Population — IERHA Zone & District Findings

	Total #	Count	%
Manitoba	1,240,700	216,855	17.5%
IERHA	122,870	2,185	1.8%
South Zone	57,125	1,075	1.9%
Stonewall/Teulon	17,075	240	1.4%
Winnipeg Beach/St. Andrews	13,680	330	2.4%
St. Clements	11,345	140	1.2%
Springfield	15,025	365	2.4%
North Zone	17,040	305	0.01%
Powerview/Pine Falls	5,010	150	3.0%
Fisher/Peguis	6,260	95	1.5%
Eriksdale/Ashern	5,770	60	1.0%
East Zone	20,495	340	1.7%
Beausejour	8,235	125	1.5%
Pinawa/Lac du Bonnet	8,950	160	1.8%
Whiteshell	3,310	55	1.7%
West Zone	14,970	210	1.4%
Gimli	6,035	40	0.7%
Arborg/Riverton	4,585	125	2.7%
St. Laurent	4,350	45	1.0%
Northern Remote	3,710	15	0.4%
Northern Remote	3,710	15	0.4%
Selkirk Zone	9,535	240	3%
Selkirk	9,535	240	2.5%

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: Statistics Canada Census 2016

Language Spoken at Home

Definition

Language spoken most often at home within a population. A person can report more than one language if they are spoken equally as often.

Regional Key Findings

- Compared to Manitoba, Interlake-Eastern sees a larger percentage of residents speaking “English” most often at home.
- 95% of residents in Interlake-Eastern indicated they speak “English” most often at home followed by non-official languages.

Table 1.7. Language Spoken Most Often at Home — Provincial & IERHA Findings

	Manitoba		IERHA	
	Number	%	Number	%
Detailed language spoken most often at home - Total population excluding institutional residents	1,240,705		122,870	
English	1,025,880	83%	117,020	95%
French	16,005	1%	515	0%
Non-official languages	135,665	11%	3,605	3%
English and French	3,125	0%	145	0%
English and non-official language	58,835	5%	1,575	1%
French and non-official language	430	0%	15	0%
English, French and non-official language	765	0%	0	0%

Source: Statistics Canada Census 2016

Knowledge of French

Definition

Knowledge of French, as an official language, measured as the ability to conduct a conversation in French (combined French only and both French and English).

Regional Key Findings

- According to 2016 Census data, a total of 7,280 Interlake-Eastern residents indicated they have knowledge of “French only or English and French”.
- Five of the six zones in Interlake-Eastern have a percentage of residents indicating they have knowledge of both official languages.

Table 1.8. Knowledge of Francophone Language – IERHA Zone Findings

	Total - Knowledge of official languages for the population in private households - 25% sample data	French Only or English and French	
		Number	%
Manitoba	1,240,700	108,575	9%
IERHA	122,875	7,280	6%
South Zone	57,125	3,595	6%
East Zone	20,495	1,700	8%
West Zone	14,970	915	6%
Selkirk Zone	9530	575	6%
North Zone	17,045	450	3%
Northern Remote Zone	-	-	

Source: Statistics Canada Census 2016

CLOSER LOOK... FRENCH LANGUAGE SERVICES

Did you know?

The Province has designated two health care facilities within Interlake-Eastern RHA as bilingual, meaning the facility delivers its services in both English and French.

Pine Falls Health Complex
Pine Falls, MB

St. Laurent Health Centre
St. Laurent, MB

Interlake-Eastern RHA undertakes to provide health care services in French to its French-speaking population. The regional French language Services Committee develops and supports the implementation of the regional French language services plan as per the Government of Manitoba French Language Services Policy. The committee's goal is to ensure people and communities within the RHA are able to connect, in the official language of their choice, to excellent health services, today and tomorrow.



Interlake-Eastern RHA's French language services coordinators Michelle Berthelette (left) and Lori Carrière.

Immigrant Status in Private Households

Definition

Immigrant status refers to whether the person is a non-immigrant, an immigrant, or a non-permanent resident, and applies to each member of a household.

Regional Key Findings

- 19% of private households in Manitoba had a person with immigration status, which is higher than Interlake-Eastern at 5.8%
- Five of the six zones in Interlake-Eastern had immigration status in private households, with the West Zone having the highest percentage at 7.5% totaling 1,120 people.

Table 1.9. Immigrant Status in Private Households — IERHA Zone Findings

	Total - Immigrant status and period of immigration for the population in private households - 25% sample data	Non-immigrants	Immigrants		Non-permanent residents
Manitoba	1,116,9640	928,390	225,005	19.2%	16,245
IERHA	122,875	115,530	7,115	5.8%	230
South Zone	57,120	53,420	3,625	6.3%	65
East Zone	20,495	19,055	1,405	6.9%	40
West Zone	14,970	13,780	1,120	7.5%	60
Selkirk Zone	9,535	9,085	420	4.4%	25
North Zone	5,775	5,620	140	2.4%	10
Northern Remote Zone	-	-	-	-	-

Source: Statistics Canada Census 2016

Immigration by Place of Birth

Definition

This indicator measures any person who has ever been a landed immigrant or permanent resident by place of birth.

Provincial Key Findings

- Provincially, Asia makes up over 50% of place of birth for immigrants or permanent residents followed by Europe at 25%.
- There is variability and uniqueness among all RHAs for immigration by place of birth.

Regional Key Findings

- The top place of birth for immigrants or permanent residents within Interlake-Eastern is Europe (61.3%) followed by the Americas (22.7%).
- Among all RHAs in Manitoba, Interlake-Eastern has the highest percentage of immigrants and permanent residents born in Europe. This includes countries such as the United Kingdom, Germany, and Poland.

Table 1.10. Immigration by Place of Birth — Provincial Findings

	Total - Selected places of birth for the immigrant population in private households - 25% sample data	Americas	Europe	Africa	Asia	Oceania and other places of birth
Manitoba	224,995	14.1%	24.9%	7.9%	52.9%	0.3%
IERHA	7,105	22.7%	61.3%	2.4%	13.3%	0.3%
WRHA	178,105	9.2%	21.2%	9.0%	60.4%	0.3%
PMH	14,080	22.3%	30.8%	7.5%	39.2%	0.2%
NRHA	-	-	-	-	-	-
SH-SS	25,705	40.5%	37.7%	2.3%	19.3%	0.2%

Source: Statistics Canada Census 2016

Lone Parent Families

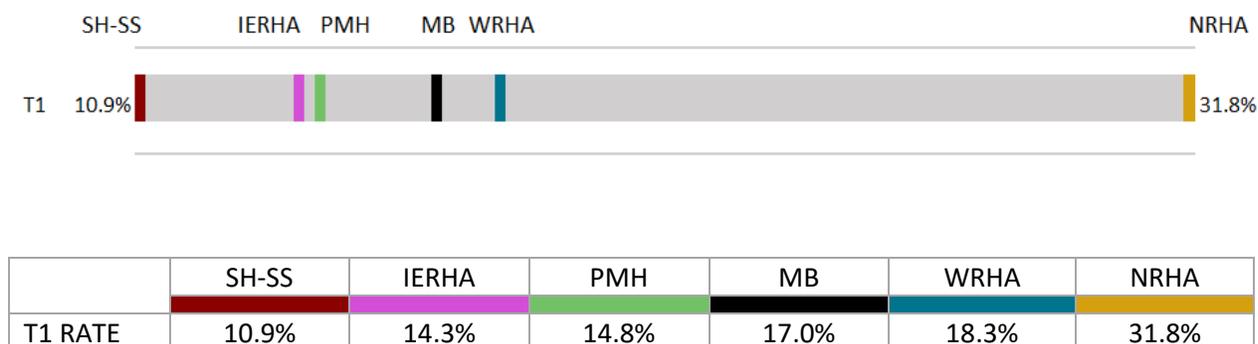
Definition

The percentage of families with only one parent of any marital status, with at least one child, living in private households.

Provincial Key Findings

- In Manitoba, there was a total of 58,865 lone parent families, which totals 17% of all private households.

Figure 1.11. Lone Parent Families, Manitoba and RHAs, 2016



Source: Statistics Canada Census 2016

Regional Key Findings

- In Interlake-Eastern, there was a total of 5,320 lone parent families, which totals 14.3% of all private households.
- Approximately one out of three private households in Northern Remote, North and Selkirk are lone-parent families.

Table 1.11. Lone Parent Families — IERHA Zone Findings

	Total number of census families in private households - 25% sample data	Total lone-parent families by sex of parent	%
Manitoba	346,130	58,865	17.0%
IERHA	37,160	5,320	14.3%
South Zone	17,745	1,765	9.9%
East Zone	6,590	690	10.5%
West Zone	4,630	545	11.8%
Selkirk Zone	2,760	765	27.7%
North Zone	4,565	1,265	27.7%
Northern Remote Zone	865	285	32.9%

Source: Statistics Canada Census 2016

Dependency Ratio

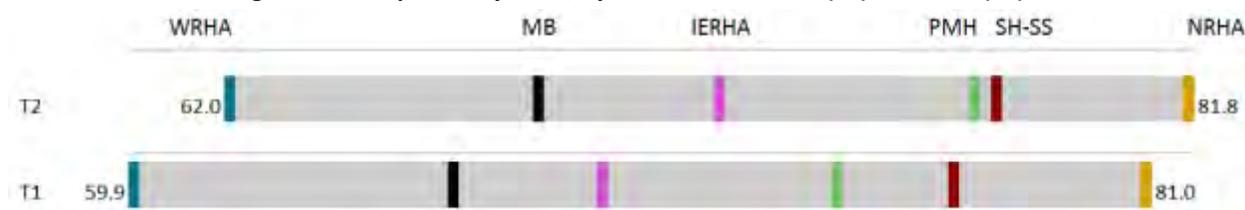
Definition

The ratio of the combined youth population (aged 19 and younger) and elderly population (aged 65 and older) to the working age population (aged 20-64).

Provincial Key Findings

- Those aged 0-19 and 65+ are more likely to socially and/or economically depend on working age residents and these age groups may put additional demands on health services.
- Dependency ratios vary across all RHAs, with the provincial average being 68.5%.
- Northern RHA has the highest dependency ratio, suggesting there is a smaller percentage of working age residents to support child, youth, and senior populations.

Figure 1.12. Dependency Ratio, by MB and RHA, 2013 (T1) and 2018 (T2)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	IERHA	PMH	SH-SS	NRHA
T2 COUNT	295,339	552,950	54,570	74,595	89,385	34,562
T2 RATE	62.0	68.5	72.1	77.5	77.8	81.8
T1 RATE	59.9	66.6	69.8	74.5	77.1	81.0

Source: Manitoba Health, IMA 2019

Table 1.12. Dependency Ratio — Provincial Findings

	Number age 0-19, 65+	%
Manitoba	552,950	68.5%
IERHA	54,570	72.1%
WRHA	295,339	62.0%
PMH	74,595	77.5%
NRHA	34,562	81.8%
SH-SS	89,385	77.8%

Source: Manitoba Health, IMA 2019

Who is Interlake-Eastern Regional Health Authority?

Regional Key Findings

- Interlake-Eastern's dependency ratio is 72.1%.
- There is varying dependency across the region, with Northern Remote having the highest dependency and South Zone having the lowest (Table 1.13.).

Table 1.13. Dependency Ratio — IERHA Zone & District Findings, 2018

	Number 0-19, 65+	%		Number 0-19, 65+	%
Manitoba	552,950	68.5%	IERHA	54,570	72.1%
South Zone	23,269	63.6%	North Zone	8,957	80.8%
Stonewall/Teulon	7,765	67.4%	Powerview/Pine Falls	2,838	82.1%
Winnipeg Beach/St. Andrews	6,349	61.0%	Fisher/Peguis	3,137	79.7%
St. Clements	3,307	59.6%	Eriksdale/Ashern	2,982	80.7%
Springfield	5,848	64.3%			
East Zone	8,832	75.4%	Northern Remote	1,974	92.9%
Beausejour	3,804	66.2%	Northern Remote	1,974	92.9%
Pinawa/Lac du Bonnet	3,805	89.2%			
Whiteshell	1,223	71.9%			
West Zone	7,004	84.6%			
Gimli	2,946	92.9%			
Arborg/Riverton	2,283	83.6%			
St. Laurent	1,775	74.8%			
Selkirk Zone	4,534	76.7%			
Selkirk	4,534	76.7%			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: Manitoba Health, IMA 2019

CLOSER LOOK... REACHING OUT

Staff hit the road to deliver training

Over a six-week period, regional staff delivered an overview of cardiovascular pulmonary resuscitation (CPR) at six different Healthy Baby groups. 'Step'N Out With Mom' is a community support program that helps pregnant women and new parents connect with other parents, families, and health professionals. These group sessions offer information, support, and resources on prenatal and postnatal nutrition and health, breastfeeding, safety, parenting tips, and lifestyle choices. They are offered in Winnipeg Beach, Eriksdale, Teulon, Fisher Branch, and to two groups in the Arborg area. One of the Arborg groups that received CPR training consisted of Mennonite women who are mostly German speaking. They were predominantly newcomers to the area, Canadian culture and to common health practices. In total, we offered training in CPR, automated external defibrillator (AED) and choking (infant/child/adult) to 52 families.

Staff collaborate to deliver summer days at the cottage one last time

It's not unusual for the home care team to receive special requests to accommodate cottagers coming into the region over the summer. Sometimes people need extra help to remain safely and comfortably in their summer homes. This year, they had an extra special request. A woman was in contact with the home care program to see if there was a way her husband, who was palliative, could enjoy one last summer at the cottage. His care needs were quite extensive so staff recognized it would pressure home care service delivery.

Summer is prime holiday time and it can be difficult to fill home care shifts because so many staff book summer holidays. The home care program is no different in that summer is a challenging time to maintain required services due to staffing shortages. But when you're given a challenge to help someone enjoy their final summer, it takes client-centered care to a whole different level. A home care case coordinator worked with the director of home care, to try and coordinate and cover the client's care. At one point, staff from four different IERHA home care offices were considered for a schedule but it still couldn't work. Staff shortages and increased needs of existing clients in each community conflicted with efforts to meet the needs of the special request. With help from human resources the team was finally able to support this client.

Thanks was extended to the Pine Falls, Lac du Bonnet, Oakbank and Selkirk resource coordinator team for their collaboration to provide service delivery and for their focus on customer service. The team truly went above and beyond to give a couple the gift of two weeks together at the cottage. The family thanked the team for the sunny skies and beautiful weather that they enjoyed. A priceless gift was provided and it is an excellent reminder of the considerable value that is delivered when focus is placed on client-centered care paired with creative thinking to problem solving.

CHAPTER 2: WHAT KEEPS US HEALTHY?



Table of Contents

CHAPTER 2: WHAT KEEPS US HEALTHY? _____	32
Table of Figures _____	35
At A Glance: What Keeps Us Healthy? _____	38
Why is this Chapter Important? _____	38
Chapter 2 Key Findings _____	39
What influences how healthy our population is? _____	40
Social Determinants of Health _____	42
Social Deprivation Index _____	42
Material Deprivation Index _____	44
Median Household Income—After-Tax _____	46
Low-income Measure – After-Tax (LIM-AT) _____	48
Household Food Insecurity _____	50
Housing Affordability _____	51
Educational Attainment _____	53
Labour Force Participation _____	56
Unemployment Rates _____	57
Industry Sectors _____	58
Work Stress _____	59
Healthy Child Development _____	60
Inadequate Prenatal Care _____	60
Preterm Birth Rate _____	62
Small for Gestational Age (SGA) _____	64
Large for Gestational Age (LGA) _____	66
Breastfeeding Initiation _____	68
Proportion of Children Low-income _____	70
Families First – Risk Factors _____	72
Readiness for School Learning _____	74
Pediatric Dental Extractions under General Anesthesia _____	78
Childhood Immunization _____	82

Teen Pregnancy Rate _____	84
Teen Birth Rate _____	86
Personal Health Determinants _____	89
Quality of Life _____	89
Self-Rated General Health _____	89
Self-Rated Mental Health _____	90
Life Stress _____	91
Sense of Community Belonging _____	92
Changes Made to Improve Health _____	93
Body Mass Index (BMI) _____	94
Substance Use Disorders _____	95
Drug Methods _____	96
Alcohol Use _____	97
Tobacco Use/Smoking _____	99
Second-hand Smoke Exposure _____	100
Physical Activity – Adults _____	101
Participation and Activity Limitation _____	102
Fruit and Vegetable Consumption _____	103
Sleep Time _____	104
Driving and Safety – Cell Phone Use While Driving _____	105
Driving and Safety – ATV Helmet Use _____	106
Use of Preventive Services _____	108
Influenza Immunization (age 65+) _____	108
Pneumococcal Immunizations (age 65+) _____	110
Colorectal Cancer Screening _____	112
Breast Cancer Screening _____	114
Cervical Cancer Screening _____	116
Oral Health (Dental Visits/Insurance) _____	118

Table of Figures

Figure 2.1. Social Determinants of Health	41
Figure 2.2. Mean Social Deprivation by RHA, Canadian Census 2011 (T1) and 2016 (T2)	42
Table 2.1. Social Deprivation Index—IERHA Zone & District Findings, 2011 (T1) and 2016 (T2).....	43
Figure 2.3. Material Deprivation Index—Provincial Findings, Mean Material Deprivation by RHA, 2011 (T1) and 2016 (T2)	44
Table 2.2. Material Deprivation Index—IERHA Zone Findings, 2011 (T1) and 2016 (T2)	45
Figure 2.4. Median Household Income (after-tax, post transfer), 2015	46
Table 2.3. Median Household Income—After-Tax—IERHA Zone & District Findings, 2015	47
Figure 2.5. Prevalence of low-income based on the Low-income measure, after tax (LIM-AT) (%)	48
Table 2.4. Low-income Measure – After-Tax—IERHA Zone & District Findings	49
Figure 2.6. Reported being ‘Moderately/Severely Food Insecure’	50
Table 2.5. Housing Affordability—Provincial Findings	51
Table 2.6. Housing Affordability—IERHA Zone & District Findings	52
Figure 2.7. Percentage of Population Aged 15+ with no Certificate, Diploma or Degree	53
Table 2.7. Educational Attainment—IERHA Zone & District Findings	54
Table 2.8. Educational Attainment	55
Table 2.9. Labour Force Participation – Provincial RHA Findings.....	56
Figure 2.8. Unemployment Rates— Unemployment Rates, Manitoba and RHAs, 2016.....	57
Table 2.10. Unemployment Rates – Provincial Findings.....	57
Table 2.11. Industry Sectors— RHA Findings.....	58
Figure 2.9. Perceived Work Stress by RHA 2016, Aged 15-75	59
Figure 2.10. Inadequate Prenatal Care Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	60
Table 2.12. Inadequate Prenatal Care—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	61
Figure 2.11 Preterm Birth Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	62
Table 2.13. Preterm Birth Rate—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	63
Figure 2.12. Small for Gestational Age Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	64
Table 2.14. Small for Gestational Age—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	65
Figure 2.13. Large for Gestational Age Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	66
Table 2.15. Large for Gestational Age—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	67
Figure 2.14. Breastfeeding Initiation Rates by RHA, 2011/12 (T1) and 2016/17 (T2)	68
Table 2.16. Breastfeeding Initiation—IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2).....	69

Figure 2.15. Children aged 17 and younger living in low-income families based on LIM-AT, Manitoba and RHAs.....	70
Table 2.17. Proportion of Children Low-income—IERHA Zone Findings	71
Figure 2.16. Families First – Risk Factors—Provincial Findings 3 or more risk factors.....	72
Table 2.18. Three or more risk factors.....	73
Table 2.19. Families First Screening.....	73
Figure 2.17. Readiness for School Learning, Physical Health and Well-Being, 2013(T1) and 2017(T2).....	75
Figure 2.18. Readiness for School Learning, Social Competence, 2013(T1) and 2017(T2).....	75
Figure 2.19. Readiness for School Learning, Emotional Maturity, 2013(T1) and 2017(T2)	76
Figure 2.20. Readiness for School Learning, Language and Thinking Skills, 2013(T1) and 2017(T2).....	76
Figure 2.21. Readiness for School Learning, Communication Skills and General Knowledge, 2013(T1) and 2017(T2)	77
Figure 2.22. Pediatric Dental Extraction Surgery—Provincial Findings Dental Extraction Surgery Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2).....	79
Table 2.20. Pediatric Dental Extraction Surgery—IERHA Zone & Districts Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2).....	80
Table 2.21. Childhood Immunization—Provincial Findings	82
Table 2.22. Childhood Immunization—IERHA Zone Findings	83
Figure 2.23. Teen Pregnancy by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2).....	84
Table 2.23. Teen Pregnancy Rate—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	85
Figure 2.24. Teen Births by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	86
Table 2.24. Teen Birth Rate—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	87
Figure 2.25. Self-Rated General Health—Provincial Findings.....	89
Figure 2.26. Self-Rated Mental Health—Provincial Findings	90
Figure 2.27. Life Stress—Provincial Findings	91
Figure 2.28. Sense of Community Belonging—Provincial Findings	92
Figure 2.29. Percent of residents who reported making a positive health change in the last year, CCHS 2015-2016 (T1).....	93
Figure 2.30. Body Mass Index—Provincial Findings	94
Figure 2.31. Prevalence of Substance Use Disorders among Adults by RHA, 2010/11-2014/15 (T1)	95
Figure 2.32. Drug Methods—Provincial Findings	96
Figure 2.33. Alcohol Use—Provincial Findings, Number of Drinks in the past Week 2015-2016.....	97
Figure 2.34. Alcohol Use—Provincial Findings	98
Figure 2.35. Tobacco Use/Smoking—Provincial Findings	99
Figure 2.36. Exposed to second-hand smoke in own home/private vehicle/public place	100
Figure 2.37. Physical Activity – Adults—Provincial Findings	101
Table 2.25. Participation and Activity Limitation—Provincial Findings	102

Table 2.26. Participation and Activity Limitation— IERHA Zone Findings	102
Figure 2.38. Reported consuming five or more servings of fruit or vegetables per day	103
Figure 2.39. Average Amount of Sleep - Provincial Findings	104
Table 2.27. Driving and Safety – Cell Phone Use—Provincial Findings, 2011-2014.....	105
Table 2.28. Driving and Safety – Cell Phone Use—IERHA Zone Findings, 2011-2014.....	106
Table 2.29. Driving and Safety – ATV Helmet Use—Provincial Findings	106
Table 2.30. Driving and Safety – ATV Helmet Use— IERHA Zone Findings	107
Table 2.31. Influenza (age 65+)—Provincial Findings	108
Table 2.32. Influenza (age 65+)—IERHA Zone Findings	109
Table 2.33. Pneumococcal (age 65+)—Provincial Findings.....	110
Table 2.34. Pneumococcal (age 65+) - IERHA Zone Findings	111
Figure 2.40. Colorectal Cancer Screening—Provincial Findings	113
Figure 2.41. Colorectal Cancer Screening—IERHA Zone Findings	113
Figure 2.42. Breast Cancer Screening—Provincial Findings, 2014-15 and 2016-17	115
Figure 2.43. Breast Cancer Screening—IERHA Zone Findings, 2014-15 and 2016-17	115
Figure 2.44. Cervical Cancer Screening—Provincial Findings, 2012-14 and 2015-17.....	116
Figure 2.45. Cervical Cancer Screening—IERHA Zone Findings	117
Figure 2.46. Oral Health (Dental Visits/Insurance)—Provincial Findings, reported having insurance for dental expenses	118

At A Glance: What Keeps Us Healthy?

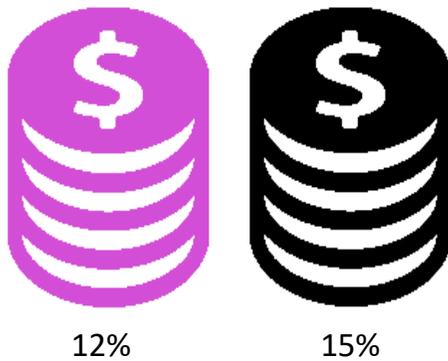
Educational Attainment no certificate, diploma or degree



Unemployment Rates



Percentage of Low Income Households



Substance Use Disorders



Why is this Chapter Important?

- This chapter outlines the geography of the region as well as demographic features of our population. The unique characteristics of our region influence the factors that determine how healthy we are and have a significant impact on the need for appropriate services and programs.
- The information in this chapter is foundational to forecast future issues that will require dedicated strategies in both the short and long-term.
- Population health surveillance is essential to health-care planning and resource allocation to ensure we develop equitable and sustainable programs and services.

Chapter 2 Key Findings

Income and Social Status:

- Median household income (after tax) ranges between districts from \$30,918 to \$82,975
- A total of 12% of residents live in low-income households

Employment:

- 66.1% of residents reported to be in the labour force
- 7.5% of residents unemployed
- Trades, transport and equipment operators and related occupations is the leading industry sector

Healthy Child Development:

- 80% of women who deliver in hospital initiate breastfeeding while in hospital
- 17.4% of children live in low-income households
- Nearly 25% of mothers screen with 3 or more risk factors by the Families First Program
- Significant decrease in teen birth rates

Health Behaviours:

- 50% of the population has made changes to improve health which includes exercising and healthy eating
- 15% of regional residents reported being a “current smoker”
- North Zone has the highest percent of residents often requiring help for activities of daily living (ADLs)
- Majority of residents getting seven or more hours of sleep per night

Cancer Screening:

- Increasing participation in colorectal cancer screening among all six zones
- Decreasing rates in all six zones for breast cancer screening
- Cervical cancer screening has the smallest disparity at the zone level in participation rates among all three screening programs



What influences how healthy our population is?

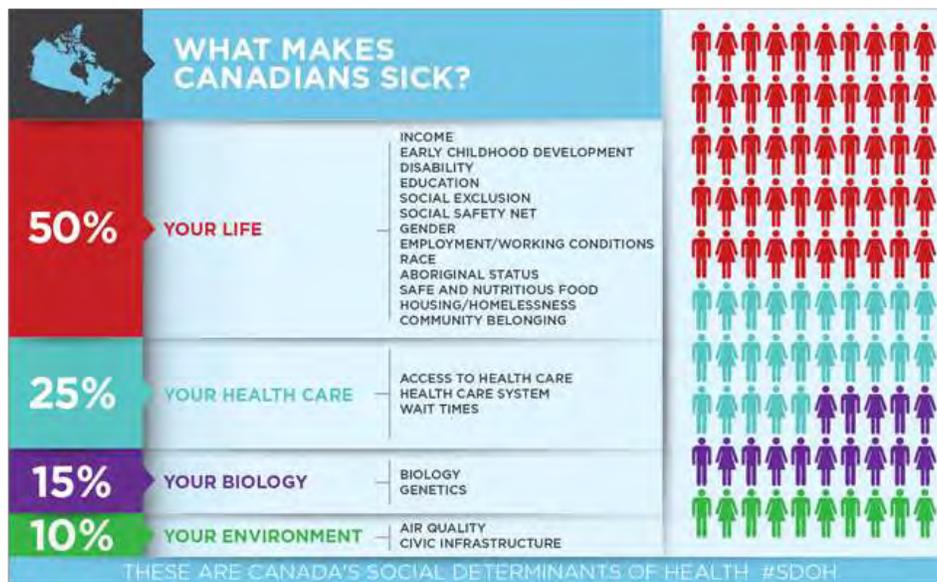
This chapter presents information regarding the social determinants of health and health status measures by geographic area in order to provide a comprehensive picture of the health of Interlake-Eastern Regional Health Authority's residents..

Interactions between the determinants of health result in differences in health status among individuals living in different geographic areas of the region and the province. Wherever possible, the report presents the health status of the population overall and identifies population groups that experience poorer health outcomes. These comparisons are essential to assess whether gaps are widening or narrowing among population groups (based on income and geographic location). Future planning efforts must take these health gaps into consideration to improve overall population health outcomes.

According to the Canadian Medical Association (CMA), social determinants of health “are systematic social and economic conditions that influence a person’s health. They include income, housing, education, gender, and race and have a greater impact on individual and population health than biological and environmental conditions. Their impact can be even greater than that of the health care system itself.”^{xiv} In 2013, the CMA published the results of the National Dialogue on Health Care Transformation.^{xv} The dialogue took place online as well as in six town halls conducted across the country. Participants identified four social determinants of health (income, housing, nutrition and food security, and early childhood development) as having equal, if not more important, roles in determining health than the health-care system. Other social determinants of health that were mentioned by participants as being important to health include: culture, the environment, education, and health literacy.^{xv}

As participants in the National Dialogue on Health Care Transformation expressed, some determinants of health affect an individual’s health more than others (see **Figure 2.1.**). According to the CMA, about 50 percent of an individual’s health is determined by their life experiences (e.g., income, early childhood development, disability, etc.). Only 25 percent of an individual’s health is determined by the health care they receive (e.g., access to health care, the health-care system, wait times, etc.) and 15 percent is determined by an individual’s biology (e.g., genetics). Finally, the environment determines about ten percent of an individual’s health (e.g., air quality, civic infrastructure, etc.).

Figure 2.1. Social Determinants of Health



Canadian Medical Association, n.d., cited in South East Local Health Integration Network, 2014.¹

In an attempt to answer the question of what keeps Interlake-Eastern Regional Health Authority residents healthy, this chapter will look at indicators related to:

- Income;
- Housing;
- Food Security;
- Education;
- Employment/Working Conditions;
- Healthy Child Development;
- Personal Health Determinants;
- Health Behaviours; and
- Use of Preventive Services.

footnote

The indicators reported in this chapter relate to the social determinants of health. However, while all determinants of health are important, data are not currently available for all social determinants at the provincial and regional levels. Further, not all determinants of health are easily modifiable or can be reasonably addressed by the region (e.g., determinants of health related to biology and genetics). It is also important to note that all factors that affect a person's health cannot be addressed solely by the health-care system.

¹ Social determinants of health infographic accessed from:
<http://www.southeastlhin.on.ca/Priorities/Planning/HealthLinks/HealthLinkCareCoordinationLearningProgram/ServingVulnerablePopulations/SVP102/SVP102-page2.aspx>

Social Determinants of Health

Social Deprivation Index

Definition

A composite score which includes the proportion of the population, aged 15 years and older, who are separated, divorced, or widowed, the proportion of the population that lives alone, and the proportion of the population that has moved at least once in the past five years.

Why is this indicator important?

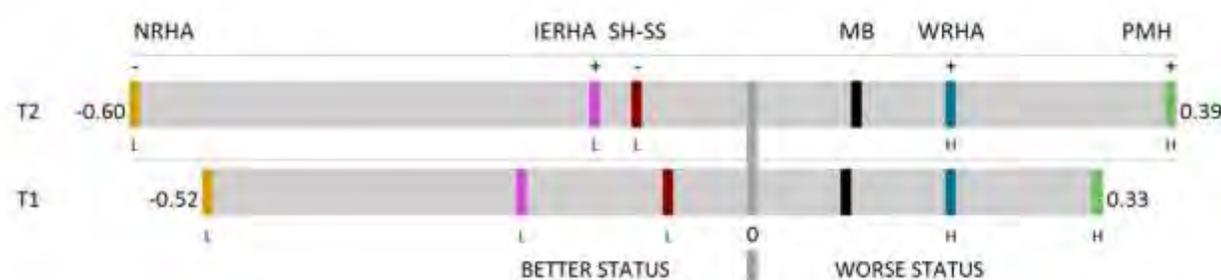
It reflects the status of relationships among individuals in the family, workplace, and the community. Scores on these indices range from -5 to +5; lower scores indicate better status or less deprivation, while higher scores indicate worse status or more deprivation.

Provincial Key Findings

- The provincial Manitoba social deprivation score has remained stable during both 2011 and 2016, showing no significant increases or decreases.
- Findings presented in **Figure 2.2.** suggest that those living in Northern RHA, Interlake-Eastern, and Southern Health Santé Sud have a better relationship in the family, workplace, and community based on their scores falling below 0.
- Both Prairie Mountain Health and Winnipeg RHA were found to have worse social deprivation compared to the other regions.

Figure 2.2. Mean Social Deprivation by RHA, Canadian Census 2011 (T1) and 2016 (T2)

Score on MCHP’s Social Deprivation Index. Lower values indicate better status



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA		IERHA		SH-SS		MB		WRHA		PMH	
T2 COUNT	77,068		128,240		198,809		1,351,359		770,185		170,521	
T2 RATE	-0.60	L-	-0.15	L+	-0.11	L-	0.09	+	0.19	H+	0.39	H+
T1 RATE	-0.52	L	-0.22	L	-0.08	L	0.08		0.18	H	0.33	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern had a social deprivation index significantly lower during both time periods compared to Manitoba, although in 2016 there appears to be shift in the region moving towards a worse status.
- At the regional level, 10 of the 15 districts have social deprivation values below “0” indicating better social status, these districts include: Stonewall/Teulon, Winnipeg Beach/St. Andrews, St. Clements, Springfield, Whiteshell, St. Laurent, Powerview/Pine Falls, Fisher/Peguis, Eriksdale/Ashern, and Northern Remote.
- The five districts that have worse social deprivation index scores may, for instance, be seeing more widowed individuals, more people living alone, and more people who have moved within the past five years.

Table 2.1. Social Deprivation Index—IERHA Zone & District Findings, 2011 (T1) and 2016 (T2)

	2016		2011
Manitoba	0.09		0.08
IERHA	-0.15	L+	-0.22
South Zone			
Stonewall/Teulon	-0.41	L+	-0.76
Winnipeg Beach/St. Andrews	-0.60	L	-0.60
St. Clements	-0.70	L-	-0.26
Springfield	-0.78	L+	-0.99
East Zone			
Beausejour	0.90	H+	0.81
Pinawa/Lac du Bonnet	0.79	H+	0.36
Whiteshell	-0.28	L+	-0.23
West Zone			
Gimli	0.92	H+	0.50
Arborg/Riverton	0.89	H-	0.98
St. Laurent	-0.23	L	-0.21
Selkirk Zone			
Selkirk	0.66	H+	0.59
North Zone			
Powerview/Pine Falls	-0.28	L+	-0.47
Fisher/Peguis	-0.59	L-	-0.28
Eriksdale/Ashern	-0.65	L-	-0.35
Northern Remote Zone			
Northern Remote	-0.97	L-	-0.70

Source: MCHP RHA Indicators Atlas 2019

Material Deprivation Index

Definition

A composite score which includes average household income, unemployment rate for ages 15 years and older, and proportion of the population aged 15 and older without high school graduation.

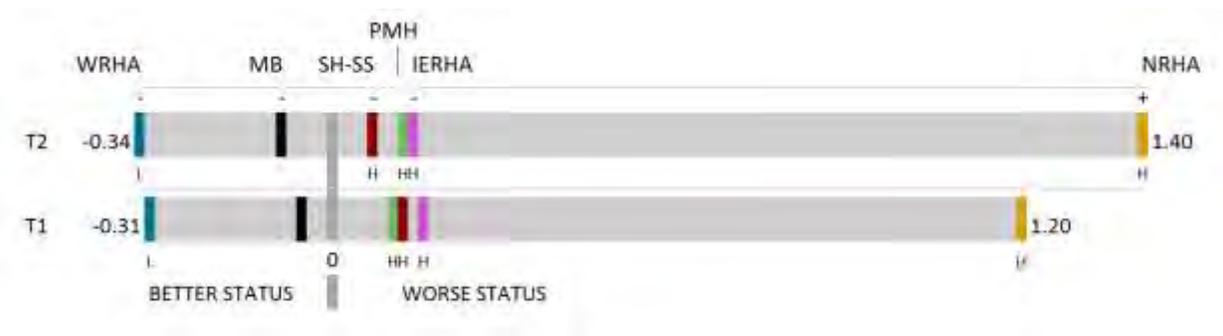
Why is this indicator important?

It reflects the status of wealth, goods, and conveniences. Scores on these indices range from -5 to +5; lower scores indicate better status or less deprivation, while higher scores indicate worse status or more deprivation.

Provincial Key Findings

- Provincially, Manitoba has experienced a shift in a positive direction with more residents having better status and less material deprivation.
- The only region that falls below “0” for having a better material index score is Winnipeg RHA. This may be driven by higher incomes or more employment opportunities.
- Southern Health Santé Sud, Prairie Mountain Health, Interlake-Eastern RHA and Northern RHA were all found to have material deprivation indexes significantly higher than the provincial average.
- These regions found to have “worse status” experience fewer opportunities for advancement into positions with higher remuneration, fewer employment opportunities, and a have a higher proportion of residents who did not complete high school.

Figure 2.3. Material Deprivation Index—Provincial Findings, Mean Material Deprivation by RHA, 2011 (T1) and 2016 (T2)
Score on MCHP’s Material Deprivation Index. Lower values indicate better status



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	SH-SS	PMH	IERHA	NRHA
T2 POP	770,185	1,351,359	198,809	170,521	128,240	77,068
T2 RATE	-0.34 L-	-0.07 -	0.08 H-	0.14 H	0.14 H-	1.40 H+
T1 RATE	-0.31 L	-0.05	0.14 H	0.13 H	0.17 H	1.20 H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern saw a statistically significant decrease between 2011 and 2016, indicating that fewer residents are experiencing material deprivation.
- At the district level, five of the 15 districts are found to have better status for material index scores. These include Beausejour, Springfield, Stonewall/Teulon, Winnipeg Beach/St. Andrews, and St. Clements.
- Material deprivation index scores decline significantly the more north you travel in Interlake-Eastern compared to districts surrounding Winnipeg's perimeter.

Table 2.2. Material Deprivation Index—IERHA Zone Findings, 2011 (T1) and 2016 (T2)

	2016		2011
Manitoba	-0.07		-0.05
IERHA	0.14	H-	0.17
South Zone			
Stonewall/Teulon	-0.44	L+	-0.58
Winnipeg Beach/St. Andrews	-0.50	L-	-0.48
St. Clements	-0.35	L+	-0.43
Springfield	-0.73	L-	-0.41
East Zone			
Beausejour	-0.27	L-	-0.16
Pinawa/Lac du Bonnet	0.35	H-	0.67
Whiteshell	0.43	H+	0.26
West Zone			
Gimli	0.02	H-	0.29
Arborg/Riverton	0.21	H-	0.46
St. Laurent	0.70	H+	0.48
Selkirk Zone			
Selkirk	0.17	H+	0.09
North Zone			
Powerview/Pine Falls	1.10	H+	1.04
Fisher/Peguis	2.01	H	2.03
Eriksdale/Ashern	1.08	H+	1.00
Northern Remote Zone			
Northern Remote	3.64	H+	2.70

Source: MCHP RHA Indicators Atlas 2019

Median Household Income—After-Tax

Definition

The median combined total income (after-tax, post transfer) of all members of household, aged 15 years and older, who reported income. Median household income is the amount which divides income size distribution, ranked by size of income, into two halves. That is, the incomes of the first half of the households are below the median while those of the second half are above the median.

Why is this indicator important?

Median Household income is an important measure of income inequality that exists in communities. It is an effective measure because health regions with smaller differences between the top and bottom ends generally experience better health status than those with more disparate incomes.

Provincial Key Findings

- Median household income (after tax) in Manitoba is \$59,003.
- Median household income ranges among all RHAs, with Prairie Mountain having the lowest and Interlake-Eastern the highest.
- All regions have experienced increased median household incomes since the 2011 Census.

Figure 2.4. Median Household Income (after-tax, post transfer), 2015

Median Household Income (after-tax, post transfer) 2015



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	PMH	MB	WRHA	NRHA	SH-SS	IERHA
T1 INCOME	\$54,014	\$59,093	\$59,510	\$60,308	\$60,802	\$61,155

Source: Statistics Canada Census 2016

Regional Key Findings

- **Table 2.3.** shows the variability of median household incomes between Interlake-Eastern zones.
- Higher median-household incomes are reported in the southern areas of the region compared to the mid and northern areas.

Table 2.3. Median Household Income—After-Tax—IERHA Zone & District Findings, 2015

	Median after-tax income of households in 2015 (\$)	Median after-tax income of one-person households in 2015 (\$)	Median after-tax income of two-or-more person households in 2015 (\$)
Manitoba	\$59,093	\$31,538	\$72,688
IERHA	\$61,155	\$ 30,056	\$ 72,869
South Zone			
Stonewall/Teulon	\$72,306	\$ 32,164	\$ 83,411
Winnipeg Beach/St. Andrews	\$71,034	\$ 35,598	\$ 82,811
St. Clements	\$71,079	\$ 35,440	\$ 83,798
Springfield	\$82,975	\$ 40,512	\$ 90,795
East Zone			
Beausejour	\$61,900	\$ 28,540	\$ 74,953
Pinawa/Lac du Bonnet	\$57,870	\$ 34,656	\$ 68,035
Whiteshell	\$56,589	\$ 30,339	\$ 69,275
West Zone			
Gimli	\$55,070	\$ 30,333	\$ 66,603
Arborg/Riverton	\$47,372	\$ 27,008	\$ 59,190
St. Laurent	\$51,333	\$ 24,761	\$ 61,960
Selkirk Zone			
Selkirk	\$53,186	\$ 28,571	\$ 67,181
North Zone			
Powerview/Pine Falls	\$37,913	\$ 24,415	\$ 44,856
Fisher/Peguis	\$38,389	\$ 18,998	\$ 48,183
Eriksdale/Ashern	\$39,801	\$ 22,079	\$ 51,772
Northern Remote Zone			
Northern Remote	\$30,918	\$ 15,797	\$ 34,304

Source: IMA, Statistics Canada Census 2016

Low-income Measure – After-Tax (LIM-AT)

Definition

In Canada, it is set at 50% of the median income after tax, adjusted for family size and composition.

Why is this indicator important?

It is used internationally as a relative measure of poverty.

Provincial Key Findings

- The overall prevalence of low-income among the Manitoba population is 15%.
- Low-income measure remains relatively consistent among all five health regions, with Interlake-Eastern having the lowest prevalence and Prairie Mountain having the highest.

Figure 2.5. Prevalence of low-income based on the Low-income measure, after tax (LIM-AT) (%)

	IERHA	SH-SS	MB	WRHA	NRHA	PMH
LIM-AT	12%	15%	15%	16%	17%	17%

Source: Statistics Canada Census 2016

Regional Key Findings

- Households are considered to be “low-income” when the income of the household falls below the threshold applicable to the household size.
- Within Interlake-Eastern, it is estimated that 12% of all households are considered to be low-income based on the LIM-AT.
- Within Interlake-Eastern, the largest percentage of low-income households includes those with children 0 to 5 years of age. Zones with high prevalence of low-income include both North and Selkirk zones.
- As the household sizes decrease and household members age, residents in Interlake-Eastern are less likely to live in low-income.

Table 2.4. Low-income Measure – After-Tax—IERHA Zone & District Findings

	Prevalence of low-income based on the Low-income measure, after tax (LIM-AT) (%)	0 to 5 years	6 to 17 years	18 to 64 years	65 years and over
Manitoba	15%	22%	25%	13%	14%
IERHA	12%	17%	20%	10%	14%
South Zone					
Stonewall/Teulon	8.0%	10.0%	8.0%	6.0%	14.0%
Winnipeg Beach/St. Andrews	8.0%	10.0%	15.0%	7.0%	10.0%
St. Clements	9.0%	13.0%	14.0%	7.0%	10.0%
Springfield	6.0%	6.0%	4.0%	5.0%	8.0%
East Zone					
Beausejour	13.0%	15.0%	19.0%	10.0%	17.0%
Pinawa/Lac du Bonnet	11.0%	21.0%	24.0%	11.0%	7.0%
Whiteshell	15.0%	34.0%	39.0%	11.0%	14.0%
West Zone					
Gimli	14.0%	28.0%	25.0%	14.0%	8.0%
Arborg/Riverton	24.0%	34.0%	39.0%	19.0%	25.0%
St. Laurent	22.0%	28.0%	32.0%	16.0%	30.0%
Selkirk Zone					
Selkirk	18.0%	30.0%	31.0%	15.0%	14.0%
North Zone					
Powerview/Pine Falls	25.0%	35.0%	46.0%	23.0%	17.0%
Fisher/Peguis	21.0%	24.0%	50.0%	17.0%	26.0%
Eriksdale/Ashern	26.0%	32.0%	46.0%	21.0%	32.0%
Northern Remote Zone					
Northern Remote	0.0%	0.0%	0.0%	0.0%	0.0%

Source: IMA, Statistics Canada Census 2016

Household Food Insecurity

Definition

The proportion of the population who reported being unable to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so.

Why is this indicator important?

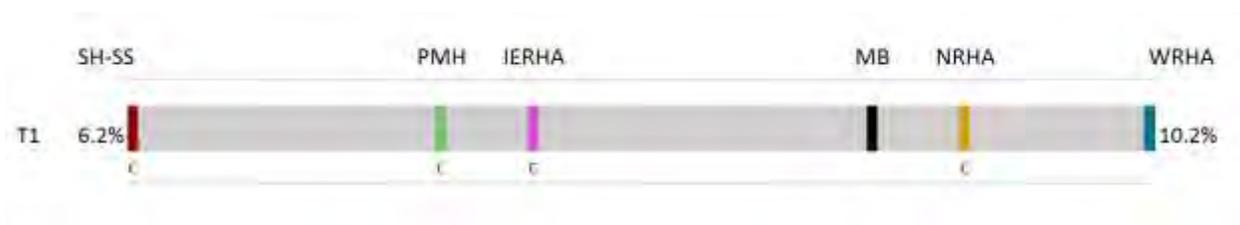
It is an important health equity indicator because it is often associated with a household's financial ability to access food.

Regional Key Findings

- Interlake-Eastern has slightly lower prevalence of food insecurity at 7.8% compared to Manitoba at 9.1%.

Figure 2.6. Reported being 'Moderately/Severely Food Insecure'

Age and sex adjusted proportion (%) of weighted sample



H/L Significantly higher or lower than the MB average for that time period C – estimate displayed with caution

	SH-SS		PMH		IERHA		MB		NRHA		WRHA	
T1 PERCENT	6.2%	C	7.4%	C	7.8%	C	9.1%		9.4%	C	10.2%	

Source: CCHS 2015-2016

Housing Affordability

Definition

The percentage of people in households that spend 30 percent or more of total household income on shelter expenses (e.g. electricity, water, municipal services, rent, monthly mortgage payments, property taxes, condo fees).

Why is this indicator important?

Housing is a critical component of a person’s environment. Living in poor housing conditions has been linked to respiratory conditions, lead poisoning, injuries and decreased mental health.

Provincial Key Findings

- In Manitoba, tenant households are more likely to spend 30% or more of household income on shelter compared to owner households.
- There is a larger percentage of the population in Winnipeg RHA spending more on shelter expenses compared to the other RHAs.

Table 2.5. Housing Affordability—Provincial Findings

% of households spending 30% or more of its income on shelter costs	Tenant households	Owner households
Manitoba	37%	11%
IERHA	32%	11%
WRHA	40%	12%
PMH	30%	10%
NRHA	22%	6%
SH-SS	34%	11%

Source: Statistics Canada Census 2016

Regional Key Findings

- In Interlake-Eastern, 25-36% of tenant households spend more than 30 percent of household income on shelter costs, while 7-14% of owner households spend more than 30 percent of household income on shelter costs.
- Consistent with provincial key findings, tenant households are more likely to spend more than 30 percent of household income on shelter costs compared to owners.

Table 2.6. Housing Affordability—IERHA Zone & District Findings

% of households spending 30% or more of its income on shelter costs	Tenant households	Owner households
Manitoba	37%	11%

% of households spending 30% or more of its income on shelter costs	Tenant households	Owner households
IERHA	32%	11%

South Zone		
Stonewall/Teulon	32%	10%
Winnipeg Beach/St. Andrews	35%	12%
St. Clements	28%	13%
Springfield	34%	10%

East Zone		
Beausejour	28%	14%
Pinawa/Lac du Bonnet	31%	10%
Whiteshell	0%	11%

West Zone		
Gimli	39%	11%
Arborg/Riverton	25%	12%
St. Laurent	28%	10%

Selkirk Zone		
Selkirk	36%	12%

North Zone		
Powerview/Pine Falls	30%	7%
Fisher/Peguis	33%	12%
Eriksdale/Ashern	26%	12%

Northern Remote		
Northern Remote	0%	0%

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: Statistics Canada Census 2016

Education

Educational Attainment

Definition

The proportion of the population, aged 15 years and older, by the highest level of education attained.

Why is this indicator important?

Educational attainment is widely acknowledged as a key component of socioeconomic status and is positively associated with health. Higher levels of education improve ability to access and understand information to stay healthy. Understanding levels of education is important for health planning.

Provincial Key Findings

- According to 2016 Census data, 22% of Manitoba residents have no certificate, diploma, or degree.
- No certificate, diploma, or degree varies among health regions, with Northern RHA having the highest and Winnipeg RHA having the lowest.

Figure 2.7. Percentage of Population Aged 15+ with no Certificate, Diploma or Degree



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	PMH	IERHA	SH-SS	NRHA
T1 PERCENT	16.9%	22.0%	25.7%	25.7%	29.4%	44.6%

Source: Statistics Canada Census 2016

Regional Key Findings

- A total of 25.7% (25,860) Interlake-Eastern residents age 15 and over do not have a certificate, diploma, or degree.
- Of the 25,860 residents, males make up the larger percentage, 56% (14,375), compared with 44% (11,485) of females.
- **Table 2.7**, breakdown the total of Interlake-Eastern residents age 15 and over do not have a certificate, diploma or degree by zone.
- **Table 2.8**, shows a breakdown of the highest level of education achieved for Interlake-Eastern residents compared to Manitoba as of 2016.

Table 2.7. Educational Attainment—IERHA Zone & District Findings

South Zone		
Stonewall/Teulon	2,730	10.6%
Winnipeg Beach/St. Andrews	2,075	8.0%
St. Clements	2,010	7.8%
Springfield	1,940	7.5%
East Zone		
Beausejour	1,695	6.6%
Pinawa/Lac du Bonnet	1,730	6.7%
Whiteshell	985	3.8%
West Zone		
Gimli	1,010	3.9%
Arborg/Riverton	1,245	4.8%
St. Laurent	1,245	4.8%
Selkirk Zone		
Selkirk	2,000	7.7%
North Zone		
Powerview/Pine Falls	1,570	6.1%
Fisher/Peguis	2,035	7.9%
Eriksdale/Ashern	1,845	7.1%
Northern Remote Zone		
Northern Remote	1,745	6.7%
Regional total without a certificate, diploma or degree:	25,860	

Source: IMA Statistics Canada Census 2016

Table 2.8. Educational Attainment

	MB	IERHA
No certificate, diploma or degree	22.0%	25.7%
Secondary (high) school diploma or equivalency certificate	29.6%	29.5%
Postsecondary certificate, diploma or degree	48.4%	44.8%
Apprenticeship or trades certificate or diploma	7.7%	10.9%
College, CEGEP or other non-university certificate or diploma	17.7%	18.9%
University certificate or diploma below bachelor level	2.9%	3.2%
University certificate, diploma or degree at bachelor level or above	20.1%	11.7%
Bachelor's degree	14.4%	8.8%
University certificate or diploma above bachelor level	1.6%	1.1%

Source: Statistics Canada Census 2016



Labour Force Participation

Definition

The percentage of the population, aged 15 years and older, who reported being in the labour force.

Why is this indicator important?

Those that are employed generally have higher levels of social inclusion, feeling they are contributing to the overall well-being of the community around them.

Regional Key Findings

- Based on the 2016 Census, a total of 62,670 Interlake-Eastern residents were in the labour force, representing two-thirds of the Interlake-Eastern population.
- Labour force participation varies between RHAs, with the lowest being in Northern RHA and the highest in Southern RHA.

Table 2.9. Labour Force Participation – Provincial RHA Findings

	Total - Population aged 15 years and over by Labour force status - 25% sample data	# in the labour force	Labour force participation
Manitoba	1,001,300	662,150	66.1%
IERHA	100,485	62,670	62.4%
WRHA	584,490	392,120	67.1%
PMH	127,385	84,155	66.1%
NRHA	49,430	28,045	56.7%
SH-SS	139,510	95,160	68.2%

Source: Statistics Canada Census 2016

Unemployment Rates

Definition

The percentage of the population, aged 15 years and older, who reported being unemployed expressed as a percentage of the labour force.

Why is this indicator important?

Unemployment is a significant risk factor for poor physical and mental health and therefore a major determinant of health inequality. It may be associated with increasingly difficult living conditions, low socioeconomic status, and health and social problems.

Regional Key Findings

- 6.8% of the Manitoba population is unemployed based on 2016 Census data.
- Rates of unemployment in Interlake-Eastern are slightly above the provincial average at 7.5%.
- Interlake-Eastern unemployment rates have increased over five years from 6.2% to 7.5%.

Figure 2.8. Unemployment Rates— Unemployment Rates, Manitoba and RHAs, 2016

Percentage of the labour force aged 15+ identified as unemployed in the first week of May 2016



	SH-SS	WRHA	PMH	MB	IERHA	NRHA
T1 PERCENT	5.3%	6.5%	6.6%	6.8%	7.5%	14.2%

Source: Statistics Canada Census 2016

Table 2.10. Unemployment Rates – Provincial Findings

	# in the labour force	# Unemployed	Unemployment rate
Manitoba	662,150	44,685	6.7%
IERHA	62,670	4,720	7.5%
WRHA	392,120	25,425	6.5%
PMH	84,155	5,535	6.6%
NRHA	28,045	3,975	14.2%
SH-SS	95,160	5,030	5.3%

Source: Statistics Canada Census 2016

Industry Sectors

Definition

The percentage of the population, aged 15 years and older, by their kind of work and the description of the main activities in their job.

Why is this indicator important?

The type of employment, irrespective of income level, may carry with it greater health risks due to exposure to harmful substances or potential risk of injuries.

Regional Key Findings

- The industry sector breakdown between Interlake-Eastern and Manitoba are very comparable.
- The top three industry sectors in Interlake-Eastern include trades/transport and related occupations, sales and service, and business/finance/administration.
- Within Interlake-Eastern, the leading industry sector among females is sales and service and for males is trades, transport and equipment operators and related occupations.

Table 2.11. Industry Sectors— RHA Findings

	Manitoba			IERHA		
	Total	Male	Female	Total	Male	Female
Management	11.0%	13.5%	8.3%	13.0%	15.6%	10.1%
Business, finance and administration	14.8%	8.1%	22.2%	13.8%	6.0%	22.7%
Natural and applied sciences and related occupations	5.3%	7.9%	2.4%	4.2%	6.0%	2.2%
Health occupations	8.0%	3.2%	13.5%	7.2%	1.9%	13.2%
Education, law and social, community and government service	13.2%	8.0%	19.0%	12.7%	6.5%	19.8%
Art, culture recreation and sport	2.2%	1.8%	2.7%	1.4%	0.8%	2.1%
Sales and service	22.2%	18.4%	26.5%	18.5%	13.7%	24.0%
Trades, transport and equipment operators and related occupations	15.8%	28.5%	1.7%	22.1%	38.9%	2.7%
Natural resources, agriculture and related production occupations	2.8%	4.2%	1.3%	4.1%	5.8%	2.2%
Manufacturing and utilities	4.6%	6.5%	2.4%	3.0%	4.7%	1.0%

Source: Statistics Canada Census 2016

Work Stress

Definition

The proportion of residents, aged 15 to 75 years, who reported most days at their main job or business to be ‘quite a bit/extremely stressful’, ‘a bit stressful’ or ‘not at all stressful’.

Why is this indicator important?

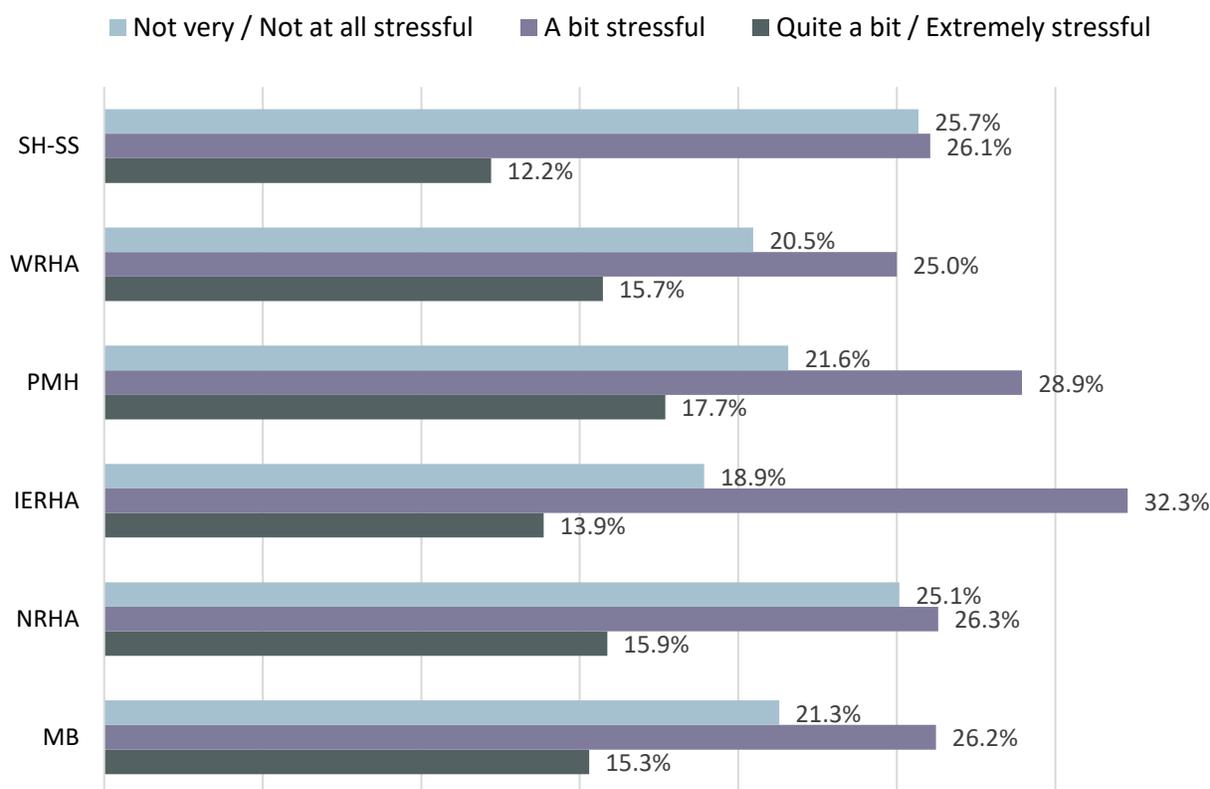
Work stress is one of the most common forms of stress, which can lead to poor health and injuries.

Regional Key Findings

- Compared to other regions, 32.3% of Interlake-Eastern residents reported work stress as “a bit stressful”.
- Overall Interlake-Eastern work stress is comparable to other regional and provincial findings.

Figure 2.9. Perceived Work Stress by RHA 2016, Aged 15-75

Age and Sex adjusted proportion (%) of weighted sample



Source: IMA, CCHS 2015/16

Healthy Child Development

Inadequate Prenatal Care

Definition

The proportion of women with a single, live, in-hospital birth receiving no or inadequate prenatal care, over a five-year time period.

Why is this indicator important?

Women who access prenatal care and receive regular prenatal visits are more likely to experience better health outcomes including a lower risk for low birth weight infant compared to women who receive no prenatal care. Inadequate prenatal care is more likely to be found in women who had less than a Grade 12 education or were younger (less than 25), living in lower income areas, on income assistance, a lone parent, socially isolated, or multiple pregnancies^{xvi}.

Provincial Key Findings

- Between 2013 and 2017 an estimated 7,300 women received inadequate prenatal care in Manitoba.
- Winnipeg women were least likely to experience in adequate prenatal care at 6.6%, significantly lower than the provincial average of 10.3%.
- Although the rate of inadequate prenatal care has declined in Northern RHA, rates are still significantly higher than the provincial average.

Figure 2.10. Inadequate Prenatal Care Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)
Maternal age adjusted average annual percent of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	IERHA	PMH	NRHA
T2 COUNT	2,117	1,139	7,300	665	971	2,391
T2 PERCENT	6.6% L	9.4% L	10.3%	10.6%	10.9%	27.8% H
T1 PERCENT	7.0% L	8.6% L	10.8%	11.8%	9.7%	31.1% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Approximately 1 out of 10 women in Interlake-Eastern receive inadequate prenatal care.
- At the zone level, inadequate prenatal care ranges from as low as 5% in the South Zone to as high as 18% in the North Zone.
- Both Northern Remote and North zones have significantly higher rates of inadequate prenatal care compared to the Manitoba average.
- At the district level, we see wide disparity in inadequate prenatal care. Based on the district disparity presented in **Table 2.12**, we know that women living in Powerview/Pine Falls are nearly eight times more likely to experience inadequate prenatal care than those in Springfield.

Table 2.12. Inadequate Prenatal Care—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2		T1	
	Count	Percent	Percent	
Manitoba	7,300	10%	11%	

	T2		T1	
	Count	Percent	Percent	
IERHA	665	11%	12%	

South Zone	106	5%	L	5%	L
Springfield	17	3%	L	5%	
Stonewall/Teulon	36	4%	L	4%	
Wpg Beach/St. Andrews	31	6%	+	3%	
St. Clements	22	7%		9%	

North Zone	300	18%	H	19%	H
Fisher/Peguis	86	15%		17%	H
Eriksdale/Ashern	101	20%	H	22%	H
Powerview/Pine Falls	113	22%	H	20%	H

East Zone	79	9%		11%	
Beausejour	20	5%	L	3%	
Whiteshell	25	13%	-	22%	
Pinawa/Lac du Bonnet	34	14%		13%	

Northern Remote	89	17%	H	22%	H
Northern Remote	89	17%	H	22%	H

West Zone	62	9%		12%	
Gimli	9	5%		7%	
St. Laurent	11	6%		7%	
Arborg/Riverton	42	14%		18%	H

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	8.3
	T2 Disparity	7.9
	Change	-0.4↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

Selkirk Zone	29	6%		6%	
Selkirk	29	6%		6%	

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Preterm Birth Rate

Definition

The proportion of live births with a gestational age of less than 37 weeks, based on a five-year time period.

Why is this indicator important?

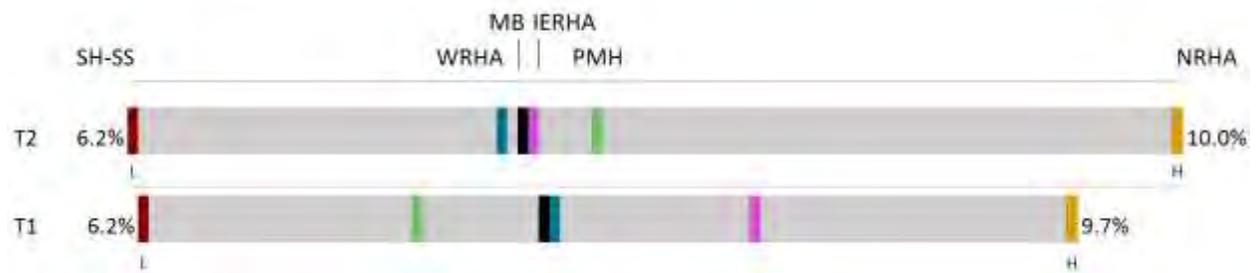
Preterm births are the leading cause of infant mortality. Preterm infants can have both short- and long-term health issues, including developmental disabilities, mental illnesses, and respiratory conditions^{xvii}.

Provincial Key Findings

- In Manitoba, pre-term birth rates have remained stable over time, with 7.6% of infants born prior to 37 weeks' gestation.
- Northern RHA was found to have a pre-term birth rate significantly higher than the Manitoba average, while Southern Health Santé Sud had rates significantly lower.

Figure 2.11 Preterm Birth Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

Maternal age adjusted average annual percent of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS		WRHA		MB		IERHA		PMH		NRHA	
T2 COUNT	877		3,105		6,089		528		781		782	
T2 PERCENT	6.2%	L	7.6%		7.6%		7.7%		7.9%		10.0%	H
T1 PERCENT	6.2%	L	7.7%		7.7%		8.5%		7.2%		9.7%	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- From 2012 to 2017, a total of 528 infants were born preterm among Interlake-Eastern women, representing 8% of all live births.
- Pre-term birth rates have remained consistent over time at the zone level, with the West Zone having the smallest percentage of pre-term births and Northern Remote having the highest.
- Within Interlake-Eastern districts, there has been a narrowing of disparity over time. This indicates that more women among all districts are giving birth to full term babies.

Table 2.13. Preterm Birth Rate—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2		T1		
	Count	Percent	Percent	Percent	
Manitoba	6,089	8%		8%	
IERHA	528	8%		9%	
South Zone	191	7%		7%	
Springfield	45	6%		8%	
Stonewall/Teulon	59	6%		6%	
St. Clements	29	8%		13%	H
Wpg Beach/St. Andrews	58	9%		6%	
North Zone	134	9%	-	12%	H
Fisher/Peguis	45	8%		10%	
Powerview/Pine Falls	39	8%	-	13%	H
Eriksdale/Ashern	50	11%		12%	H
East Zone	73	8%		8%	
Beausejour	26	5%		6%	
Pinawa/Lac du Bonnet	24	9%		10%	
Whiteshell	23	11%		9%	
Northern Remote	45	10%		13%	H
Northern Remote	45	10%		13%	H
West Zone	43	6%		5%	L
Arborg/Riverton	12	4%		5%	
Gimli	14	7%		6%	
St. Laurent	17	9%	+	3%	
Selkirk Zone	42	9%		8%	
Selkirk	42	9%		8%	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	4.6	
	T2 Disparity	3.1	
	Change	-1.5↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Small for Gestational Age (SGA)

Definition

The percentage of live hospital births in which birth weight falls below the 10th percentile of sex-specified birth weight for a given gestational age, based on a five-year time period.

Why is this indicator important?

SGA infants are more likely to face both short-term and long-term health issues including diabetes, hypertension, and cardiovascular disease. SGA is often related to maternal smoking, substance use, poor nutrition during pregnancy, placental insufficiency, and other conditions^{xviii}.

Provincial Key Findings

- In Manitoba, 8.3% of hospital births fall below the 10th percentile, which totals 6,576 infants from 2012 to 2017.
- Winnipeg RHA was found to have significantly higher percentage of women delivering infants below the 10th percentile compared to Interlake-Eastern, Northern RHA, Southern Health Santé Sud and Prairie Mountain Health that are all significantly below the provincial average.

Figure 2.12. Small for Gestational Age Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)
Maternal age adjusted average annual percent of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	IERHA		NRHA		SH-SS		PMH		MB		WRHA	
T2 COUNT	440		535		985		734		6,576		3,873	
T2 PERCENT	6.4%	L	6.6%	L	6.9%	L	7.4%	L	8.3%	+	9.8%	H+
T1 PERCENT	6.3%	L	6.6%	L	7.0%	L	6.8%	L	7.9%		9.1%	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern’s rates for small for gestational age have remained stable at 6% over time.
- Three of the six zones within Interlake-Eastern have rates significantly lower than the provincial rate of 8%, this includes: East Zone, North Zone, and Northern Remote Zone.
- Rates are relatively consistent at the zone level, there appears to be disparity at the district level where some districts are experiencing a higher percentage of women delivering infants small for gestational age.
- For example, Gimli women are nearly four times more likely to deliver a baby small for gestational age than those in the Whiteshell. Over time, disparity has increased among the districts.

Table 2.14. Small for Gestational Age—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2			T1	
	Count	Percent		Percent	
Manitoba	6,576	8%	+	8%	

	T2			T1	
	Count	Percent		Percent	
IERHA	440	6%	L	6%	L

South Zone	187	7%		7%	
Springfield	47	6%		6%	
Stonewall/Teulon	67	7%		7%	
Wpg Beach/St. Andrews	46	8%		7%	
St. Clements	27	8%		7%	

North Zone	100	6%	L	6%	L
Fisher/Peguis	29	5%		4%	L
Eriksdale/Ashern	35	7%		5%	
Powerview/Pine Falls	36	7%		8%	

East Zone	52	5%	L	6%	
Whiteshell	7	3%		4%	
Pinawa/Lac du Bonnet	15	6%		6%	
Beausejour	30	6%		6%	

Northern Remote	21	4%	L-	8%	
Northern Remote	21	4%	L-	8%	

West Zone	52	7%		6%	
St. Laurent	6	3%		7%	
Arborg/Riverton	21	6%		4%	
Gimli	25	12%		9%	

Selkirk Zone	28	6%		7%	
Selkirk	28	6%		7%	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	2.0
	T2 Disparity	3.6
	Change	+1.6↑
Disparity with a value of “0” suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Large for Gestational Age (LGA)

Definition

The percentage of live hospital births in which birth weight falls above the Canadian 90th percentile of sex-specified birth weight for a given gestational age, based on a five-year time period.

Why is this indicator important?

LGA infants may have a higher risk for injury and complications during birth, fetal and neonatal illnesses and death, impaired cognitive development, childhood and adult obesity and chronic conditions such as diabetes and heart disease later in life. LGA infants can be associated with prolonged pregnancies and gestational diabetes^{xix}.

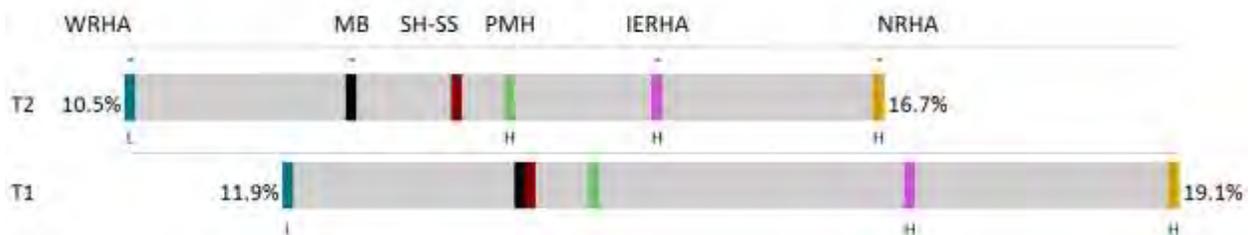
Provincial Key Findings

- In Manitoba, rates for LGA have decreased significantly over time from 13.8% down to 12.4%.
- All of the five health regions have experienced declines over time.
- Prairie Mountain Health, Interlake-Eastern RHA, and Northern RHA, although declining, continue to have rates which are significantly higher than the Manitoba average.
- The percentage of births large for gestational age among low-income residents was 1.4 times higher than the highest income residents.



Figure 2.13. Large for Gestational Age Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

Maternal age adjusted average annual percent of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	SH-SS	PMH	IERHA	NRHA
T2 COUNT	4,213	9,830	1,887	1,356	1,026	1,337
T2 PERCENT	10.5% L-	12.4% -	13.2% H	13.7% H	14.9% H-	16.7% H-
T1 PERCENT	11.9% L	13.8%	13.8%	14.4%	17.0% H	19.1% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- In Interlake-Eastern, rates for LGA have decreased significantly over time from 17% down to 15%.
- Three of the six zones within Interlake-Eastern have rates significantly higher than the provincial rate of 12%, this includes, West Zone (17%), North Zone (21%), and Northern Remote Zone (24%).
- Although all districts experience LGA, some districts see a significantly higher proportion. For instance, women living in Northern Remote are more likely to deliver a baby LGA than those in Springfield. **Table 2.15**, shows that disparity has increased over time between districts.

Table 2.15. Large for Gestational Age—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2			T1	
	Count	Percent		Percent	
Manitoba	9,830	12%	-	14%	

	T2			T1	
	Count	Percent		Percent	
IERHA	1,026	15%	H-	17%	H

South Zone		283	11%	L-	13%	
Springfield	67	9%		11%		
Stonewall/Teulon	105	11%		13%		
Wpg Beach/St. Andrews	69	11%		14%		
St. Clements	42	12%		17%		

East Zone		112	12%	-	16%	
Beausejour	49	10%	-	16%		
Pinawa/Lac du Bonnet	33	12%		15%		
Whiteshell	30	14%		17%		

West Zone		122	17%	H	16%	
Gimli	23	11%		14%		
St. Laurent	23	13%		12%		
Arborg/Riverton	76	22%	H	20%	H	

Selkirk Zone		77	16%		16%	
Selkirk	77	16%		16%		

IERHA DISTRICT DISPARITY RATIO					
	T1 Disparity	2.5			
	T2 Disparity	2.7			
	Change	+0.2↑			
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>					

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Breastfeeding Initiation

Definition

The percentage of women who deliver in hospital and initiate breastfeeding while in hospital, based on a one-year time period.

Why is this indicator important?

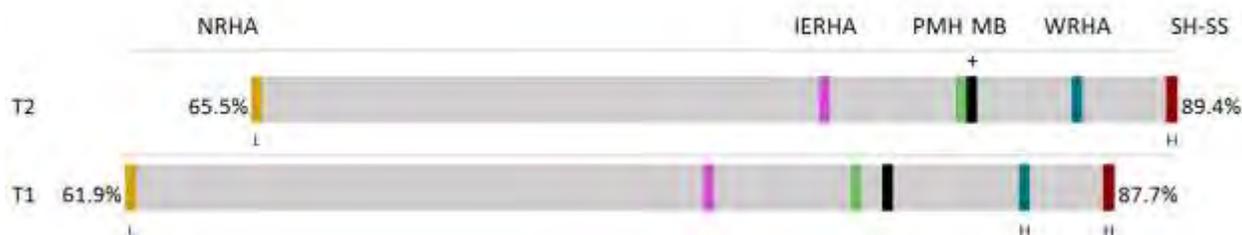
Breastfeeding is a key part of the healthy development and growth of infants. It is associated with lower rates of obesity and chronic diseases such as diabetes and asthma, and better early childhood development. Breastfeeding also has health benefits for mothers including lower risk for breast cancer, ovarian cancer and osteoporosis. Some of the most significant predictors of lower breastfeeding initiation are lower income, less than Grade 12 education and inadequate prenatal care.

Provincial Key Findings

- In Manitoba, the percentage of women who initiated breastfeeding while in hospital has increased significantly over time from 82.1% up to 84.2%.
- All regions have experienced increased breastfeeding initiation rates over time.
- Southern Health-Santé Sud (89.4%) has rates significantly higher than the provincial Manitoba average (84.2%) while Northern RHA (65.5%) has rates which are significantly lower.

Figure 2.14. Breastfeeding Initiation Rates by RHA, 2011/12 (T1) and 2016/17 (T2)

Maternal age adjusted percent of singleton live in-hospital births



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA		IERHA		PMH		MB		WRHA		SH-SS	
T2 COUNT	1,032		1,075		1,693		13,215		6,893		2,515	
T2 PERCENT	65.5%	L	80.2%		83.9%		84.2%	+	86.8%		89.4%	H
T1 PERCENT	61.9%	L	77.3%		81.2%		82.1%		85.4%	H	87.7%	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- 80% of Interlake-Eastern women initiated breastfeeding while in hospital, which is slightly below the provincial rate of 84%.
- Breastfeeding initiation rates vary considerably between zones, with the highest being 90% (South Zone) and the lowest being 37% (Northern Remote Zone).
- The North Zone has experienced a statistically significant increase in breastfeeding initiation rates over time from 60% up to 73%.
- Although, breastfeeding initiation rates vary across the region, it is important to note that disparity over time has decreased and we see a smaller gap between our highest and lowest rates.

Table 2.16. Breastfeeding Initiation—IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)

	T2			T1
	Count	Percent		Percent
Manitoba	13,215	84%	+	82%

	T2			T1
	Count	Percent		Percent
IERHA	1,075	80%		77%

South Zone	465	90%		90%
St. Clements	54	92%		86%
Springfield	136	92%		91%
Wpg Beach/St. Andrews	106	91%		90%
Stonewall/Teulon	169	89%		91%

North Zone	228	73%	+	60%	L
Powerview/Pine Falls	66	77%		55%	L
Eriksdale/Ashern	65	74%		62%	
Fisher/Peguis	97	70%		61%	

East Zone	138	82%		86%
Beausejour	78	85%		90%
Pinawa/Lac du Bonnet	29	79%		82%
Whiteshell	31	79%		80%

Northern Remote	36	37%	L	24%	L
Northern Remote	36	37%	L	24%	L

West Zone	135	89%		97%
Arborg/Riverton	58	93%		95%
Gimli	37	88%		85%
St. Laurent	40	85%		76%

Selkirk Zone	73	75%		82%
Selkirk	73	75%		82%

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	4.0	
	T2 Disparity	2.5	
	Change	-1.5↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Proportion of Children Low-income

Definition

The proportion of children, age 17 years and younger, living in low-income families according to low-income measure – after tax (LIM-AT).

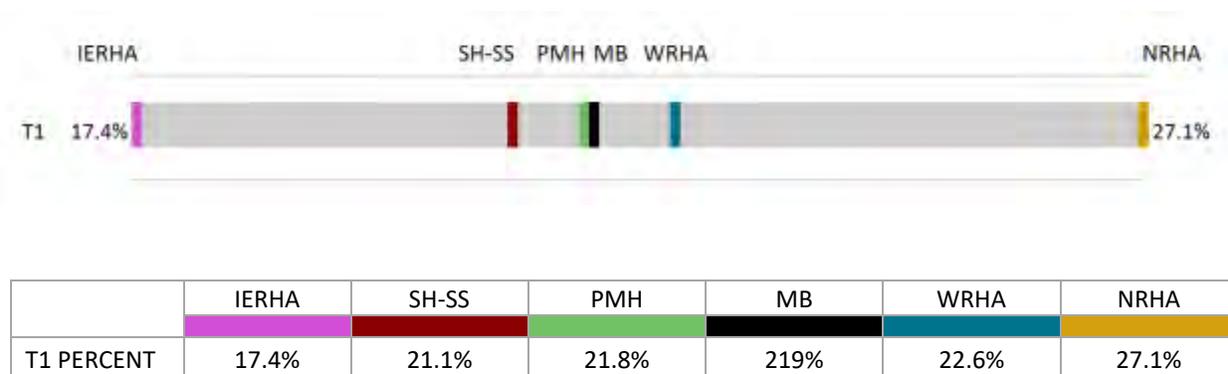
Why is this indicator important?

Family income affects children’s access to basic necessities such as adequate housing, nutritious food and clothing. Living in low-income poses many challenges for child growth and development including early learning and care programs, and access to recreation and art programs.

Provincial Key Findings

- Census 2016 data suggests that approximately one in five children live in low-income in Manitoba.
- According to the LIM-AT, Interlake-Eastern has the smallest percentage of children living in low-income families among all regions in Manitoba.

Figure 2.15. Children aged 17 and younger living in low-income families based on LIM-AT, Manitoba and RHAs



Source: Statistics Canada Census 2016

Regional Key Findings

- Between the ages of 0 to 17, a total of 21,900 children were living in low-income households in Interlake-Eastern.
- The proportion of children living in low-income varies across the region with both the South and East zones having a smaller percentage compared to those living in Selkirk, West, and North zones.

Table 2.17. Proportion of Children Low-income—IERHA Zone Findings

	Total 0 to 17 years in low-income	%
Manitoba	57,370	21.9%
IERHA	3,815	17.4%
South Zone	1,105	9.3%
East Zone	720	20.1%
West Zone	940	30.9%
Selkirk Zone	580	29.5%
North Zone	470	31.4%
Northern Remote Zone	-	-

Source: IMA Statistics Canada Census, 2016

Families First – Risk Factors

Definition

The proportion of mothers with three or more risk factors identified as leading to poor childhood outcomes, based on the regional post-partum population screened for enrollment in the Families First Program, for a one-year time period.

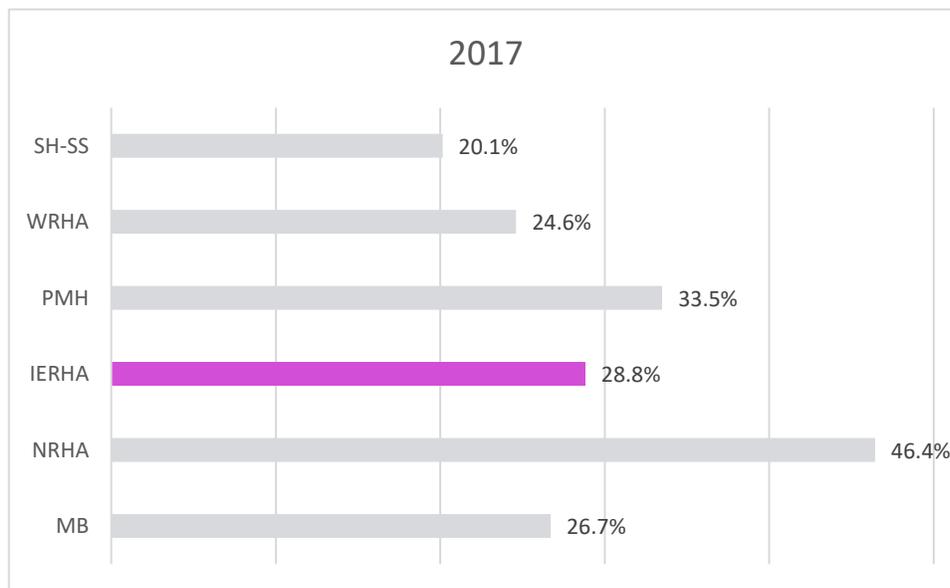
Why is this indicator important?

The early years comprise a significant period of brain development and set the foundation for health and success in all aspects of life. Risk factors identify families who may need further support and assistance to ensure children are raised in a healthy environment.

Provincial Key Findings

- In 2017, 26.7% of mothers screened with 3 or more risk factors.
- Based on 2017 data, both Prairie Mountain Health and Northern RHA experienced a larger proportion of women being screened with three or more risk factors compared to those in Southern Health Santé Sud, Winnipeg Regional Health, and Interlake-Eastern.

Figure 2.16. Families First – Risk Factors—Provincial Findings 3 or more risk factors



Source: Healthy Child Manitoba Office 2019

Table 2.18. Three or more risk factors

Three or more risk factors	2017	2016	2015	2014	2013
Manitoba	26.7%	26.7%	26.7%	26.7%	43.1%
IERHA	28.8%	31.4%	35.2%	32.8%	32.9%
WRHA	24.6%	25.8%	25.3%	27.3%	27.0%
PMH	33.5%	32.3%	30.6%	31.5%	31.3%
NRHA	46.4%	46.8%	43.8%	42.8%	26.7%
SH-SS	20.1%	22.0%	16.8%	19.6%	17.1%

Source: Healthy Child Manitoba Office 2019

Table 2.19. Families First Screening

Families First Screening					
IERHA					
	2017	2016	2015	2014	2013
Alcohol use by mother during pregnancy	7.8%	11.1%	11.2%	15.7%	16.4%
Maternal smoking during pregnancy	12.9%	13.3%	22.5%	21.1%	22.9%
Mother with less than Grade 12 education	14.5%	14.8%	20.2%	17.4%	21.7%
Income support or financial difficulties	14.8%	13.3%	16.2%	14.4%	14.8%
Maternal depression and/or maternal anxiety disorders combined	22.9%	24.3%	24.3%	19.4%	19.1%
Number of women screened by the program:	1,117	1,011	1,254	1,138	996

Source: Healthy Child Manitoba Office 2019

Readiness for School Learning

Definition

The proportion of kindergarten children 'vulnerable' or struggling, 'at risk' or lower than expected, and 'on track' meaning meeting age appropriate expectations for school based on the Early Development Instrument (EDI), for a one-year time period. It measures five areas of development: physical health and well-being, social competence, emotional maturity, language and thinking skills, and communication skills and general knowledge.

Why is this indicator important?

EDI is an important measure of the well-being and health of children. It has been shown to be strongly linked to parental involvement in a child's early learning, household income levels, as well as educational outcomes later in childhood. EDI results assist communities in planning for the services and programs children need in order to learn and enjoy their school experience.

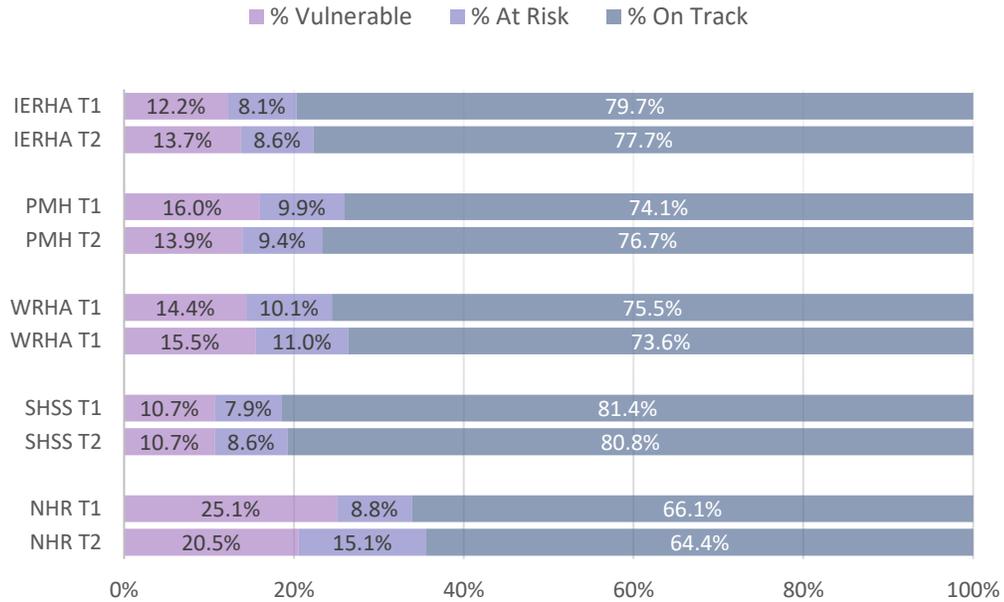
Provincial Key Findings

- Click on the link below to be directed to the Healthy Child Manitoba website which contains multiple report options: provincial roll up, school division, and former health regions (pre amalgamation in 2012)
- Hyperlink: https://www.gov.mb.ca/healthychild/edi/edi_reports.html



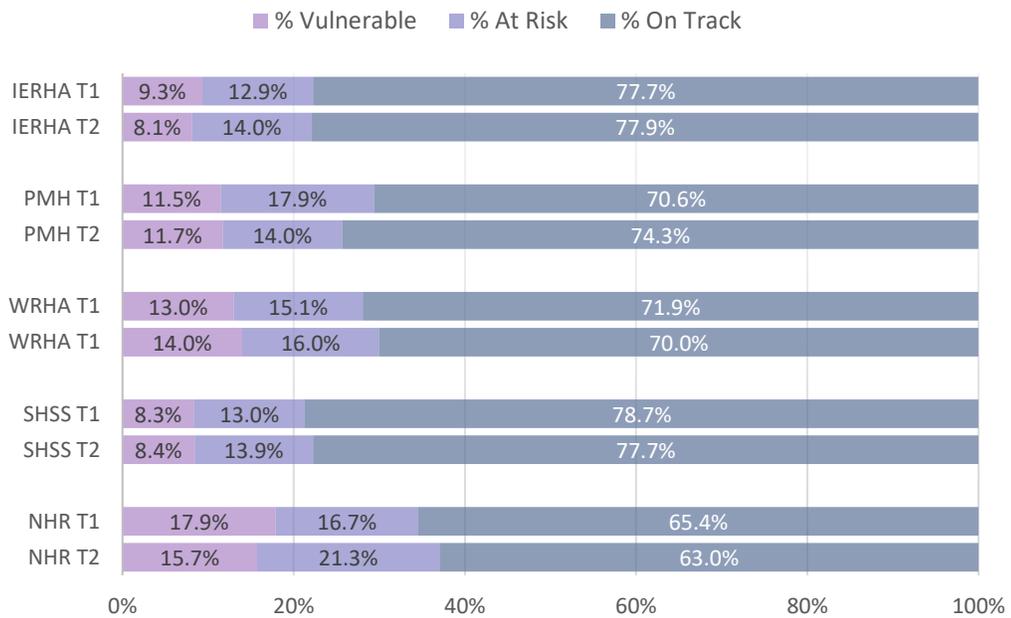
- Generally, Southern Health-Santé Sud had the least kindergarten aged children in the 'vulnerable' percentile and the NHR had the most children in the 'vulnerable' percentile for all five EDI measures.
- Likewise, Southern Health-Santé Sud and the IERHA had the highest percent of kindergarten aged children who were 'on track', meaning meeting age appropriate expectations for school based on the EDI in all five areas of development and the NHR had the lowest percent of children 'on track' in both time periods.

Figure 2.17. Readiness for School Learning, Physical Health and Well-Being, 2013(T1) and 2017(T2)
Kindergarten Children



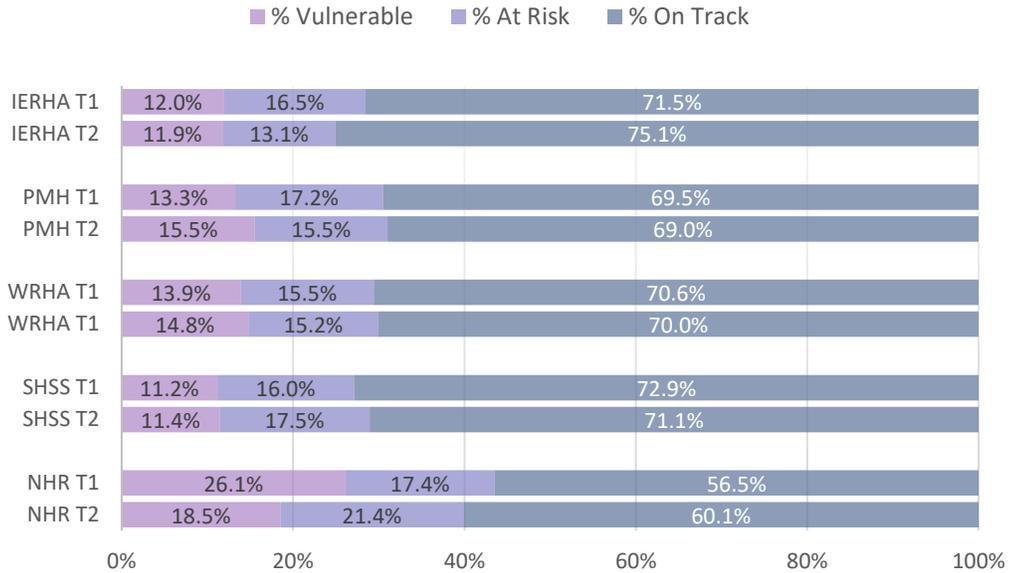
HCMO, 2019

Figure 2.18. Readiness for School Learning, Social Competence, 2013(T1) and 2017(T2)
Kindergarten Children



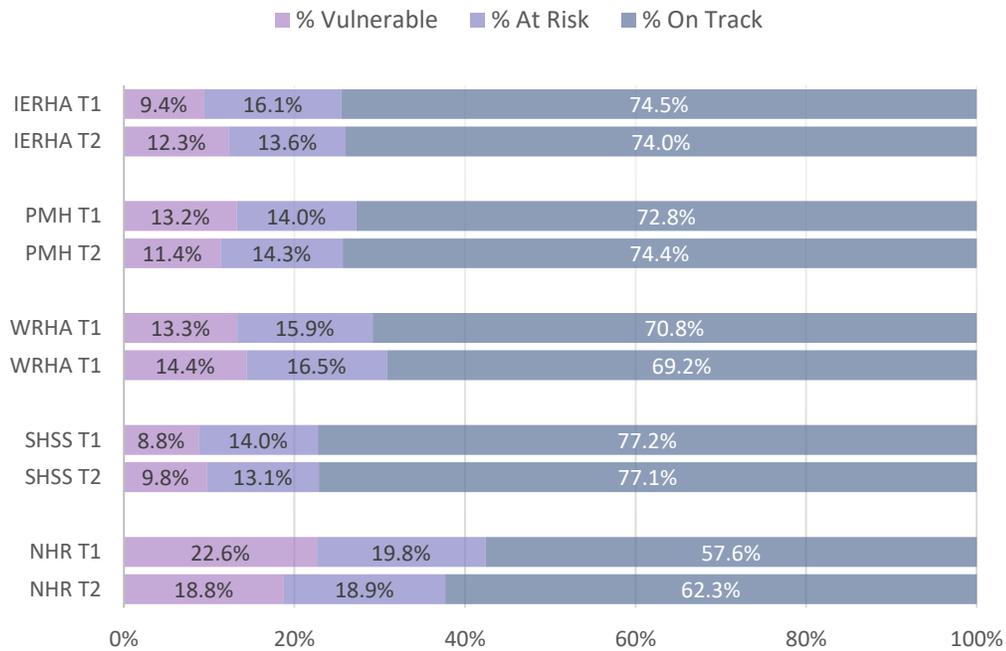
HCMO, 2019

Figure 2.19. Readiness for School Learning, Emotional Maturity, 2013(T1) and 2017(T2)
Kindergarten Children



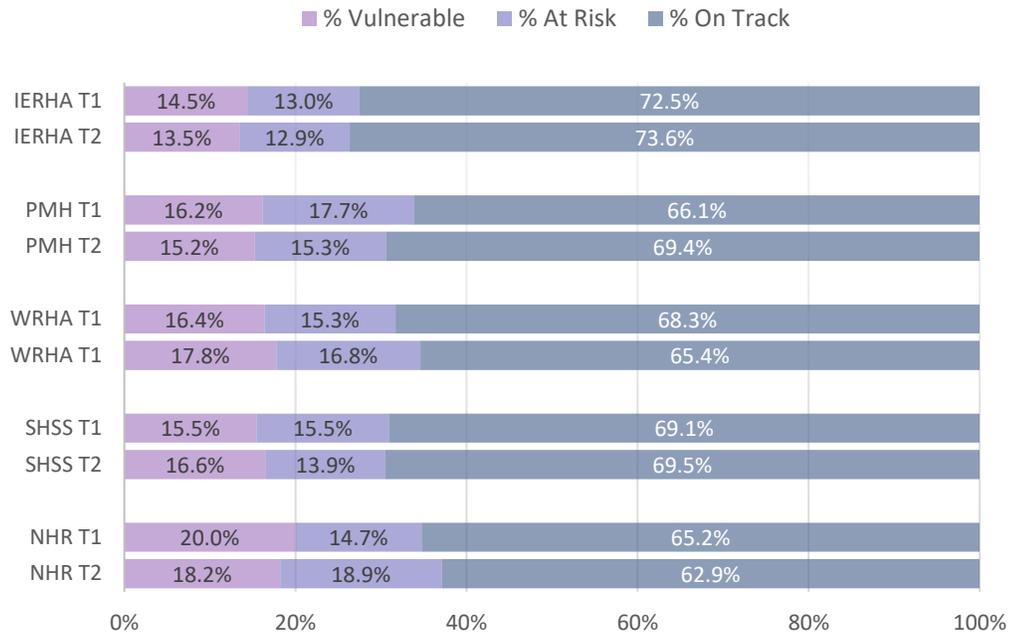
HCMO, 2019

Figure 2.20. Readiness for School Learning, Language and Thinking Skills, 2013(T1) and 2017(T2)
Kindergarten Children



HCMO, 2019

Figure 2.21. Readiness for School Learning, Communication Skills and General Knowledge, 2013(T1) and 2017(T2)
Kindergarten Children



HCMO, 2019

Regional Key Findings

From 2013 to 2017:

- The percentage of kindergarten children that were *vulnerable or struggling* related to ‘physical health and well-being’ and ‘language and thinking skills’ increased. A decrease was noted for ‘social competence’ and ‘communication skills and general knowledge’. Emotional maturity remained unchanged.
- The percent of children who were *at risk* or lower than expected for age appropriate expectations increased in two domains; ‘physical health and well-being’ and ‘social competence’. Decreases were noted in ‘emotional maturity’ and ‘language and thinking skills’. ‘Communication skills and general knowledge’ remained unchanged.
- The percent of children who were *on track* meaning meeting age appropriate expectations for school based on the EDI increased related to ‘emotional maturity’ and ‘communication skills and general knowledge’. A decrease was noted in ‘physical health and well-being’. Minimal change was noted in ‘social competence’ and ‘language and thinking skills’.

Pediatric Dental Extractions under General Anesthesia

Definition

The average annual rate of hospital-based dental surgeries involving extractions for children under the age of six years, per 1,000 population, over a five-year time period.

Why is this indicator important?

Early childhood caries (ECC) (e.g., dental decay in the primary teeth in children under the age of six years) reflects the effect of many social inequalities including income, nutrition, and personal health practices. Monitoring pediatric dental surgery involving extraction of primary teeth gauges ongoing access to care and preventive dental services for children.

Provincial Key Findings

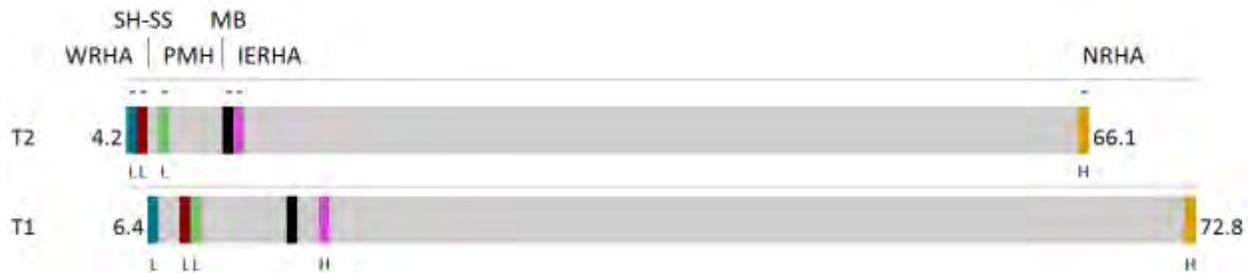
- The rate of hospital-based dental surgeries under general anesthesia involving extraction of primary teeth for children in Manitoba significantly decreased over time (24% or 3.5/1,000 children). Over the past ten years, nearly all (99.4%) of dental extraction surgeries in hospital had direct admission and were coded as elective procedures (e.g., scheduled day procedures, planned urgent/emergent procedures).^{xx}
- However, the rates of severe childhood tooth decay may be underestimated as data for dental extraction surgeries performed outside of hospitals (e.g., dentists' offices) are not available. Additionally, not all surgeries to treat early childhood caries involve extraction of primary teeth as many are restored with fillings and stainless steel crowns.
- Rates decreased significantly in all health regions over time.
- Rates in Northern Health Region were higher than the provincial average, while those in Winnipeg Health Region, Southern Health-Santé Sud and Prairie Mountain Health were significantly lower in T1 and T2. The rate in Interlake-Eastern RHA was significantly higher than the provincial average in T1 only.
- **Income disparity:** Dental surgery rates involving extraction were strongly associated with income in urban and rural areas in both time periods with children in lower income areas having higher rates of surgery. The income disparity gap narrowed over time in rural settings.



Rural Quintiles	
T1	6.8x
T2	6.5x
CHANGE	0.3↓

Figure 2.22. Pediatric Dental Extraction Surgery—Provincial Findings Dental Extraction Surgery Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

Crude average annual rate per 1,000 residents under age 6 years



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA		SH-SS		PMH		MB		IERHA		NRHA	
T2 COUNT	1,060		450		448		5,786		530		3,279	
T2 RATE	4.2	L-	4.9	L-	6.8	L-	11.5	-	12.1	-	66.1	H-
T1 RATE	6.4	L	8.0	L	9.0	L	15.0		17.1	H	72.8	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- From 2012 to 2017, a total of 530 Interlake-Eastern children under the age of six had a dental extraction surgery.
- South Zone, East Zone, and West Zone all have rates significantly lower than the provincial rate of 11.5 per 1,000, while North and Northern Remote zones were found to have rates significantly higher.
- All zones have experienced declines over time but not at the same rate. For instance, Stonewall/Teulon had a 30% decrease while Northern Remote only had a 9% decrease.
- Although rates are declining, the disparity continues to widen between the highest and lowest performing districts.

Table 2.20. Pediatric Dental Extraction Surgery—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2		T1
	Count	Rate	Rate
Manitoba	5,786	11.5	15.0

	T2		T1
	Count	Rate	Rate
IERHA	530	12.1	17.1

South Zone	25	1.4	L-	2.6	L
Stonewall/Teulon	10	1.5	L	2.2	L
St. Clements	7	3.1	L-	12.8	
Springfield	s			s	
Wpg Beach/St. Andrews	s			s	

North Zone	253	26.2	H-	38.7	H
Fisher/Peguis	92	25.6	H	31.5	H
Eriksdale/Ashern	75	25.9	H-	38.6	H
Powerview/Pine Falls	86	27.2	H-	45.9	H

East Zone	44	7.4	L	9.9	L
Pinawa/Lac du Bonnet	13	7.7		9.1	
Whiteshell	28	22.4	H	28.3	H
Beausejour	s			s	

Northern Remote	182	63.5	H	70.5	H
Northern Remote	182	63.5	H	70.5	H

West Zone	8	1.8	L	4.0	L
Arborg/Riverton	s			5.2	L
Gimli	s			s	
St. Laurent	s			s	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	32.1
	T2 Disparity	41.3
	Change	+9.2↑
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

Selkirk Zone	18	6.1		6.8	L
Selkirk	18	6.1		6.8	L

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

CLOSER LOOK... PEDIATRIC DENTAL EXTRACTION SURGERIES

There was extreme variation across districts in rural regions from under two to over 100/1,000 residents under age 6, and was strongly related to income.

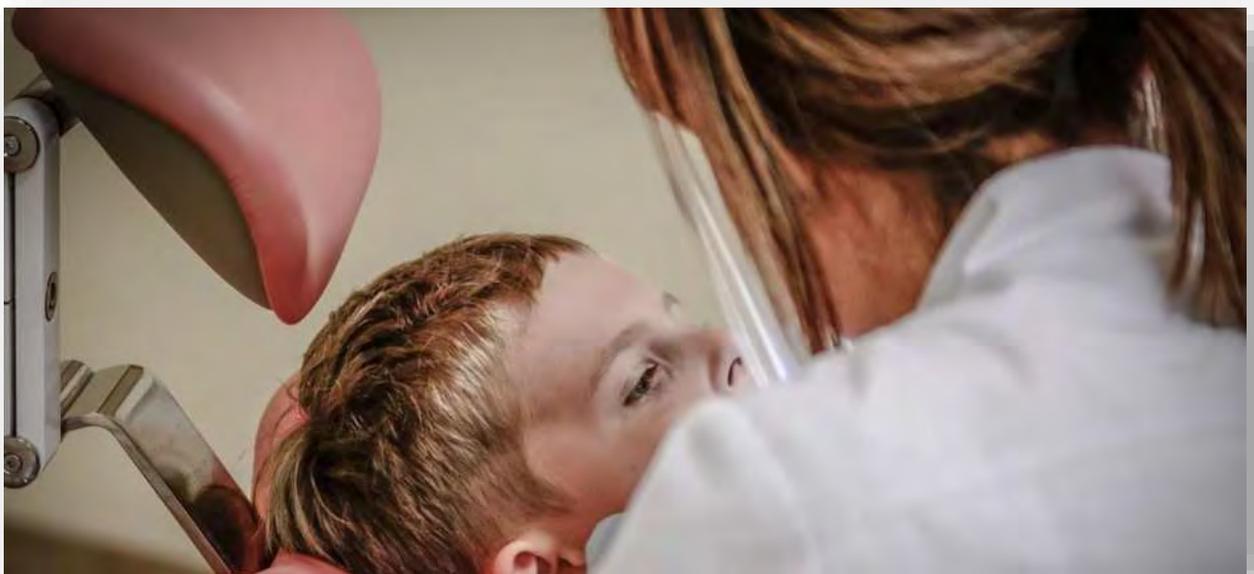
Within Southern Health Santé Sud, the lowest income district (Seven Regions) was the only one which was significantly higher than the provincial average at 43/1,000. The same variation was found within Winnipeg Health Region, where the number of dental extractions in the lowest income neighbourhood cluster (NC) (Point Douglas South) was 6.1 times that of the highest income NC (River East North). For Prairie Mountain Health, the dental extraction rate for children living in the northern part of the region was more than twice as high (14.3/1,000) than for children living in Brandon (5.9/1,000).

However, the highest rates were found in northern communities of Manitoba. For Interlake-Eastern RHA, while data were suppressed for five districts due to small numbers, the Northern Remote district registered 70.5/1,000. Within Northern RHA, only the Flin Flon/Snow Lake/Cranberry Portage/Sherridon Cold Lake district (14.8) was similar to the provincial rate while every other district in the region was significantly higher than the Manitoba average. Residents of Island Lake had the highest rate in the province at 108.8/1,000. Data for Churchill was suppressed due to small numbers.

Excerpt copied from the Women's Health Provincial Clinical Team Report Pg. 13

May 10, 2018

Prepared by Community Health Assessment Network for Wave One Launch



Childhood Immunization

Definition

The proportion of children who had complete immunization schedules by age 17 years for diphtheria, pertussis and Tetanus, for a one-year time period.

Why is this indicator important?

Vaccines are one of the most important parts of child health programs because they can prevent death, disability, and control the spread of infectious diseases. It is the single most important public health achievement in the past century, as infectious diseases have dropped from the leading cause of death to less than five percent of all deaths in Canada.

Provincial Key Findings

- Based on 2017 data, Prairie Mountain Health was found to have the highest percentage of 17 year olds who had received a booster dose since age 10 against diphtheria, tetanus and pertussis, followed by Interlake-Eastern.
- Coverage rates with a booster dose from age 10 to 17 year olds in Southern Health Santé Sud, Winnipeg RHA, and Northern RHA were similar.
- The coverage rate with a booster dose against pertussis is slightly lower than diphtheria and tetanus probably due to different vaccine products administered.

Table 2.21. Childhood Immunization—Provincial Findings

Booster dose form age 10	Diphtheria	Tetanus	Pertussis
IERHA	77.9%	77.9%	76.2%
WRHA	69.9%	69.9%	68.6%
PMH	82.1%	82.1%	80.4%
NRHA	69.9%	69.9%	68.6%
SH-SS	69.4%	69.4%	67.1%

Source: Public Health, 2019

Regional Key Findings

- In Interlake-Eastern, Selkirk Zone and the South Zone had the highest coverage rates with a booster dose against all three antigens in 17 year olds.
- Coverage rates with a booster dose for all three antigens were the lowest in North Zone and Northern Remote Zone.

Table 2.22. Childhood Immunization—IERHA Zone Findings

	Diphtheria age 10	Tetanus age10	Pertussis age10
IERHA	77.9%	77.9%	76.2%
South Zone	82.7%	82.7%	81.3%
East Zone	75.9%	75.9%	73.6%
West Zone	76.7%	76.7%	75.0%
Selkirk Zone	83.5%	83.5%	82.6%
North Zone	69.1%	69.1%	66.3%
Northern Remote Zone	63.8%	63.8%	62.1%

Source: Public Health, 2019



Teen Pregnancy Rate

Definition

The annual rate of pregnancies including live births, stillbirths, abortions, and ectopic pregnancies per 1,000 female residents, ages 15 to 19 years, over a five-year time period.

Why is this indicator important?

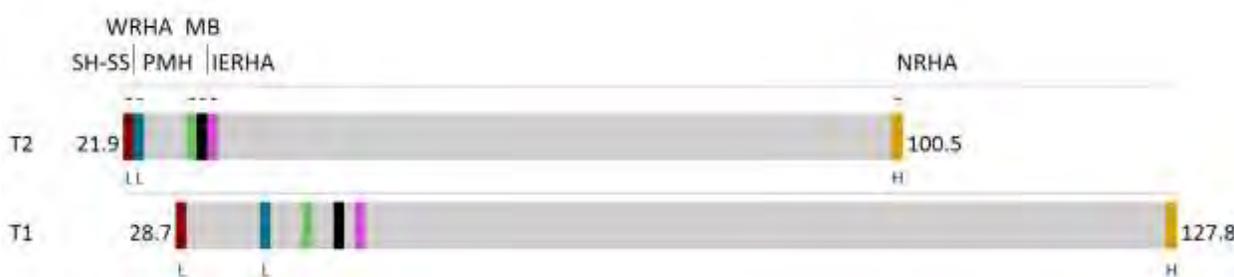
Pregnant teens are less likely to receive early prenatal care and more likely to experience anemia, eclampsia, and depressive disorders. Teenage pregnancy is often associated with high risk activities such as substance use, smoking during pregnancy, and physical or sexual abuse^{xxi}. Teenage mothers tend to have lower socioeconomic status, as well as reduced educational opportunities^{xxii}.

Provincial Key Findings

- In Manitoba, there has been a statistically significant decrease in teen pregnancy from 44.5 to 30.0 per 1,000 females aged 15 to 19.
- All RHAs in Manitoba have experienced statistically significant decreases in teen pregnancy over time.

Figure 2.23. Teen Pregnancy by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

Age adjusted annual average rate per 1,000 females aged 15-19



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS		WRHA		PMH		MB		IERHA		NRHA	
T2 COUNT	817		2,765		807		6,679		658		1,533	
T2 RATE	22.0	L-	23.3	L-	29.3	-	30.0	-	30.8	-	100.5	H-
T1 RATE	28.7	L	36.9	L	40.8		44.5		46.1		127.8	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- In Interlake-Eastern, over a five-year time period there was a total of 658 teen pregnancies, at a rate of 30.8 per 1,000 females aged 15 to 19.
- There have been statistically significant decreases in teen pregnancy rates within the East Zone, North Zone and Northern Remote Zone.

- At the district level, there has been a narrowing of disparity over time. Although some districts experience higher rates of teen pregnancy, the data suggests that there is a decreasing gap between our highest and lowest districts.

Table 2.23. Teen Pregnancy Rate—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2			T1	
	Count	Rate		Rate	
Manitoba	6,679	30.0	-	44.5	

	T2			T1	
	Count	Rate		Rate	
IERHA	658	30.8	-	46.1	

South Zone	140	13.8	L	15.6	L
Springfield	24	10.2	L	9.6	L
Stonewall/Teulon	43	13.3	L	17.7	L
Wpg Beach/St. Andrews	36	13.5	L	17.7	L
St. Clements	37	25.6		29.6	

North Zone	295	77.6	H-	115.2	H
Fisher/Peguis	97	75.1	H-	107.5	H
Eriksdale/Ashern	93	79.6	H-	108.5	H
Powerview/Pine Falls	105	84.0	H-	133.5	H

East Zone	58	20.0	L-	33.5	
Beausejour	23	17.2	L	21.0	L
Pinawa/Lac du Bonnet	20	22.8	-	47.6	
Whiteshell	15	25.9		42.0	

Northern Remote	88	111.1	H-	168.1	H
Northern Remote	88	111.1	H-	168.1	H

West Zone	47	21.6		31.0	L
Arborg/Riverton	13	14.2	L	26.6	
St. Laurent	14	23.8		38.1	
Gimli	20	34.3		33.8	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	17.6
	T2 Disparity	10.9
	Change	-6.7
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

Selkirk Zone	30	19.0	-	33.2	
Selkirk	30	19.0	-	33.2	

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Teen Birth Rate

Definition

The annual rate of live births per 1,000 female residents, ages 15 to 19 years, over a five-year time period.

Why is this indicator important?

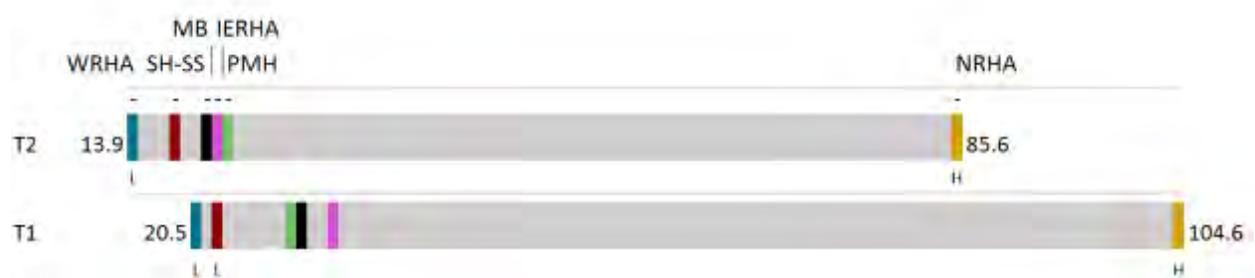
Very similar to teen pregnancy rate, teen birth rates are of concern because babies born to teen mothers are at higher risk of adverse health outcomes such as low birth rate, death during infancy, and preterm birth. There are also strong economic consequences, since teenage mothers are more likely to drop out of school and have fewer economic opportunities.

Provincial Key Findings

- In Manitoba, there has been a statistically significant decrease in teen birth rates from 29.8 to 21.5 per 1,000 females aged 15 to 19.
- All RHAs in Manitoba have experienced statistically significant decreases in teen birth rates over time.

Figure 2.24. Teen Births by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

Age adjusted average annual rate per 1,000 females aged 15-19



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	IERHA	PMH	NRHA		
T2 COUNT	1,644	691	4,786	476	619	1,290		
T2 RATE	13.9	L-	21.5	-	22.5	-	85.6	H-
T1 RATE	20.5	L	29.8		28.4		104.6	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- In Interlake-Eastern, over a five-year time period there was a total of 476 teen births, at a rate of 22.3 per 1,000 females aged 15 to 19.
- There have been statistically significant decreases in teen birth rates within the East Zone, North Zone and Northern Remote Zone.
- At the district level, there has been a narrowing of disparity over time. Although some districts experience higher rates of teen birth, the data suggests that there is a decreasing gap between our highest and lowest districts.

Table 2.24. Teen Birth Rate—IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2		T1	
	Count	Rate		Rate
Manitoba	4,786	21.5	-	29.7

	T2		T1	
	Count	Rate		Rate
IERHA	476	22.3	-	31.6

South	78	7.5	L	7.7	L
Springfield	13	5.5	L	5.0	L
Wpg Beach/St. Andrews	18	6.8	L	7.5	L
Stonewall/Teulon	28	8.7	L	10.6	L
St. Clements	19	13.2		11.5	L

North	234	61.9	H-	86.1	H
Fisher/Peguis	71	55.0	H-	81.0	H
Powerview/Pine Falls	84	67.2	H-	94.9	H
Eriksdale/Ashern	79	67.6	H	86.9	H

East	36	12.5	L-	21.1	
Beausejour	9	6.7	L	10.5	L
Pinawa/Lac du Bonnet	12	13.1	-	29.7	
Whiteshell	15	25.9		32.7	

West	28	12.7		17.1	L
Arborg/Riverton	7	7.7	L	15.5	
St. Laurent	9	15.3		24.1	
Gimli	12	20.6		14.4	

Selkirk Zone	20	12.7		19.0	
Selkirk	20	12.7		19.0	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	27.7	
	T2 Disparity	18.3	
	Change	-9.4↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

CLOSER LOOK... EVOLVING SERVICES TO HELP TEENS

Strong demand for regional teen clinics

Recently, public and primary health care teams have noted that IERHA teen clinics are showing a growing need for mental health and addictions supports as well as continued support for reproductive health services and education. The IERHA is examining ways to expand these services both in schools and regional facilities.

Interlake-Eastern RHA's Teen Clinics began as a way to address service gaps to serve youth (aged 12 to 25) who want confidential health services with the core principles of choice, confidentiality, accessibility, harm reduction and cultural responsiveness. These clinics include three IERHA facilities in Oakbank, Beausejour and Selkirk as well as many community-based clinics hosted out of schools in the region.

Teen clinics provide a strong educational component for youth with comprehensive, non-judgmental information to enhance their ability to make positive personal health decisions. They provide opportunities to learn about health issues, identify strategies for maintaining good health and access health promotion tools and resources communicated in a manner and language that youth understand.

Since their inception in 2002, the demand for teen health clinics has been strong and continually growing. As a model for reaching this population, the IERHA has worked with schools and communities to establish service centres where nurse practitioners and public health nurses are available, providing accurate, non-judgmental information and a full array of respectful primary health care that acknowledges our region's diversity of cultures, values, and experiences.

To learn more about our regional Teen Clinics, visit the IERHA website at ierha.ca, Care in Your Community, Public Health or check out our dedicated Teen clinic accounts on Facebook: [Interlake Eastern Teen Clinics](#) and Instagram [interlake.eastern.teen.clinic](#).



Personal Health Determinants

Quality of Life

These indicators are all based on client experience.

Self-Rated General Health

Definition

The percentage of residents, aged 12 years and older, who rated their overall health as ‘poor’, ‘fair’, ‘good’, ‘very good’ or ‘excellent’. Overall health was based on the absence of disease or injury as well as overall physical, mental, and social-well-being.

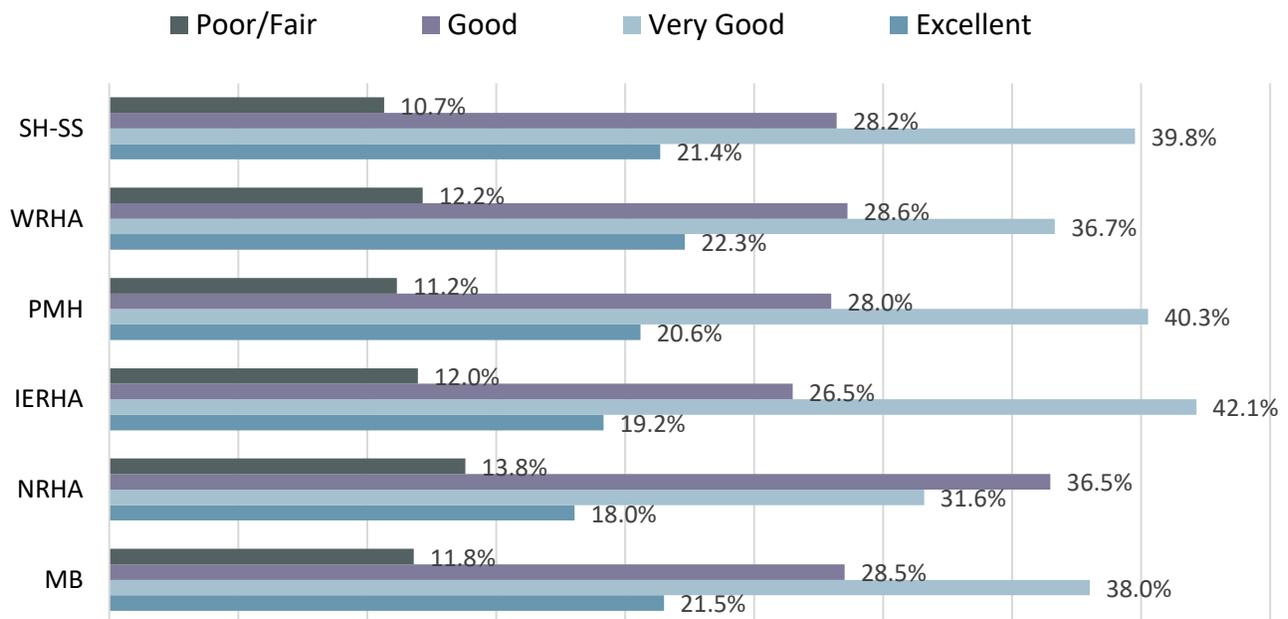
Why is this indicator important?

Good-to-excellent self-reported health status is associated with lower risk of mortality and use of health services. Poor self-reported health status is a good predictor of future illness and premature death.

Provincial Key Findings

- Self-rated general health scores were found to be stable among all RHAs with no region being statistically different from the Manitoba average.
- Interlake-Eastern had the highest percentage of respondents indicating that their general health was either very good or excellent (61.3%) compared to the other regions.

Figure 2.25. Self-Rated General Health—Provincial Findings



Source: IMA CCHS 2015/16

Self-Rated Mental Health

Definition

The percentage of residents, aged 12 years and older, who rated their mental health as ‘poor’, ‘fair’ ‘good’, ‘very good’ or ‘excellent’.

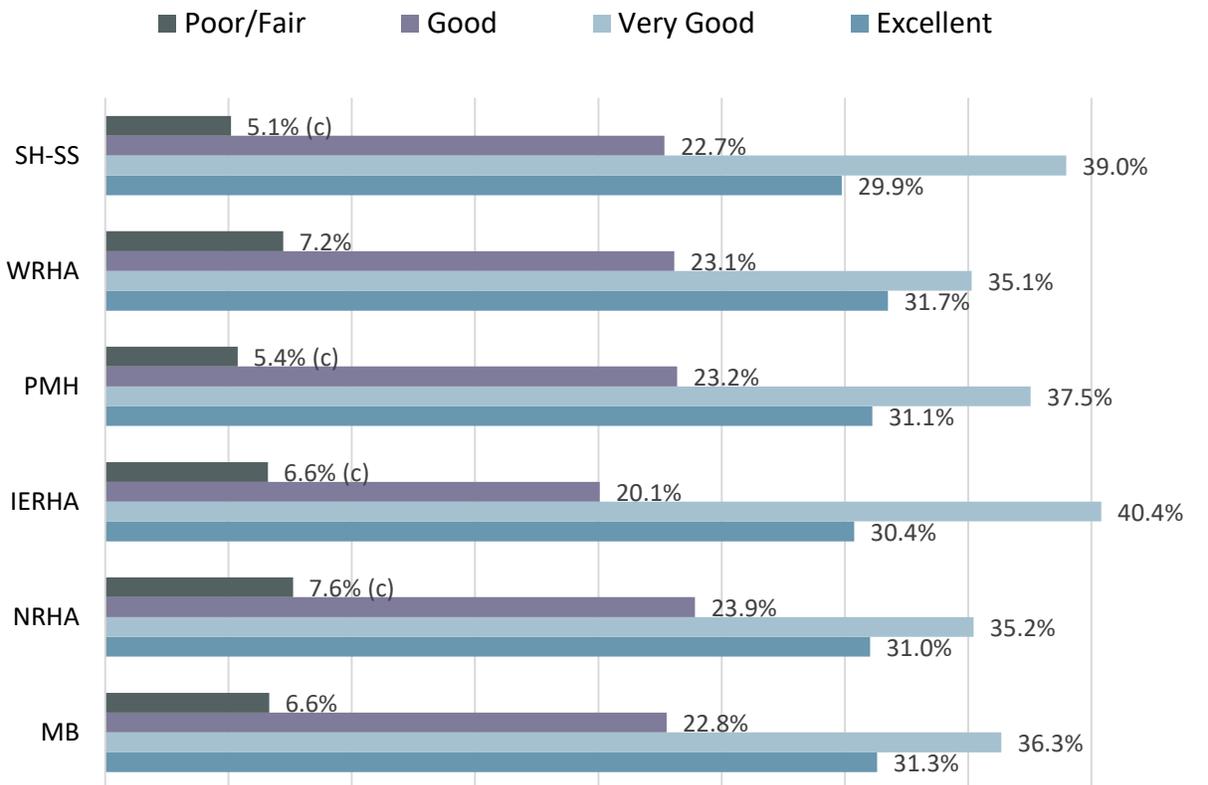
Why is this indicator important?

Mental health issues, including emotional health problems, can manifest at any time across the lifespan and are often related to challenges associated with changing roles and responsibilities. While perceived mental health is a subjective measure and does not directly correspond with diagnosed mental illnesses, it may still affect health service use and quality of life.

Regional Key Findings

- Nearly one-third of all Manitobans scored their mental health as excellent and fewer than 10% indicated that their mental health was either poor/fair.
- Seven of ten Interlake-Eastern respondents reported that their mental health was either very good or excellent.

Figure 2.26. Self-Rated Mental Health—Provincial Findings



(c) = estimate displayed with caution.
Source: IMA, CCHS 2015/16

Life Stress

Definition

The percentage of residents, aged 15 years or older, who reported most days to be ‘quite a bit stressful’, ‘extremely stressful’, or ‘not at all stressful’.

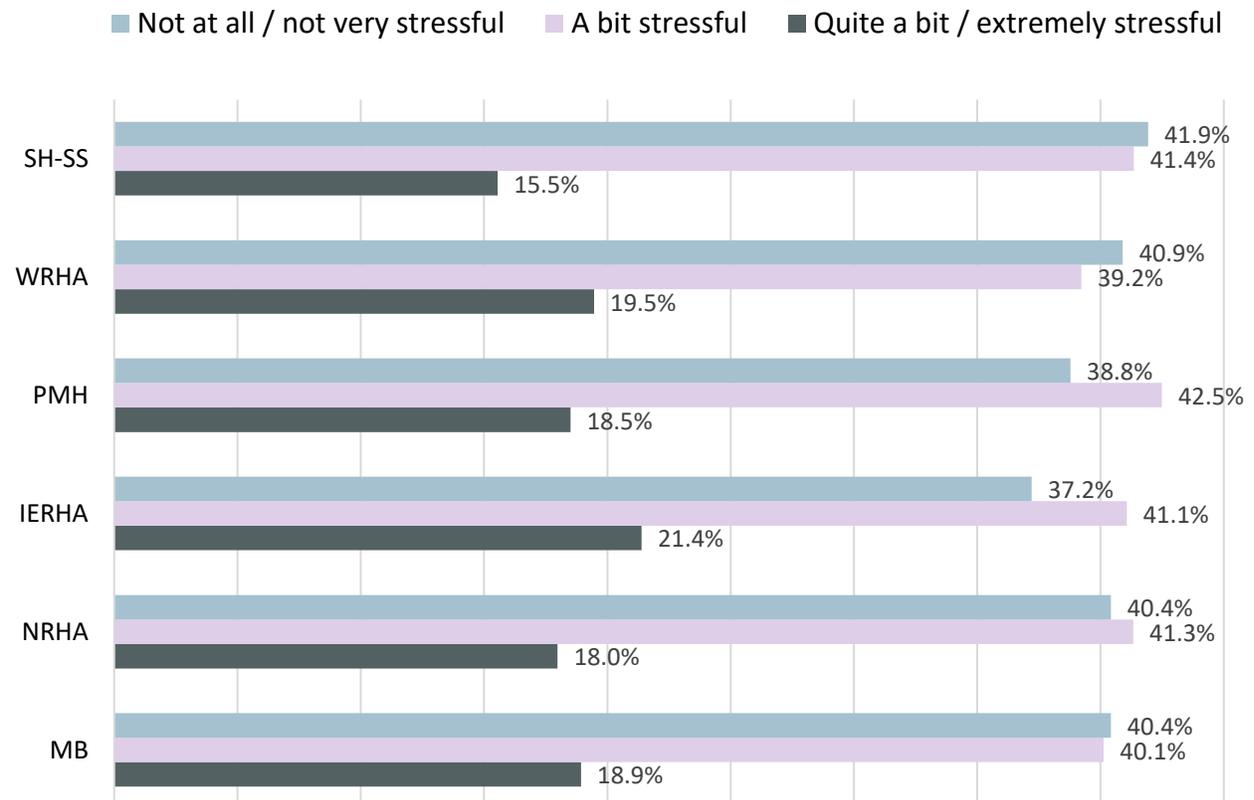
Why is this indicator important?

Prolonged exposure to high levels of stress can have negative consequences for health including increased risk of illness and chronic disease. Stress is often an underlying cause of high risk behaviours, such as substance use, as coping mechanisms.

Regional Key Findings

- Life stress results were found to be stable between all RHAs with no region being statistically different from the Manitoba average.
- Interlake-Eastern had the lowest percentage of respondents indicating “not at all/not very stressful” and the highest percentage compared to other RHAs to report “quite a bit/very stressful”.

Figure 2.27. Life Stress—Provincial Findings



Source: IMA, CCHS 2015-16

Sense of Community Belonging

Definition

The percentage of population, aged 12 years and older, who described their sense of belonging to their local community as ‘somewhat/very weak,’ ‘somewhat strong’ or ‘very strong’.

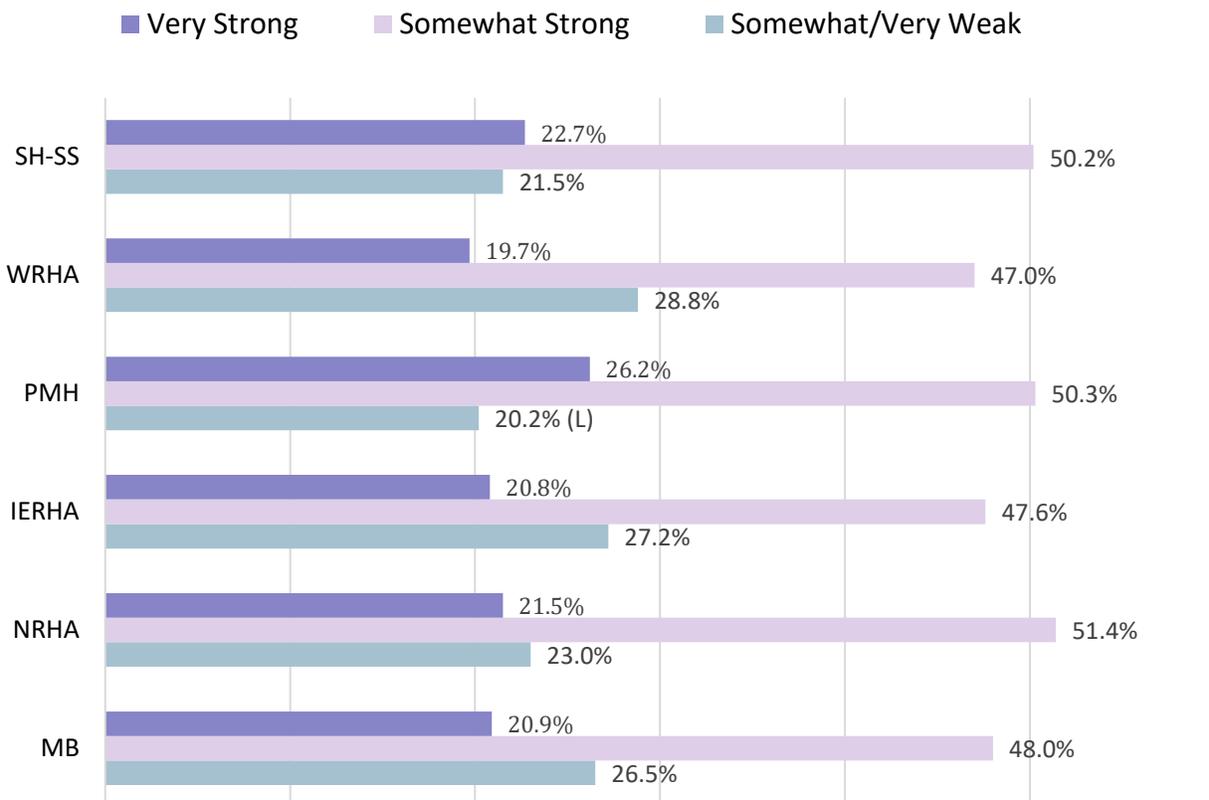
Why is this indicator important?

A strong sense of community belonging reflects attachments, social engagement and participation within communities which is associated with positive health outcomes. Individuals who do not have a strong sense of community belonging may experience social isolation which can be detrimental to their health. Understanding community connectedness supports an upstream approach to health promotion and illness prevention.

Provincial Key Findings

- The majority of all respondents in all RHAs reported that they have a “somewhat strong” belonging to their community.
- Between all regions, the responses for community belonging were consistent, with no regions found to be statistically different.

Figure 2.28. Sense of Community Belonging—Provincial Findings



(H/L) = significantly higher/lower than MB average.

Source: IMA, CCHS 2015/16

Changes Made to Improve Health

Definition

The percentage of residents who reported making positive health changes in the last 12 months.

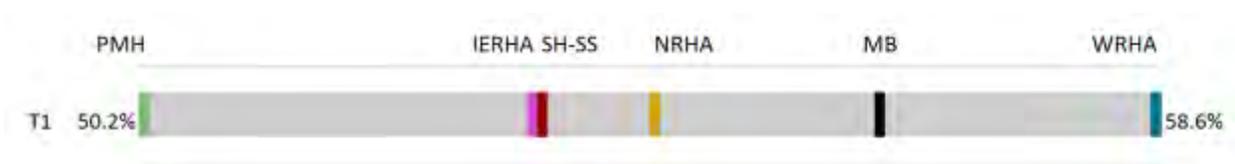
Why is this indicator important?

This measure provides insight into people’s willingness to make changes to improve their health.

Regional Key Findings

- Nearly 60% of Manitobans indicated that they made changes in the past 12 months to improve their health.
- Winnipeg RHA had the highest percentage of respondents indicating they had made a change while Prairie Mountain Health had the smallest percentage at 50.2%.
- Within Interlake-Eastern, 53.5% reported they made changes to improve health. The top three changes that were identified included: increasing exercise (46.2%), improving eating habits (20.9%) and reducing weight/smoking/alcohol, or stress (14.6%).

Figure 2.29. Percent of residents who reported making a positive health change in the last year, CCHS 2015-2016 (T1)
Age & Sex Adjusted proportion of weighted sample (%)



H/L Significantly higher or lower than the MB average for that time period.

	PMH	IERHA	SH-SS	NRHA	MB	WRHA
T1 PERCENT	50.2%	53.5%	53.6%	54.5%	56.3%	58.6%

Source: CCHS 2015-2016

Body Mass Index (BMI)

Definition

The percentage of residents, aged 18 years and older, who are underweight/normal, overweight or obese, based upon self-reported height and weight.

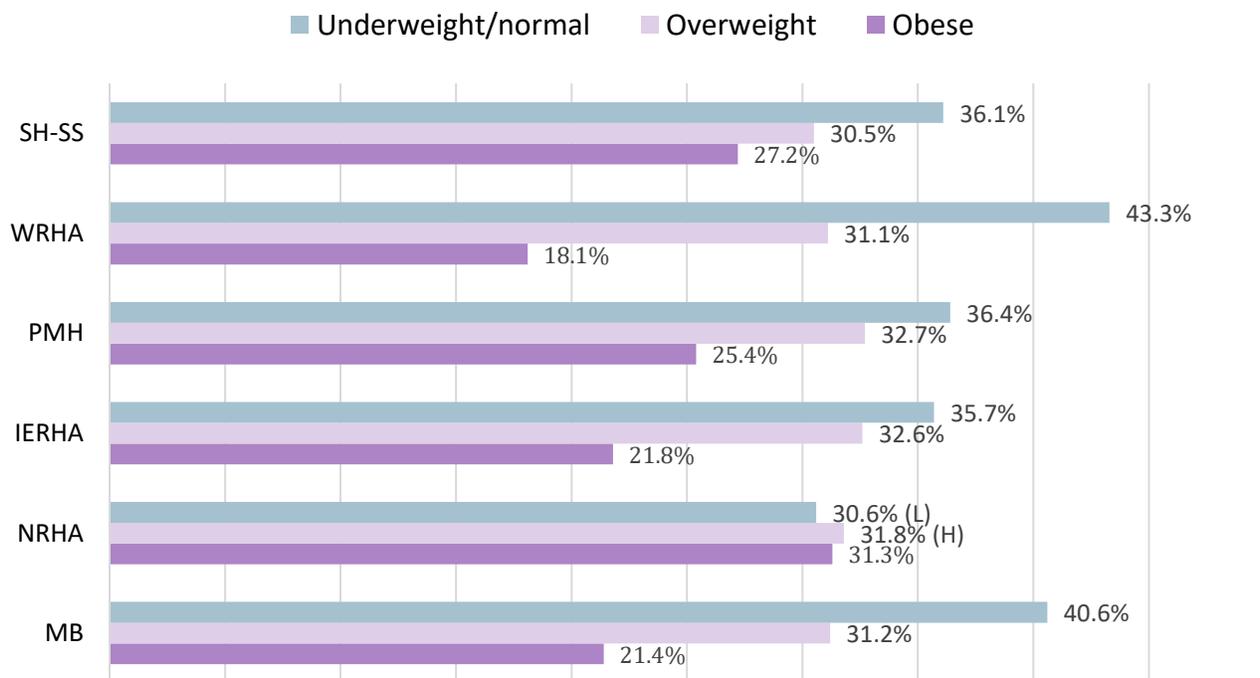
Why is this indicator important?

BMI is a widely used diagnostic tool used to monitor weight patterns in the population. Obesity affects quality of life, life expectancy, is a major risk factor for a number of chronic diseases and affects the use of health services.

Regional Key Findings

- Over 40% of Manitoba adults reported that they are either underweight/normal.
- Between all regions, BMI varies. For instance, the percentage “underweight/normal” in Winnipeg RHA is 43.3% compared to 30.6% in Northern RHA.
- Within Interlake-Eastern, approximately one third of residents are considered to be “underweight/normal”.

Figure 2.30. Body Mass Index—Provincial Findings



(H/L) = significantly higher/lower than MB average.

Source: IMA, CCHS 2015/16

Substance Use

Substance Use Disorders

Definition

The percentage of residents, aged 18 years and older, diagnosed with a substance use disorder (including alcohol and/or drug dependence), over a five-year time period.

Why is this indicator important?

Substance use may be associated with injuries and deaths, vandalism, alcohol poisoning and violence. Harmful use patterns started at a young age and carried into adulthood exacerbate these problems, and prolonged substance use may lead to a number of acute and chronic disease conditions.

Regional Key Findings

- Between 2010-2015, 58,178 Manitobans were diagnosed with a substance use disorder.
- Both Prairie Mountain Health and Northern RHA were found to have prevalence of substance abuse significantly higher than the Manitoba average, while Southern Health Santé Sud and Winning RHA had prevalence rates significantly lower.
- Interlake-Eastern saw 5,627 diagnoses over a five-year time period, which represents about 6% of the population aged 18 and older.
- Substance use prevalence is evident among all zones and districts in Interlake-Eastern, although rates vary significantly. For instance, the lowest prevalence for substance use disorders was found in Arborg/Riverton (2.9%) and the highest in Powerview/Pine falls (11.3%).

Figure 2.31. Prevalence of Substance Use Disorders among Adults by RHA, 2010/11-2014/15 (T1)

Age- and sex-adjusted percent of adults aged 18+ diagnosed with disorder in five-year time period



H/L Significantly higher or lower than the MB average for that time period.

	SH-SS		WRHA		IERHA		MB		PMH		NRHA	
T1 COUNT	5,956		32,208		5,627		58,178		8,354		5,593	
T1 PERCENT	4.4%	L	5.6%	L	5.9%		5.9%		6.7%	H	10.8%	H

Source: MCHP Mental Illness Among Adult Manitobans 2018

Drug Methods

Definition

The methods individuals reported using for illicit drug consumption over the course of their lifetime for a one-year time period.

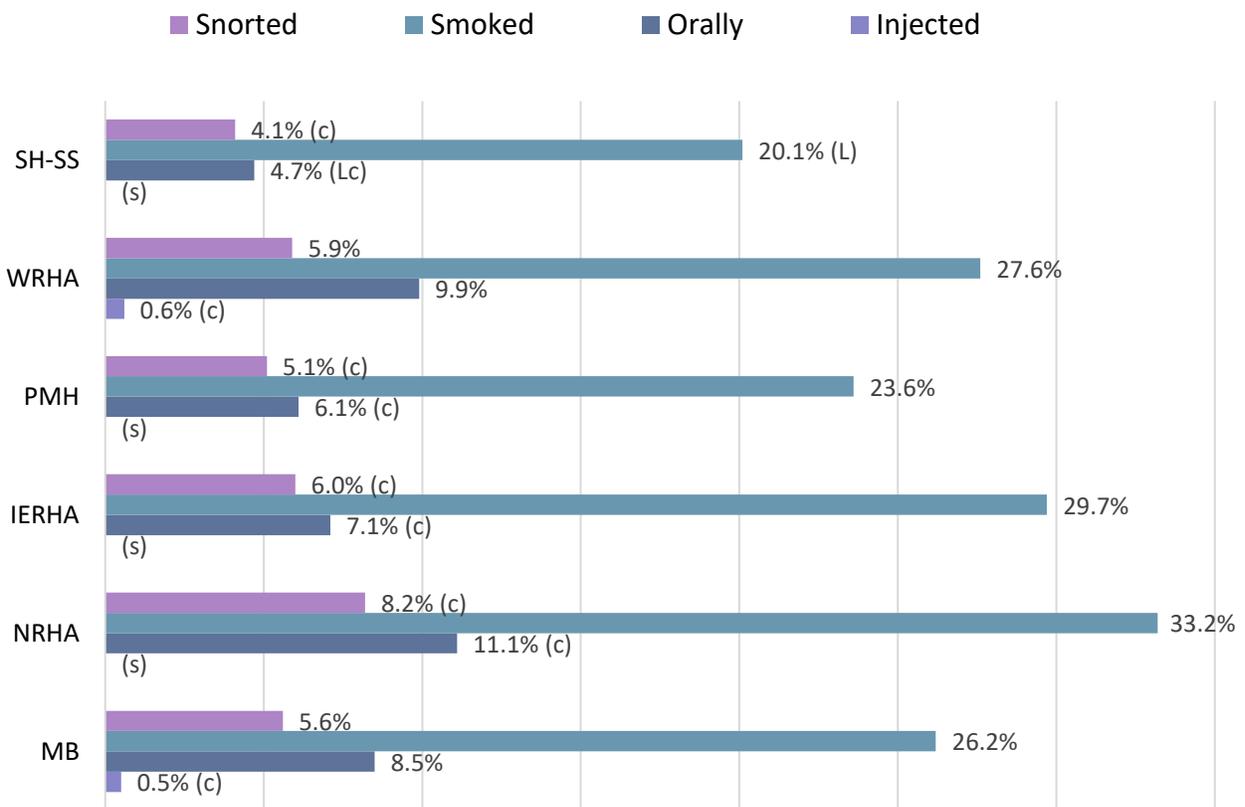
Why is this indicator important?

Understanding methods of drug consumption help inform harm reduction interventions including public awareness, sexually transmitted blood-borne infection (STBBI) prevention and public policy.

Regional Key Findings

- According to the 2015-16 CCHS survey, “smoked” was found to be the most used method for drug use followed by “orally”.
- Within Interlake-Eastern, of those who reported they used drugs, approximately 30% indicated that the method used was “smoked”.

Figure 2.32. Drug Methods—Provincial Findings



(H/L) = significantly higher/lower than MB average. (C) = estimate displayed with caution.
Source: IMA, CCHS 2015/16

Note: Unlike the majority of CCHS indicators reported, this indicator includes ‘don’t know’ and missing responses in the denominator

Alcohol Use

Definition

The percentage of the population, aged 12 years and older, who reported using alcohol in the past week by drink amount and type of drinker (based on frequency) over the past year.

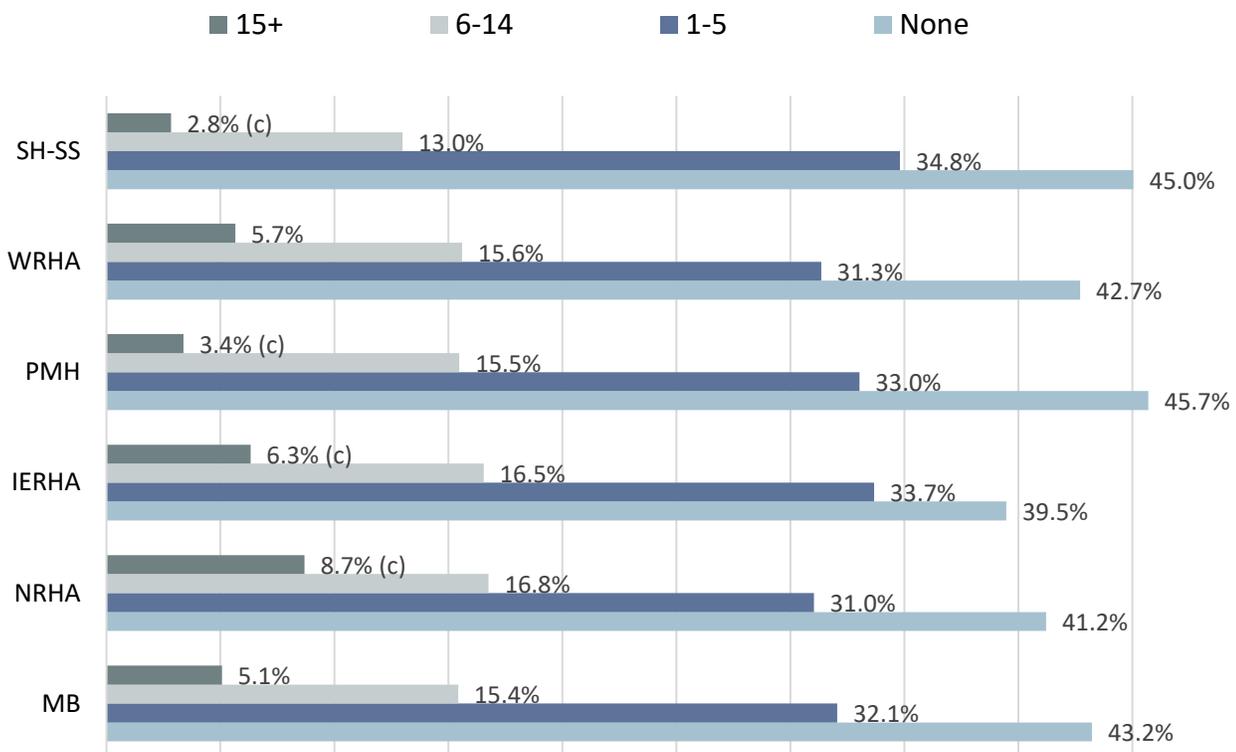
Why is this indicator important?

Alcohol consumption is linked to over 200 different diseases, conditions, and types of injuries. Drinking patterns matter – how much and how often a person drinks alcohol are key factors that increase or decrease overall health and well-being.^{xxiii}

Regional Key Findings (Past Week)

- Weekly alcohol use between RHAs was found to be very similar, with 43.2% of Manitobans reporting that they consumed no alcohol during the past week.
- No alcohol use makes up the largest percentage of response, followed by those having 1-5 drinks during the past week.

Figure 2.33. Alcohol Use—Provincial Findings, Number of Drinks in the past Week 2015-2016

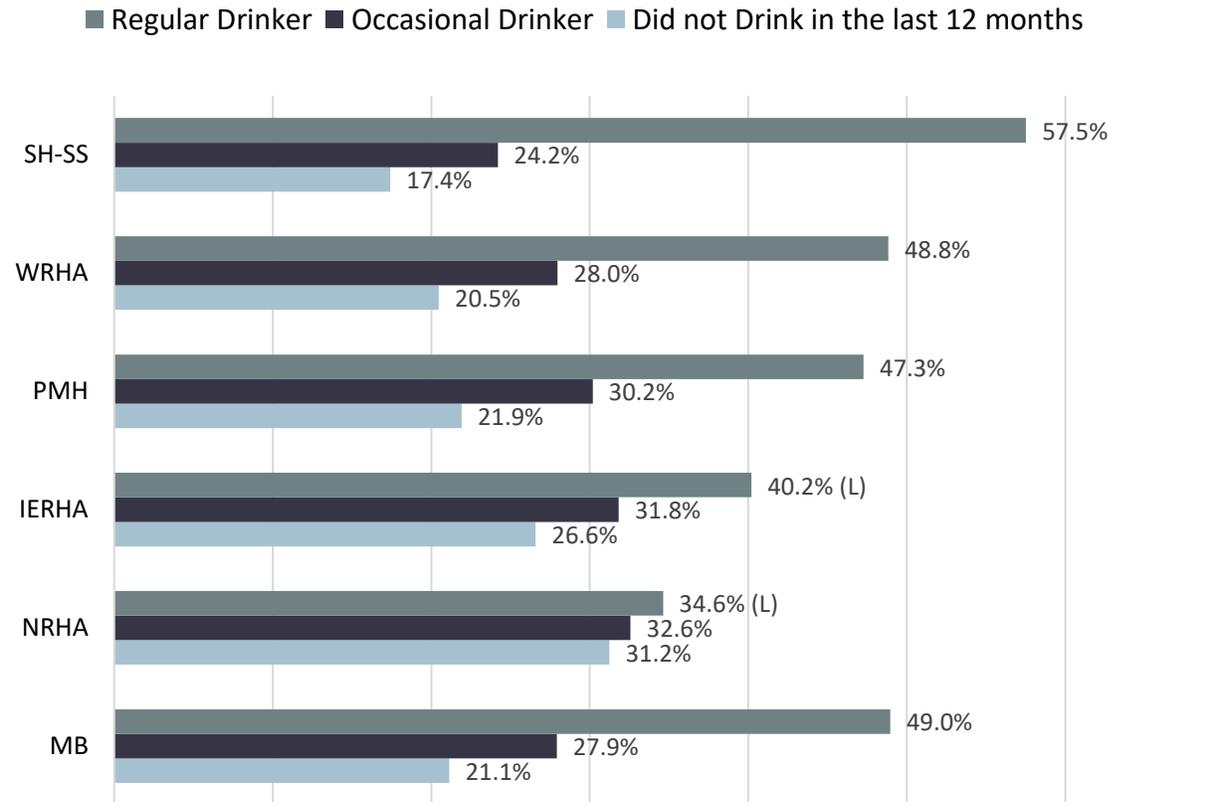


(C) = estimate displayed with caution.
Source: IMA, CCHS 2015/16

Regional Key Findings (Past Year)

- Nearly 50% of Manitobans reported they are a “regular drinker”. “Regular drinker” was found to be significantly lower in both Interlake-Eastern RHA and Northern RHA.
- Interlake-Eastern, in general was found to have a larger percentage of residents who consider themselves to be “occasional drinkers” or “did not drink within the past 12 months”.

Figure 2.34. Alcohol Use—Provincial Findings



(H/L) = significantly higher/lower than MB average.
Source: IMA, CCHS 2015/16

Tobacco

Tobacco Use/Smoking

Definition

The percentage of the population, aged 12 years and older, who reported being either a current smoker, a former smoker, or a non-smoker over a one-year time period.

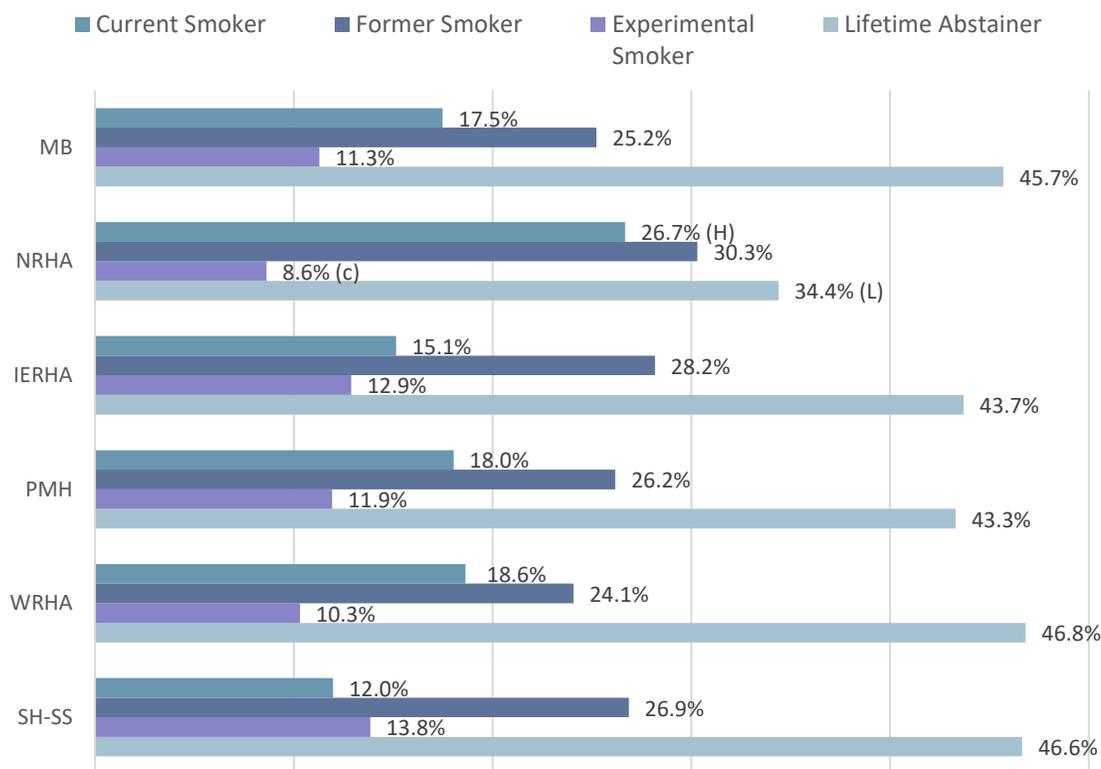
Why is this indicator important?

Tobacco continues to be the leading cause of preventable death in Canada. Smoking and exposure to second-hand smoke are significant risk factors for lung cancer, respiratory diseases, and other health problems.

Regional Key Findings

- Provincially, the majority of respondents indicated that they were “lifetime abstainer” (e.g. never smoked), followed by “former smoker”.
- Responses varied among RHAs on “current smoker”, with Southern Health Santé Sud having the lowest at 12.0% while Winnipeg RHA had the highest at 46.8%.

Figure 2.35. Tobacco Use/Smoking—Provincial Findings



(H/L) = significantly higher/lower than MB average. (C) = estimate displayed with caution.
 Source: IMA, CCHS 2015/16

Second-hand Smoke Exposure

Definition

The percentage of the non-smokers, 12 years and older, who reported exposure to second-hand smoke over a period of one year.

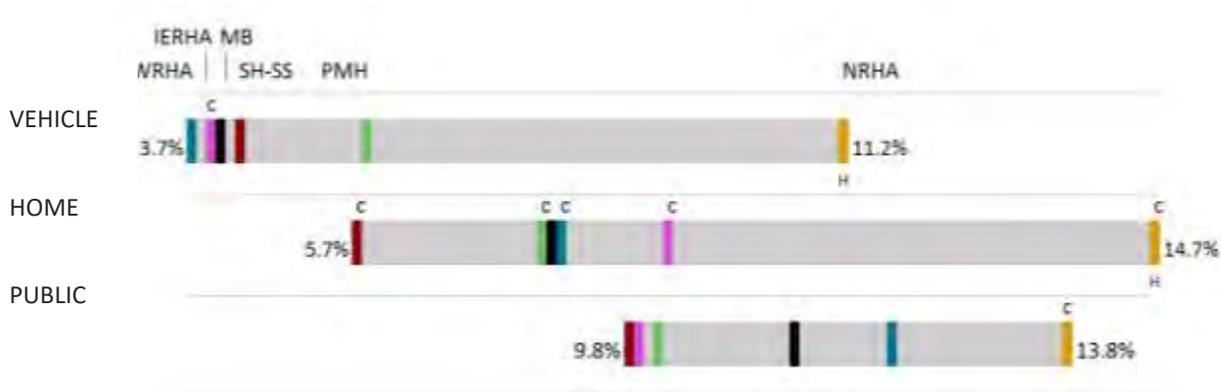
Why is this indicator important?

Second-hand smoke causes numerous health problems in infants and children including more frequent and severe asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS). For adults, health conditions caused by second-hand smoke include coronary heart disease, stroke, and lung cancer.

Provincial Key Findings

- In Manitoba, the most frequent location where residents reported being exposed to second hand smoke was in public (11.5%) and being exposed to second hand smoke in a vehicle was least reported at 4.1%.
- Among regions, Northern RHA had the highest reported rates for second hand smoke in all home, vehicle, and public places.
- Similar to the provincial key findings, Interlake-Eastern respondents indicated they are exposed to second hand smoke in “public places” more often than at home or in a vehicle.

Figure 2.36. Exposed to second-hand smoke in own home/private vehicle/public place
Age and sex adjusted proportion (%) of weighted sample



H/L Significantly higher or lower than the MB average. c – estimate displayed with caution.

	WRHA	IERHA	MB	SH-SS	PMH	NRHA
VEHICLE	3.7%	4.0% c	4.1%	4.4%	5.8%	11.2% H
HOME	8.0%	9.2% c	7.9%	5.7% c	7.9% c	14.7% Hc
PUBLIC	12.4%	9.9%	11.5%	9.8%	10.2%	13.8% c

Source: CCHS 2015-2016

Physical Activity

Physical Activity – Adults

Definition

Physical activity level of residents, aged 12 years and older, based on self-reported average daily physical activity including the frequency, duration, and intensity of their participation in physical activities, over the previous three months.^{xxiv}

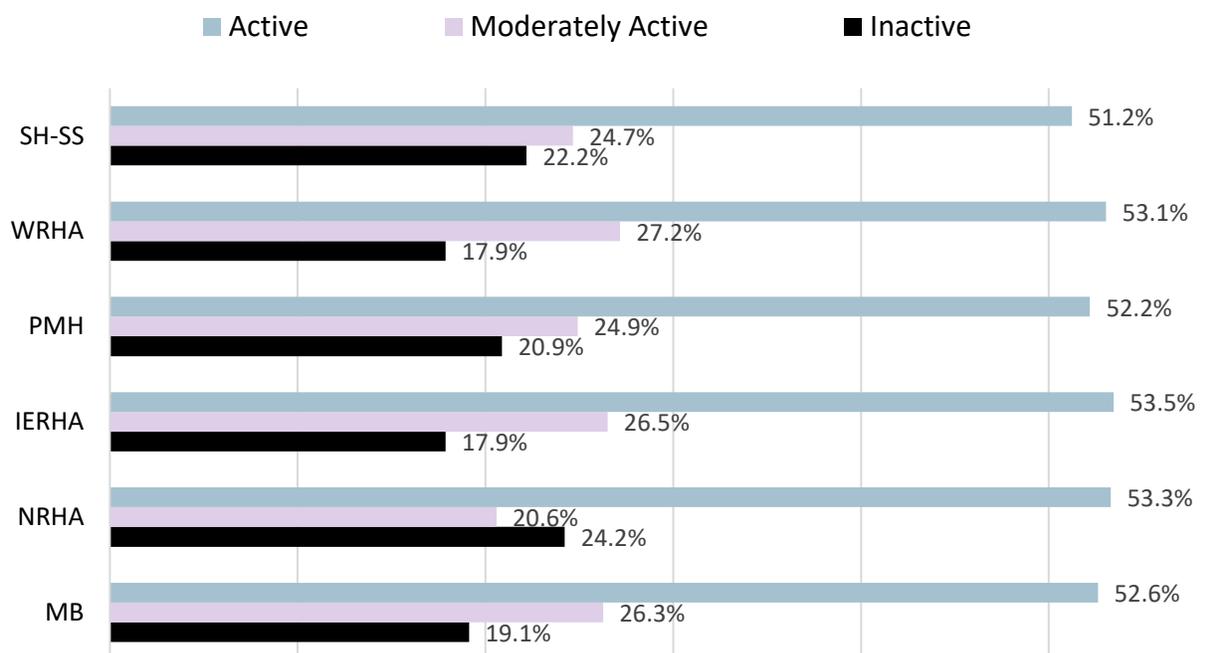
Why is this indicator important?

Appropriate levels of physical activity have been demonstrated to promote normal growth and bone development, foster psychological well-being, help maintain a healthy body weight, and reduce the risk of several chronic diseases.

Regional Key Findings

- Over 50% of Manitoba adults reported being “active” and fewer than 20% reported being “inactive”.
- Among all regions, the responses for physical activity levels were consistent.
- Interlake-Eastern values were not found to be statistically different from the Manitoba data.

Figure 2.37. Physical Activity – Adults—Provincial Findings



Source: IMA, CCHS 2015/16

Participation and Activity Limitation

Definition

The percentage of respondents, aged 12 years and older, who reported they require help for activities of daily living (ADL) because of a physical or mental condition or health issue.

Why is this indicator important?

While it is imperative to measure the prevalence of specific health conditions, it is also important to understand the burden these conditions place on the daily lives of residents. The participation and activity limitation indicator helps to monitor this burden in the population.

Provincial Key Findings

- Over 40% of Manitoba adults reported that they never require help for ADLs.
- Among all regions, responses for participation and activity limitation were consistent.

Table 2.25. Participation and Activity Limitation—Provincial Findings

	Never	Sometimes	Often
Manitoba	43.0%	14.4%	8.8%
IERHA	42.8%	14.5%	9.1%
WRHA	42.6%	14.3%	9.1%
PMH	43.1%	15.1%	8.2%
NRHA	42.5%	14.6%	9.8%
SH-SS	44.2%	14.1%	8.0%

Source: IMA, CCHS 2015/16

Regional Key Findings

- Interlake-Eastern had a slightly higher percentage of respondents who reported that they “often” require assistance for ADL.
- Across the zones, North Zone had the highest percentage of residents requiring assistance “often”.

Table 2.26. Participation and Activity Limitation—IERHA Zone Findings

	Never		Sometimes		Often	
Manitoba	43.0%		14.4%		8.8%	
IERHA	42.8%		14.5%		9.1%	
South Zone	47.7%		13.8%		9.5%	
East Zone	39.8%		14.3%		8.7%	
West Zone	40.3%		13.9%		9.5%	c
Selkirk Zone	32.8%	c	14.4%	c	6.3%	c
North Zone	41.3%		15.1%	c	10.0%	c
Northern Remote Zone	N/A		N/A		N/A	

(c) = estimate displayed with caution. (s) = estimate suppressed. (N/A)= no sample was drawn from this area.

Fruit and Vegetable Consumption

Fruit and Vegetable Consumption

Definition

The percentage of the population, aged 12 years and older, who reported consuming five or more servings on average, of fruit and vegetables daily.

Why is this indicator important?

Low fruit and vegetable consumption is one of the leading factors contributing to chronic disease.

Regional Key Findings

- Nearly one-quarter of Manitoba adults reported that they consume five or more servings of fruit and vegetables daily.
- Among all regions, responses for fruit and vegetable consumption were consistent, ranging from a low of 23.7% (Winnipeg RHA) to a high of 27.1% (Prairie Mountain Health).

Figure 2.38. Reported Consuming Five or More Servings of Fruit or Vegetables per day
Age and sex adjusted proportion (%) of weighted sample



H/L Significantly higher or lower than the MB average.

	WRHA	MB	NRHA	IERHA	SH-SS	PMH
T1 PERCENT	23.7%	24.6%	25.7%	25.7%	26.7%	27.1%

Source: CCHS 2015-2016

Sleep Time

Sleep Time

Definition

The average number of hours individuals reported they spent sleeping in a 24 hour period.

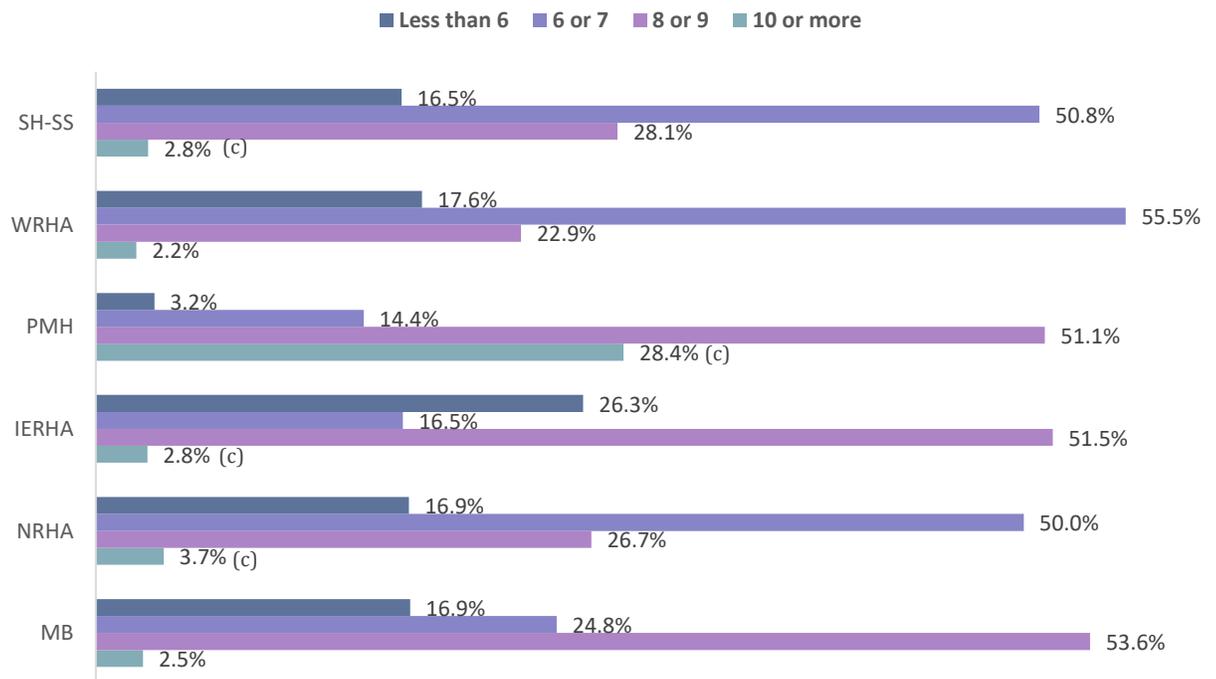
Why is this indicator important?

Sleep is a vital component of good health and well-being throughout an individual’s life. An adequate amount of quality sleep every day can help promote good mental and physical health, quality of life, and safety.

Provincial Key Findings

- The majority of Manitobans get at least seven or more hours of sleep per night.
- Among all regions, responses for sleep time were consistent with no regions found to be statistically different.
- In Interlake-Eastern, the majority of residents reported sleeping seven hours or more. 26.3% reported sleep time of six hours or less.

Figure 2.39. Average Amount of Sleep - Provincial Findings



(C)= estimate displayed with caution.
Source: CCHS 2014

Note: Unlike the majority of CCHS indicators reported, this indicator includes ‘don’t know’ and missing responses in the denominator

Driving Safety

Driving and Safety – Cell Phone Use While Driving

Definition

The percentage of the population who reported the use of a cell phone while driving, over a one-year time period.

Why is this indicator important?

Cell phone use while driving decreases driver awareness and increases the risk for collisions, leading to higher levels of unnecessary injuries and fatalities. Monitoring this behaviour helps to provide information on the effectiveness of public education activities.

Provincial Key Findings

- Over 70% of Manitoba respondents reported that they “never” use a cell phone while driving.
- Across all regions, respondents in Interlake-Eastern were most likely to report the use of a cell phone while driving.

Table 2.27. Driving and Safety – Cell Phone Use—Provincial Findings, 2011-2014

	Never	Rarely	Often/Sometimes
Manitoba	72.0%	14.5%	9.5%
IERHA	67.7%	16.2%	11.9%
WRHA	71.6%	13.6%	8.4%
PMH	69.7%	14.8%	11.0%
NRHA	71.9%	12.4%	8.0%
SH-SS	69.2%	16.6%	10.7%

Source: CCHS 2011-14

Regional Key Findings

- Interlake-Eastern had a higher percentage of drivers who reported using their cell phone “rarely” or “often/sometimes” compared to provincial results.
- Those “never” using a cell phone while driving was found to be significantly lower in the South Zone, and East Zone. Therefore, within these zones we see a higher percentage of respondents who reported using a cell phone while driving.

Table 2.28. Driving and Safety – Cell Phone Use—IERHA Zone Findings, 2011-2014

	Never		Rarely		Often/Sometimes	
Manitoba	72.0%		14.5%		9.5%	
IERHA	67.7%		16.2%		11.9%	
South Zone	63.1%	L	20.9%		13.8%	
East Zone	62.7%	L	14.4%	c	17.2%	c
West Zone	59.5%		17.9%	c	17.9%	c
Selkirk Zone	78.2%		15.6%	c	-	s
North Zone	72.6%		14.6%	c	12.3%	c
Northern Remote Zone	N/A		N/A		N/A	N/A

(L)= rate is significantly lower than Manitoba. (c) = estimate displayed with caution. (N/A)= no sample was drawn from this are. Source: IMA 2011-2014

Driving and Safety – ATV Helmet Use

Definition

The percentage of the population who reported using a helmet while riding an all-terrain vehicle (ATV), over a one-year time period.

Why is this indicator important?

Wearing an approved proper fitting helmet is one of the ways to reduce the risk of acquiring a head or spinal cord injury during an ATV accident. Monitoring this behavior helps to inform public education activities.

Provincial Key Findings

- In Manitoba, over 40% of the population reported that they rarely or never wear a helmet while on ATVs.
- Across the regions, “rarely/never” ranges from a low of 31.9% (Northern RHA) to a high of 48.7% (Prairie Mountain Health).

Table 2.29. Driving and Safety – ATV Helmet Use—Provincial Findings

	Rarely/Never	Often/Mostly
Manitoba	41.7%	43.7%
IERHA	47.0%	40.8%
WRHA	40.7%	38.1%
PMH	48.7%	39.9%
NRHA	31.9%	55.0%
SH-SS	41.1%	47.4%

Source: IMA 2011-2014

Regional Key Findings

- Interlake-Eastern respondents were less likely to report wearing a helmet “often/mostly” and more likely to report “rarely/never”.
- At the zone level, both the West Zone and North Zone have a significant higher percentage of residents “rarely/never” wearing helmets.

Table 2.30. Driving and Safety – ATV Helmet Use— IERHA Zone Findings

	Rarely/Never		Often/Mostly	
Manitoba	41.7%		43.7%	
IERHA	47.0%		40.8%	
South Zone	52.6%		42.6%	
East Zone	35.3%		53.1%	
West Zone	62.1%	H	25.0%	Lc
Selkirk Zone	-	s	52.6%	c
North Zone	71.5%	H	26.5%	c
Northern Remote Zone	N/A		N/A	

(H/L)= rate is significantly higher/lower than Manitoba. (c) = estimate displayed with caution.
 (N/A)= no sample was drawn from this area. Source: IMA 2011-2014



Use of Preventive Services

Immunization

Influenza Immunization (age 65+)

Definition

The percentage of the population, aged 65 years and older, who were immunized for influenza (received the flu shot), over a one-year time period.

Why is this indicator important?

People 65 years and older are at greater risk of serious complications from the flu, often leading to hospitalization and death, because immune defenses become weaker with age. Monitoring the uptake of influenza vaccination helps to inform health promotion and public health interventions, including public awareness messages, in an effort to reach the national target of 80 percent coverage.

Provincial Key Findings

- According to Manitoba Health Immunization data, 55.2% of residents aged 65 and older received the annual flu shot.
- Regionally, there is variation with the highest uptake being in Winnipeg RHA and the lowest uptake in Northern RHA.

Table 2.31. Influenza Immunization (age 65+)—Provincial Findings

	Age 65+
Manitoba	55.2%
IERHA	54.3%
WRHA	58.2%
PMH	53.2%
NRHA	43.2%
SH-SS	47.5%

Source: Public Health

Regional Key Findings

- In 2018, 54.3% of Interlake-Eastern residents aged 65 and older received the annual flu shot.
- Data in **Table 2.32.** suggests that there is varying uptake across Interlake-Eastern zones.
- For instance, highest uptake was found within Selkirk Zone (61.5%) and the lowest uptake was found in Northern Remote Zone (30.7%).

Table 2.32. Influenza Immunization (age 65+)—IERHA Zone Findings

Influenza	Age 65+
Manitoba	55.2%
IERHA	54.3%
South Zone	53.6%
East Zone	54.0%
West Zone	58.1%
Selkirk Zone	61.5%
North Zone	46.9%
Northern Remote Zone	30.7%

Source: Public Health



Pneumococcal Immunizations (age 65+)

Definition

The percentage of the population, aged 65 years and older, who were immunized for pneumonia (pneumococcal conjugate vaccine). Unlike influenza, this immunization is usually only given once in a lifetime, therefore the rate is cumulative.

Why is this indicator important?

Pneumococcal disease can cause severe infections of the lungs, bloodstream, lining of the brain, and spinal cord, that may sometimes be fatal. A weakened immune system puts older adults at greater risk of developing life threatening pneumococcal infections and, for those who survive, to suffer permanent damage to health, especially if living with other comorbid conditions. Monitoring the uptake of pneumococcal vaccination helps to inform on health promotion and primary health care interventions.

Provincial Key Findings

- According to Manitoba Health Immunization data, 61.2% of residents aged 65 and older received the immunization for pneumonia.
- Regionally, there is variation, with the highest uptake being in Winnipeg RHA and the lowest uptake in Southern Health Santé Sud.

Table 2.33. Pneumococcal Immunizations (age 65+)—Provincial Findings

Pneumococcal	Age 65+
Manitoba	61.2%
IERHA	60.2%
WRHA	62.6%
PMH	61.7%
NRHA	58.8%
SH-SS	55.3%

Source: Public Health

Regional Key Findings

- In 2018, 60.2% of Interlake-Eastern residents aged 65 and older received the immunization for pneumonia.
- Data in **Table 2.34.** suggests that there is varying uptake across Interlake-Eastern zones.
- For instance, highest uptake is within Selkirk Zone (67.8%) and the lowest uptake in Northern Remote Zone (44.5%).

Table 2.34. Pneumococcal Immunizations (age 65+)—IERHA Zone Findings

Pneumococcal	Age 65+
Manitoba	61.2%
IERHA	60.2%
South Zone	59.5%
East Zone	60.1%
West Zone	62.9%
Selkirk Zone	67.8%
North Zone	53.4%
Northern Remote Zone	44.5%

Source: Public Health

Screening

Colorectal Cancer Screening

Definition

The percentage of the population, aged 50 to 74 years, who participated in screening for colorectal cancer (including Fecal Occult Blood Test (FOBT), Fecal Immunochemical Test (FIT), Colonoscopy, and Flexible Sigmoidoscopy).

Why is this indicator important?

In Manitoba, it is recommended that most people age 50 to 74 years do a fecal occult blood test (FOBT) every two years. Screening done through a regular FOBT or a colonoscopy or sigmoidoscopy has been shown to greatly reduce the chance of dying from colorectal cancer because early detection of pre-cancerous polyps often leads to more effective treatment.

Provincial Key Findings

- In 2016-17, 53.2% of Manitobans participated in screening for colorectal cancer.
- All regions have experienced increased colorectal cancer screening participation rates from 2014 to 2017.
- Colorectal cancer screening participation rates were found to be significantly higher in Winnipeg RHA, Prairie Mountain Health, and Interlake-Eastern, while rates in Northern RHA are significantly lower at 37.9%.
- The income disparity remained unchanged over time. Colorectal cancer screening among low-income residents was 0.8 times lower than the highest income residents.

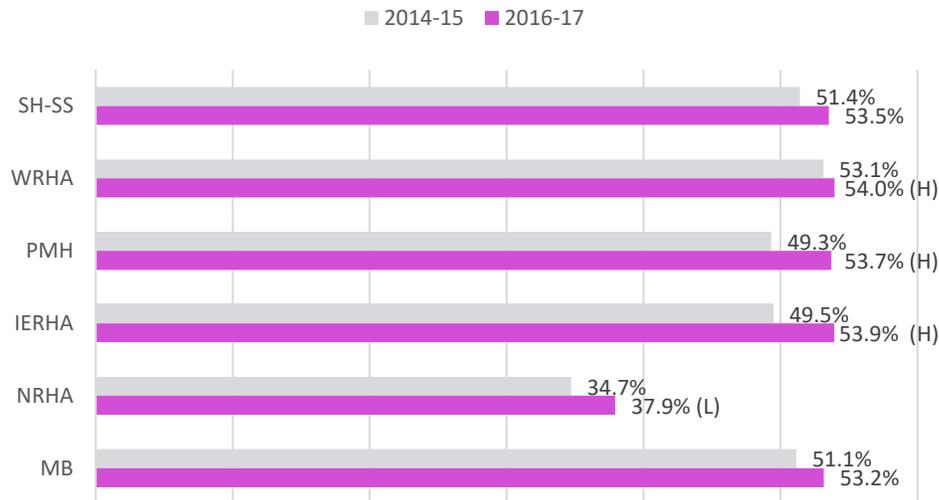


Rural Quintiles

T1	0.8x
T2	0.8x
CHANGE	0.0

Figure 2.40. Colorectal Cancer Screening—Provincial Findings

All screened (ColonCheck FOBT, ColonCheck FiT, Other FOBT, Colonoscopy, Flexible Sigmoidoscopy)
Ages 50-74

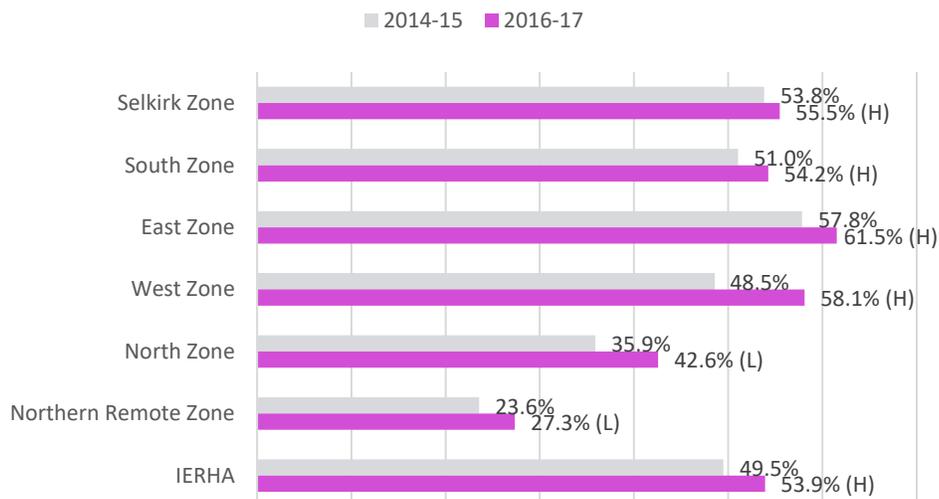


H/L Significantly higher or lower than the MB average for that time period.
Source: CancerCare Manitoba 2019

Regional Key Findings

- From 2014 to 2017, there has been a 4.4% increase in Interlake-Eastern residents participating in colorectal cancer screening.
- Similar to the provincial key findings, all zones have experienced increased participation rates over time.
- Although rates have increased, both North (42.3%) and Northern Remote Zone (27.3%) have rates significantly lower than Manitoba (53.2%)

Figure 2.41. Colorectal Cancer Screening—IERHA Zone Findings



H/L Significantly higher or lower than the MB average for that time period.
Source: CancerCare Manitoba 2019

Breast Cancer Screening

Definition

The percentage of females, aged 50 to 74 years, who received at least one mammogram in a two-year time period.

Why is this indicator important?

In Manitoba, it is recommended that screening mammography be offered every two years to all women 50 to 74 years of age. Although breast cancer can occur at any age, more than 80 percent of new cases occur among women 50 years of age and older. Early detection, combined with effective treatment, remains the best option available to reduce deaths in this age group.

Provincial Key Findings

- In 2016-17, there was a decrease in the percentage of residents who received a mammogram from 58.4% down to 55.8%.
- All regions reported 'significantly different' results in comparison with the Manitoba rate. Three of the five regions all have rates significantly lower than the Manitoba average while two have rates which are significantly higher.
- It is important to note that all regions experienced a decline in breast cancer screening participation rates overall.
- The income disparity remained unchanged over time. Breast cancer screening among low-income residents was 0.8 times lower than the highest income residents.

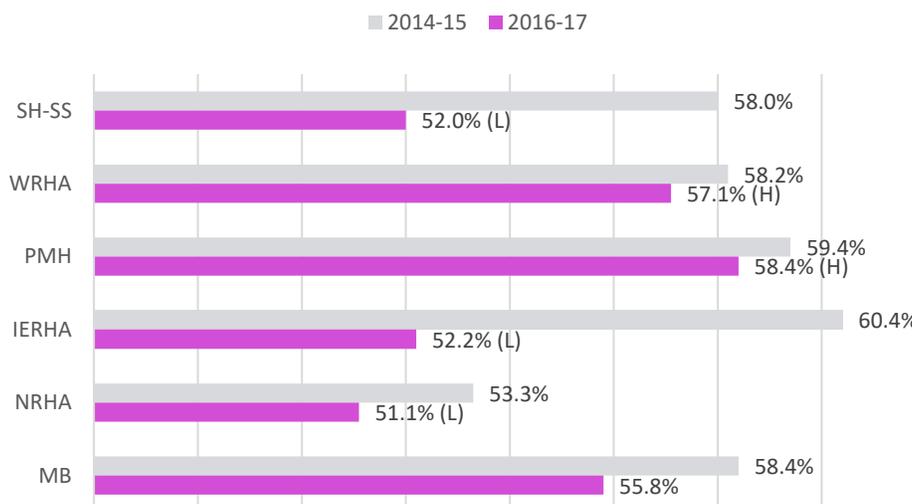


Rural Quintiles

T1	0.8x
T2	0.8x
CHANGE	0.0

Figure 2.42. Breast Cancer Screening—Provincial Findings, 2014-15 and 2016-17

Percent of women (ages 50 to 74) who had a mammogram within the last two years



H/L Significantly higher or lower than the MB average for that time period.

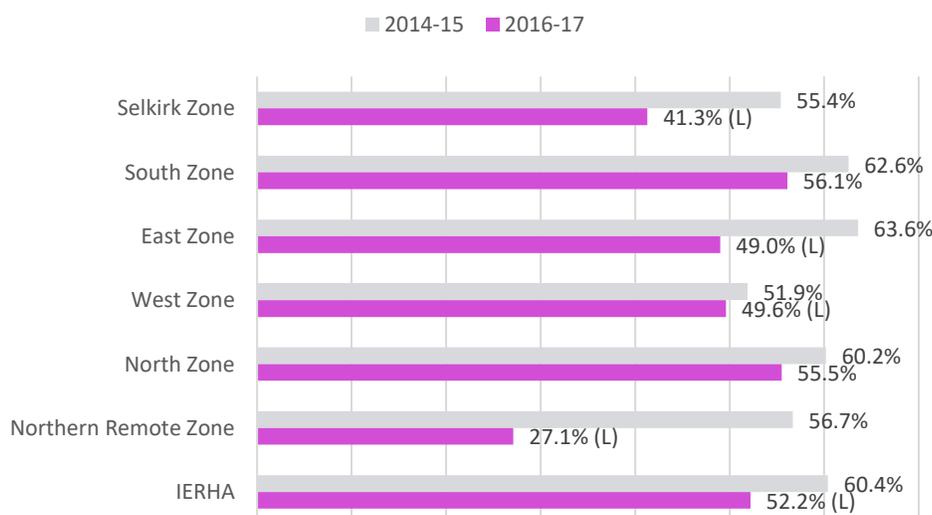
Source: CancerCare Manitoba 2019

Regional Key Findings

- In 2016-17, 52.2% of eligible women in Interlake-Eastern received a mammogram.
- Across the zones, both the North and South zones were found to have the highest breast cancer screening rates.
- Selkirk Zone, East Zone, West Zone, and Northern Remote Zone all have breast cancer screenings significantly lower than the provincial average of 55.8%.

Figure 2.43. Breast Cancer Screening—IERHA Zone Findings, 2014-15 and 2016-17

Percent of women (ages 50 to 74) who had a mammogram within the last two years



H/L Significantly higher or lower than the MB average for that time period.

Source: CancerCare Manitoba 2019

Cervical Cancer Screening

Definition

The percentage of females aged 21 to 69 years who were screened for cervical cancer over a two-year time period.

Why is this indicator important?

Regular pap smears every three years can prevent or detect early cell changes that can be the precursor to cervical cancer. Risk factors associated with cervical cancer include early age of sexual intercourse, sexually transmitted infection, low socioeconomic status, and smoking.

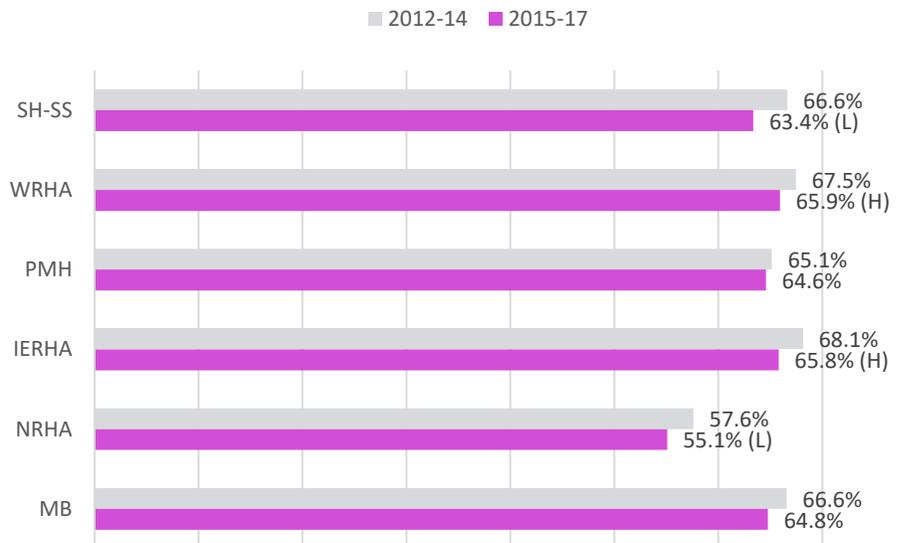
Provincial Key Findings

- There has been a slight decline in cervical cancer screening rates, from 66.6% down to 64.8% among all eligible females in Manitoba.
- Cervical cancer screening rates are relatively consistent between all RHAs with exception of Northern RHA.
- The income disparity remained unchanged over time. Cervical cancer screening among low-income residents was 0.8 times lower than the highest income residents.



Figure 2.44. Cervical Cancer Screening—Provincial Findings, 2012-14 and 2015-17

Percent of women (ages 21 to 69) who were screened for cervical cancer in the last two years



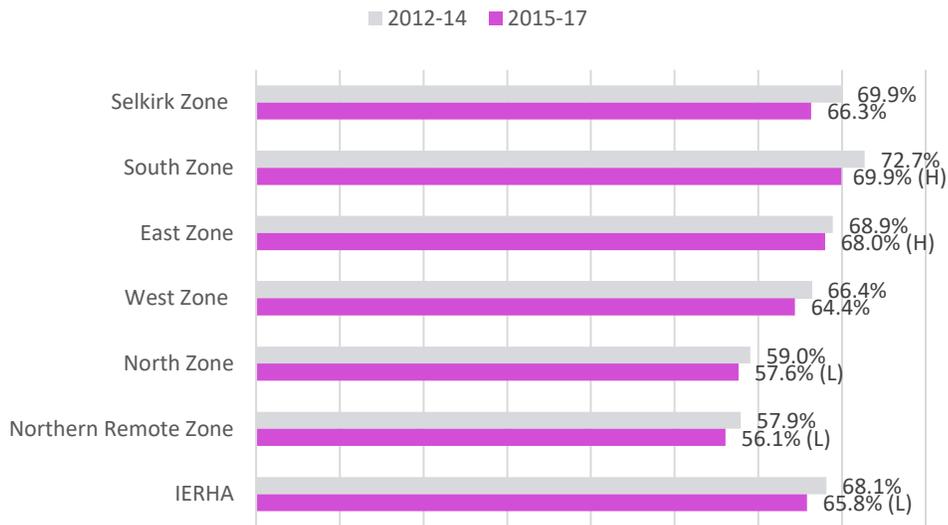
H/L Significantly higher or lower than the MB average for that time period.

Source: CancerCare Manitoba 2019

Regional Key Findings

- In 2015-17, 65.8% of eligible women in Interlake-Eastern participated in cervical cancer screening.
- Both the South Zone and the East Zone have participation rates significantly higher than the provincial average of 64.8%, while both North Zone and Northern Remote Zone have significantly lower rates of cervical cancer screening.
- From 2014 to 2017, there has been declining trends among all zones for participation in cervical cancer screening.

Figure 2.45. Cervical Cancer Screening—IERHA Zone Findings
 Percent of women (ages 21 to 69) who were screened for cervical cancer in the last two years



H/L Significantly higher or lower than the MB average for that time period.
 Source: CancerCare Manitoba 2019

Oral Health

Oral Health (Dental Visits/Insurance)

Definition

The percentage of respondents who reported on the annual frequency of dental visits and dental insurance coverage.

Why is this indicator important?

The promotion of good oral health habits such as healthy food choices, brushing teeth twice a day with fluoridated toothpaste, regular flossing, and visits to a dentist can all help to prevent decay and maintain a healthy mouth for a lifetime

^{xxv}. There is a strong association between early periodontal disease and cardiac disease in later life.

Provincial/Regional Key Findings

- 65% of Manitoba residents reported they had insurance for dental expenses.
- Coverage varies among RHAs, with a larger percentage having coverage in Northern RHA compared to Southern Health Santé Sud.
- A total of 62.5% of Interlake-Eastern residents reported having insurance for dental expenses. Dental insurance coverage varies across the zones in Interlake-Eastern between 69.5% in Selkirk Zone and 48.1% in the West Zone.
- Approximately 60% of Interlake-Eastern residents reported visiting the dentist 2+ times annually in 2015-2016; this was similar in the majority of regions.

Figure 2.46. Oral Health (Dental Visits/Insurance)—Provincial Findings, reported having insurance for dental expenses
Age and sex adjusted proportion (%) of weighted sample CCHS 2011/12, 2013/14



H/L Significantly higher or lower than the MB average.

	SH-SS		PMH		IERHA		MB		WRHA		NRHA	
T1 PERCENT	57.1%	L	58.9%	L	62.5%		65.0%		68.2%		76.2%	H

Source: CCHS 2011/2012, 2013/2014

CHAPTER 3:

HOW HEALTHY ARE WE?



Table of Contents

CHAPTER 3: HOW HEALTHY ARE WE?	119
Tables and Figures	122
At A Glance: How Healthy Are We?	125
Chapter 3 Key Findings	126
Mortality	128
Life Expectancy	128
Total Mortality Rates	132
Premature Mortality Rate (PMR)	134
Infant Mortality	137
Child Mortality	138
Potential Years of Life Lost (PYLL)—All Deaths	139
Potential Years of Life Lost—Unintentional Injuries	142
Potential Years of Life Lost — Suicide	143
Potentially Avoidable Deaths	144
Unintentional Injury Causes of Death	146
Cancers	149
Cancer Incidence — All Cancers	149
Cancer Incidence—Top 4 Diagnoses	151
Cancer Mortality — All & Top 4	152
Cancer Late Stage Diagnosis	153
Cancer Survival—All & Top 4	155
Cardiovascular	159
Hypertension Prevalence	159
Ischemic Heart Disease Prevalence	161
Heart Attack Incidence Rate	163
Congestive Heart Failure Prevalence	165
Stroke Rate	167
Diabetes	170
Diabetes Incidence	170

Diabetes Prevalence _____	172
Lower Limb Amputation Due to Diabetes _____	174
Diabetes Care - Eye Exams _____	176
Injury _____	180
Injury Hospitalization - Intentional _____	180
Injury Hospitalization - Unintentional _____	182
Hip Fracture Hospitalization Rate _____	184
Mental Illness _____	187
Mood & Anxiety Disorders _____	187
Dementia Prevalence _____	189
Antidepressant Prescription _____	191
Suicide Rates _____	193
Musculoskeletal _____	196
Arthritis Prevalence _____	196
Osteoporosis Prevalence _____	198
Renal _____	201
Chronic Kidney Disease Prevalence _____	201
End Stage Kidney Disease _____	202
Observed and Projected End Stage Kidney Disease _____	203
Respiratory _____	206
Total Respiratory Morbidity (TRM) Prevalence _____	206
Asthma Prevalence for Children _____	208
Asthma Care: Controller Medication Use _____	210
Communicable Diseases: Sexually Transmitted Infections _____	213
Chlamydia Rates _____	213
Gonorrhea Rates _____	214
HIV Rates _____	215
Syphilis Rates _____	216

Tables and Figures

Figure 3.1. Female Life Expectancy at Birth by RHA, based on mortality in 2007-2011 (T1) and 2012-2016 (T2)	128
Table 3.1. Female Life expectancy by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2).....	129
Figure 3.2. Male Life Expectancy at Birth by RHA, based on mortality in 2007-2011 (T1) and 2012-2016 (T2)...	130
Table 3.2. Male Life expectancy by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)	131
Figure 3.3 Average Annual Total Mortality Rate by RHA, 2007-2011 (T1) & 2012-2016 (T2).....	132
Table 3.3. Total Mortality Rates by IERHA Zone & District Findings, 2007-2011 (T1) & 2012-2016 (T2).....	133
Table 3.4. Leading 10 Causes of Mortality for Interlake-Eastern, 2007-2011 (T1) & 2012-2016 (T2)	134
Figure 3.4. Premature Mortality by RHA, 2007-2016 (T1) and 2012-2016 (T2)	135
Table 3.5. Premature Mortality Rate by IERHA Zone & District Findings, 2007-2016 (T1) and 2012-2016 (T2)...	136
Table 3.6. Top Five Causes of Premature Mortality for IERHA Zone Findings, 2007-2016 (T1) and 2012-2016 (T2)	136
Figure 3.5. Infant Mortality Rates by RHA, 2007-2011(T1) and 2012-2016 (T2)	137
Figure 3.6. Child Mortality Rates by RHA, 2007-2011(T1) and 2012-2016 (T2).....	138
Figure 3.7. Potential Years of Life Lost by RHA, 2007-2011 (T1) and 2012-2016 (T2)	139
Table 3.7. Potential Years of Life Lost—All Deaths by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2).....	140
Table 3.8. Most Frequent Causes of PYLL for IERHA Zone Findings, 2007-2016 (T1) and 2012-2016 (T2).....	141
Figure 3.8. Potential Years of Life Lost (PYLL) due to Unintentional Injury by RHA, 2006/07-2010/11 (T1) and 2011/12-2015/16 (T2)	142
Figure 3.9. Potential Years of Life Lost (PYLL) due to Suicide, 2011/12 (T1) and 2016/17 (T2)	143
Figure 3.10. Potentially Avoidable Death Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2).....	144
Table 3.9. Potentially Avoidable Deaths—IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)	145
Figure 3.11. Average Annual Unintentional Injury Causing Death Rates by RHA, 2007-2011(T1) and 2012-2016(T2)	146
Table 3.10. Unintentional Injury Causes of Death by IERHA Zone & District Findings 2011-2013 (T1) and 2014-2016 (T2).....	147
Table 3.11. Summary of Mortality District Disparities within IERHA.	148
Figure 3.12. All Invasive Cancers – Incidence rate by RHA 2011-13 (T1) and 2014-16 (T2)	149
Table 3.12. Cancer Incidence — All cancers by IERHA Zone findings, 2011-2013 (T1) and 2014-2016 (T2)	150
Table 3.13. Cancer Incidence – Top 4 Diagnoses Interlake-Eastern, 2011-2013 (T1) and 2014-2016 (T2)	151
Table 3.14. Cancer Mortality – Top Four Diagnoses IERHA, 2011-2013 (T1) and 2014-2016 (T2).....	152
Figure 3.13. Percent of all Invasive Cancers diagnosed at Stage IV, by RHA, 2011-2013 (T1) and 201-2016 (T2)	153

Table 3.15. Cancer Stage 4 Diagnosis by IERHA Zone Findings, 2011-2013 (T1) and 2014-2016 (T2)	154
Figure 3.14. Cancer Survival for all Invasive Cancers by RHA observed years 2007-2011, with follow-up to 2011 (T1) and observed years 2012-2016, with follow-up to 2016 (T2)	155
Table 3.16. Cancer Survival – Five-Year Relative Survival Rate, 2007-2011 (T1) and 2012-2016 (T2)	156
Figure 3.15. Prevalence of Hypertension by RHA, 2011/12 (T1) and 2016/17 (T2)	159
Table 3.17. Hypertension Prevalence by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)	160
Figure 3.16. Prevalence of Ischemic Heart Disease by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	161
Table 3.18. IHD Prevalence by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	162
Figure 3.17. Heart Attack (AMI) Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2)	163
Table 3.19. Heart Attack Incidence Rate by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)	164
Figure 3.18. Congestive Heart Failure Prevalence by RHA, 2011/12 (T1) and 2016/17 (T2)	165
Table 3.20. CHF Prevalence by IERHA Zone & District Findings, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)	166
Figure 3.19. Stroke Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2)	167
Table 3.21. Stroke Rate by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)	168
Figure 3.20. Incidence of Diabetes by RHA, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)	170
Table 3.22. Diabetes Incidence by IERHA Zone & District Findings, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)	171
Figure 3.21. Prevalence of Diabetes by RHA, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)	172
Table 3.23. Diabetes Prevalence by IERHA Zone & District Findings, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)	173
Figure 3.22. Lower Limb Amputations due to Diabetes by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	174
Table 3.24. Lower Limb Amputation Due to Diabetes by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	175
Figure 3.23. Diabetes Care: Eye Examinations by RHA, 2011/12 (T1) and 2016/17 (T2)	177
Table 3.25. Diabetes Care: Eye Examinations by IERHA Zone & District (age 19+), 2011/12 (T1) and 2016/17 (T2)	177
Figure 3.24. Intentional Injury Hospitalization Rates by RHA, 2011/12 (T1) and 2016/17 (T2)	180
Table 3.26. Injury Hospitalization (Intentional) by IERHA Zone Finding, 2011/12 (T1) and 2016/17 (T2)	181
Figure 3.25. Unintentional Injury Hospitalization Rates by RHA, 2011/12 (T1) and 2016/17 (T2)	182
Table 3.27. Injury Hospitalization (Unintentional) by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)	183
Table 3.28. Most Frequent Causes for Injury Hospitalization, for IERHA, 2011/12 (T1) and 2016/17 (T2)	183
Figure 3.26. Hip Fracture Hospitalization Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	184
Table 3.29. Hip Fracture Rate by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	185

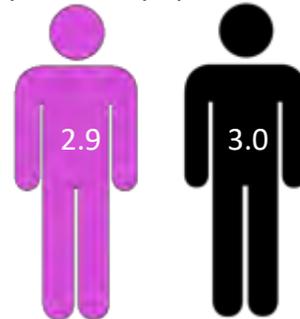
Figure 3.27. Percentage of 2018 EMS Primary Call Response Times.....	186
Figure 3.28. Prevalence of Mood and Anxiety Disorders among Adults by RHA, 2010/11 – 2014/15 (T1).....	187
Table 3.30. Mood & Anxiety Disorders by IERHA Zone & District Findings, 2010/11 – 2014/15 (T1)	188
Figure 3.29. Prevalence of Dementia among Adults by RHA, 2010/11 – 2014/15 (T1)	189
Table 3.31. Dementia Prevalence by IERHA Zone & District Findings, 2010/11 – 2014/15 (T1)	190
Figure 3.30. Antidepressant Prescription Follow-up by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	191
Table 3.32. Antidepressant Prescription by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	192
Figure 3.31. Average Annual Suicide Rates by RHA, 2007-2011(T1) and 2012-2016(T2)	193
Table 3.33. Suicide Rates by IERHA Zone Findings, 2007-2011(T1) and 2012-2016(T2)	194
Figure 3.32. Annual ED Assessments at SRHC by MHLNs, 2014-15 to 2018-19.	195
Figure 3.33. Prevalence of Arthritis by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)	196
Table 3.34. Arthritis Prevalence by IERHA Zone & District Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)	197
Figure 3.34. Prevalence of Osteoporosis by RHA, 2011/12 (T1) and 2016/17 (T2)	198
Table 3.35. Osteoporosis Prevalence by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2).....	199
Figure 3.35. Prevalence of Adults with Chronic Kidney Disease by RHA, March 31, 2012	201
Figure 3.36. End Stage Kidney Disease Prevalence by RHA, 2007 Q2 (T1) and 2012 Q2 (T2)	202
Table 3.36. Observed and Projected Number of Patients with ESKD by RHA, 2012 and 2024.....	203
Figure 3.37. Observed and Projected Number of Patients with End Stage Kidney Disease by Treatment Type in Interlake-Eastern Health Region, 2004-2024.....	204
Figure 3.38. Prevalence of Total Respiratory Morbidity by RHA, 2011/12 (T1) and 2016/17 (T2)	206
Table 3.37. Total Respiratory Morbidity Prevalence by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)	207
Figure 3.39. Asthma Prevalence by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)	208
Table 3.38. Asthma Rate for Children by IERHA Zone & District Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)	209
Figure 3.40. Asthma Care by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2).....	210
Table 3.39. Controller Medication Use by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	211
Figure 3.41. Crude Rate of Reported Chlamydia Infections, 2014-2018	213
Figure 3.42. Crude Rate of Reported Gonorrhea Infections, 2014-2018.....	214
Figure 3.43. Proportion of new HIV cases in Manitoba by RHA, 2017	215
Figure 3.44. Crude rate of reported Syphilis infections calendar years 2014 to 2018.....	216

At A Glance: How Healthy Are We?

Life Expectancy



Premature Mortality Rate per 1,000 population



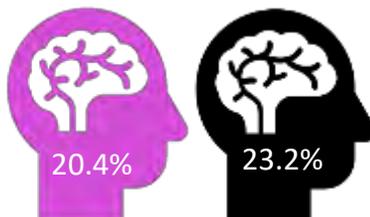
Infant Mortality deaths per 1,000 births



Cancer Incidence per 100,000 population



Proportion of Residents with a Mood and Anxiety Disorder



Chapter 3 Key Findings

Mortality:

- Significant decrease in potentially avoidable deaths among residents
- All six zones experienced improvements in premature mortality rates
- Cancer is the leading cause of premature death

Cancer:

- Lung cancer had the highest rate of new cancer incidences
- Over 20% of cancer patients diagnosed in late-stage (IV)

Cardiovascular:

- Over 25,000 residents diagnosed with hypertension (high blood pressure) annually
- Significant decrease in heart attack rates

Diabetes:

- One in 10 residents diagnosed with diabetes
- Diabetes prevalence increased in five out of six zones

Injury:

- Falls represent nearly 50% of all injury related hospitalizations
- Decreasing rates for hospitalization due to unintentional injuries

Mental Illness:

- One in five residents diagnosed with a mood or anxiety disorder

Renal Health:

- Nearly 200 residents require renal replacement therapy annually (e.g. dialysis or transplant)

Respiratory:

- Increasing rates of children diagnosed with asthma

Communicable Diseases:

- Gonorrhea rates have increased significantly over the past five years
- Syphilis rates increase by 749%



Mortality

Life Expectancy

Definition

The expected length of life from birth, based on patterns of mortality in the population for the preceding five years.

Why is this indicator important?

Life expectancy is one of the most widely used indicators to measure the health of a population, and the overall effectiveness of a health care system in maintaining the health status of its population.

Provincial Female Key Findings

- Life expectancy for females in Manitoba increased significantly over time from 82.2 to 82.8 years.
- Female life expectancy increased for all RHAs, though only the changes in Winnipeg and Prairie Mountain reached statistical significance.
- Income: In rural settings, the highest income females had a life expectancy about 1.1 times longer than that of lowest income females.



Figure 3.1. Female Life Expectancy at Birth by RHA, based on mortality in 2007-2011 (T1) and 2012-2016 (T2)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA		IERHA		MB		PMH		WRHA		SH-SS	
T2 COUNT	925		2,432		25,881		4,059		14,841		2,965	
T2 RATE	76.9	L	82.5		82.8	+	83.3	+	83.4	H+	83.9	H
T1 RATE	76.3	L	82.1		82.2		82.2		82.7	H	83.7	H

Source: MCHP RHA Indicators Atlas 2019

Regional Female Key Findings

- Interlake-Eastern female life expectancy has increased slightly over time to 82.5 years.
- **Table 3.1.** shows females living in the South Zone of Interlake-Eastern have the highest life expectancy at 84.7 years.
- The East Zone saw a decrease in life expectancy, particularly within the Pinawa/Lac du Bonnet district where rates fell from 86.8 years to 83.7 years.
- The district disparity ratios in Table 3.1 show that over time there has been little to no change at the district level in female life expectancy. Therefore, there has been no narrowing or widening in disparity in female life expectancy at the district level.

Table 3.1. Female Life expectancy by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)

	T2			T1	
	Count	Rate		Rate	
Manitoba	25,881	82.8	+	82.2	
South Zone	774	84.7	H	84.2	H
Wpg Beach/ St. Andrews	196	85.7	H	86.7	H
Stonewall/Teulon	306	85.7	H	84.4	H
Springfield	172	83.9		83.1	
St. Clements	100	83.8		68.8	H
East Zone	453	82.9	-	84.7	H
Pinawa/Lac du Bonnet	188	83.7	-	86.8	H
Beausejour	201	82.6		83.8	
Whiteshell	64	82.1		85.1	
West Zone	395	83.2		81.5	
St. Laurent	82	84.4		85.5	
Arborg/Riverton	121	83.0		81.8	
Gimli	192	82.9		80.5	
Selkirk Zone	435	80.0	L	79.7	L
Selkirk	435	80.0	L	79.7	L
IERHA	2,432	82.5		82.1	
North Zone	334	79.8	L	79.3	L
Eriksdale/Ashern	112	83.0		79.9	
Fisher/Peguis	119	79.0	L	80.5	
Powerview/Pine Falls	103	77.8	L	77.8	L
Northern Remote	41	74.2	L+	66.6	L
Northern Remote	41	74.2	L+	66.6	L

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	1.3	
	T2 Disparity	1.2	
	Change	-0.1 ↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Provincial Male Key Findings

- Life expectancy for males in Manitoba increased significantly over time from 77.5 to 78.5 years.
- Male life expectancy increased significantly for all RHAs.
- Income: The highest income males had a life expectancy about 1.1 times longer than that of lowest income males.



Figure 3.2. Male Life Expectancy at Birth by RHA, based on mortality in 2007-2011 (T1) and 2012-2016 (T2)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA		IERHA		PMH		MB		SH-SS		WRHA	
T2 COUNT	1,177		2,786		4,144		25,781		3,294		13,605	
T2 RATE	72.7	L+	78.2	+	78.3	+	78.5	+	79.4	H	79.4	H+
T1 RATE	71.3	L	76.7		77.3		77.5		79.1	H	78.3	H

Source: MCHP RHA Indicators Atlas 2019

Regional Male Key Findings

- Male life expectancy saw a significant increase from 76.7 years to 78.2 years as shown in Table 3.2
- Districts within the South Zone saw the most significant improvements for male life expectancy from 78.6 years to 80.9 years.
- The district disparity ratios in **Table 3.2.** show that over time there has been no change at the district level in male expectancy. Therefore, there has been no narrowing or widening in life expectancy rates at the district level between the highest and lowest performing districts.

Table 3.2. Male Life expectancy by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)

	T2		+	T1	
	Count	Rate		Rate	
Manitoba	25,781	78.5	+	77.5	

South Zone	949	80.9	H+	78.6	H
Wpg Beach/St. Andrews	273	81.8	H+	78.3	
St. Clements	131	81.8	H+	76.7	
Springfield	203	81.3	H	79.8	H
Stonewall/Teulon	342	80.7	H+	79.0	

East Zone	493	79.7		78.4	
Pinawa/Lac du Bonnet	216	81.1		81.4	H
Beausejour	189	79.5	+	76.7	
Whiteshell	88	79.4		77.3	

West Zone	471	78.1		78.2	
Arborg/Riverton	106	79.4		76.4	
Gimli	219	79.4		78.8	
St. Laurent	146	75.2	-	79.1	

Selkirk Zone	361	73.5	L	72.8	L
Selkirk	361	73.5	L	72.8	L

IERHA	T2		+	T1	
	Count	Rate		Rate	
IERHA	2,786	78.2	+	76.7	

North Zone	450	74.1	L	72.8	L
Fisher/Peguis	148	74.8	L	72.7	L
Eriksdale/Ashern	172	74.1	L	74.6	
Powerview/Pine Falls	130	74.0	L	71.0	L

Northern Remote	62	66.9	L	64.9	L
Northern Remote	62	66.9	L	64.9	L

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	1.2
	T2 Disparity	1.2
	Change	0
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Total Mortality Rates

Definition

The total average annual number of deaths, per 1,000 population, for a five-year time period.

Why is this indicator important?

Mortality statistics provide a valuable measure for assessing community health status and are useful when formulating health plans and policies to prevent or reduce premature mortality and improve overall quality of life.

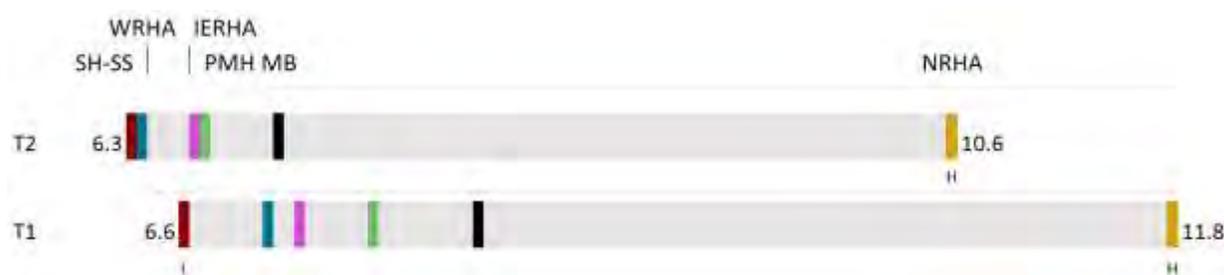
Provincial Key Findings

- There were 51,723 deaths reported in Manitoba in 2012-2016. The total mortality rate decreased over time from 8.17 to 7.14 deaths per 1,000 residents per year.
- In 2012-2016, the most frequent causes of death in Manitoba were circulatory diseases and cancer.
- Income: Low-income residents' mortality rate was about 1.9 times higher than that of highest income residents.



Figure 3.3 Average Annual Total Mortality Rate by RHA, 2007-2011 (T1) & 2012-2016 (T2)

Age- and sex-adjusted rate per 1,000 (all ages)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	IERHA	PMH	MB	NRHA
T2 COUNT	6,266	28,477	5,225	8,218	51,723	2,103
T2 RATE	6.3	6.3	6.7	6.7	7.1	10.6 H
T1 RATE	6.6 L	7.0	7.2	7.6	8.2	11.8 H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern mortality rate was 6.6 deaths per 1,000 residents which totaled 5,225 deaths over a five-year time period.
- At the zone level, Northern Remote (17.8), Selkirk (10.4) and North (9.9) have experienced mortality rates significantly higher than the provincial average of 7.1 per 1,000 (**Table 3.3**).
- The district disparity ratio indicates that over time we have experienced a narrowing of rates between our districts with the highest and lowest total mortality rates.
- Similar to the provincial key findings, both cancer and circulatory diseases account for the majority of all deaths within Interlake-Eastern.
- There were no significant changes in the order of most frequent causes of death for Interlake-Eastern residents during the two time periods, with exception to mental illness where the proportions of deaths increased over time from 2.6% to 4.7% as shown in **Table 3.4**.

Table 3.3. Total Mortality Rates by IERHA Zone & District Findings, 2007-2011 (T1) & 2012-2016 (T2)

	T2		T1	
	Count	Rate	Rate	
Manitoba	51,723	7.1	8.2	

	T2		T1	
	Count	Rate	Rate	
IERHA	5,225	6.7	7.2	

South Zone	1,727	6.3	L	7.0	L
Wpg Beach/St. Andrews	471	6.1	L	6.8	
St. Clements	231	6.2		7.3	
Springfield	375	6.4		7.1	
Stonewall/Teulon	650	6.6		7.2	

North Zone	785	10.0	H	10.6	H
Fisher/Peguis	284	8.5		9.6	
Eriksdale/Ashern	267	10.3	H	10.4	H
Powerview/Pine Falls	234	10.8	H	12.0	H

East Zone	946	7.1		7.3	
Pinawa/ Lac du Bonnet	404	6.5		6.1	L
Whiteshell	152	7.6		7.4	
Beausejour	390	7.6		8.5	

West Zone	867	7.9		8.1	
Gimli	412	7.5		8.1	
Arborg/Riverton	227	7.8		8.7	
St. Laurent	228	8.5		7.6	

Selkirk Zone	797	10.4	H	10.9	H
Selkirk	797	10.4	H	10.9	H

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	3.7
	T2 Disparity	2.9
	Change	-0.8↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Table 3.4. Leading 10 Causes of Mortality for Interlake-Eastern, 2007-2011 (T1) & 2012-2016 (T2)

	T2		T1
	Count	Percentage	Percentage
Cancer	1,571	29.9%	30.7%
Circulatory	1,543	29.4%	31.6%
Respiratory	437	8.3%	8.1%
Injury and Poisoning	426	8.1%	8.7%
Mental Illness	249	4.7%	2.6%
Endocrine and Metabolic	223	4.3%	4.9%
Digestive	214	4.1%	3.8%
Nervous System	181	3.4%	3.7%
Genitourinary and Breast	108	2.1%	1.6%
Ill-Defined Conditions	107	2.0%	1.4%

Source: MCHP RHA Indicators Atlas 2019

Premature Mortality Rate (PMR)

Definition

The average annual number of deaths before the age of 75 years, per 1,000 population, for a five-year time period.

Why is this indicator important?

PMR is an important overall indicator of population health status with high rates indicating poor health. These rates are often correlated with morbidity and self-rated health as well as socioeconomic indicators such as food security, housing, and education level.

Provincial Key Findings

- A total of 19,915 Manitobans died prematurely in 2012-2016. PMR in Manitoba decreased over time from 3.29 to 2.98 deaths per 1,000 residents before the age of 75. This suggests an improvement in population health.
- In 2012–2016, the most frequent causes of premature death in Manitoba were cancer and circulatory diseases, followed by injury and poisoning, respiratory diseases, and digestive disease.
- Income: Low-income residents' premature mortality rate (PMR) was 2.2 times higher than that of highest income residents.



Rural Quintiles

T2

2.2x

Figure 3.4. Premature Mortality by RHA, 2007-2016 (T1) and 2012-2016 (T2)

Age- and sex-adjusted average annual rate of death before age 75 per 1,000 residents (age 0-74)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	PMH	IERHA	MB	NRHA
T2 COUNT	2,334	10,563	2,702	2,253	19,915	1,456
T2 RATE	2.46	2.64	2.79	2.90	2.98	5.44 H
T1 RATE	2.52 L	2.87	3.25	3.26	3.29	5.83 H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- A total of 2,253 residents died prematurely in Interlake-Eastern over a five-year time period.
- All zones within Interlake-Eastern experienced improvements over time, which indicates that a smaller number of residents are dying prematurely.
- Although improvements were experienced across the region, Northern Remote, North and Selkirk zones are seeing a higher proportion of deaths before the age of 75 and at a rate significantly higher than the provincial average.
- The top five causes of premature death for Interlake-Eastern residents remained the same over time as shown in **Table 3.6**.
- The change over time indicates that disparity has narrowed slightly from 4.5 to 4.0. As of 2016, residents living in Northern Remote are 4.0 times more likely to die prematurely than residents living in St. Clements.

Table 3.5. Premature Mortality Rate by IERHA Zone & District Findings, 2007-2016 (T1) and 2012-2016 (T2)

	T2		T1		
	Count	Rate		Rate	
Manitoba	19,915	2.98		3.29	
South Zone	804	2.35	L-	2.79	L
St. Clements	113	2.11	L-	3.16	
Springfield	171	2.17	L	2.38	L
Stonewall/Teulon	256	2.47	L	2.86	
Wpg Beach/St. Andrews	264	2.48	L	2.85	
East Zone	363	2.54	L	2.62	L
Pinawa/Lac du Bonnet	170	2.45	L	2.36	L
Beausejour	132	2.62		2.97	
Whiteshell	61	2.68		2.73	
West Zone	331	3.15		3.35	
Arborg/Riverton	72	2.76		3.76	
Gimli	158	3.13		3.12	
St. Laurent	101	3.58		3.41	
Selkirk Zone	242	4.38	H	4.55	H
Selkirk	242	4.38	H	4.55	H

	T2		T1		
	Count	Rate		Rate	
IERHA	2,253	2.90		3.26	
North Zone	424	4.61	H	5.17	H
Eriksdale/Ashern	137	4.12	H	4.63	H
Fisher/Peguis	133	4.34	H	5.10	H
Powerview/Pine Falls	154	5.49	H	5.98	H
Northern Remote	89	8.41	H	10.58	H
Northern Remote	89	8.41	H	10.58	H

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	4.5	
	T2 Disparity	4.0	
	Change	-0.5↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Table 3.6. Top Five Causes of Premature Mortality for IERHA Zone Findings, 2007-2016 (T1) and 2012-2016 (T2)

	T2		T1
	Count	Percentage	Percentage
Cancer	831	36.8%	37.0%
Circulatory	517	22.9%	23.9%
Injury and Poisoning	314	13.9%	14.4%
Digestive	122	5.4%	4.6%
Respiratory	117	5.2%	5.1%

Source: MCHP RHA Indicators Atlas 2019

Infant Mortality

Definition

The average annual number of deaths prior to one year of age, per 1,000 live births, over a five-year time period.

Why is this indicator important?

Infant mortality is considered to be one of the most important indicators of child and overall population health, and the well-being of a society over time. This is a health equity indicator as it is largely driven by social determinants of health and helps to inform planning of appropriate upstream interventions.

Provincial Key Findings

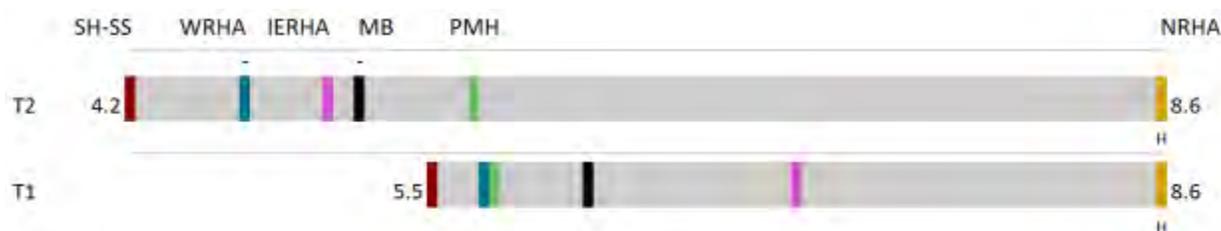
- There were 407 infant deaths in 2012-2016. The rate for infant mortality decreased significantly over time in the province, from 6.2 to 5.2 per 1,000 live births.
- Rates decreased in all regions, though only the decrease in Winnipeg was statistically significant.
- Rates in the Northern RHA were significantly higher than the provincial average in both time periods.

Regional Key Findings

- Interlake-Eastern saw a decrease in infant mortality rates from 7.1 to 5.1 per 1,000 live births, totaling 35 deaths in 2012-2016.
- Data has been suppressed at the zone/district level to protect the privacy of patients.

Figure 3.5. Infant Mortality Rates by RHA, 2007-2011(T1) and 2012-2016 (T2)

Maternal age adjusted average annual rate per 1,000 live births per year



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	IERHA	MB	PMH	NRHA
T2 COUNT	59	182	35	407	57	73
T2 RATE	4.2	4.7	5.1	5.2	5.7	8.6 H
T1 RATE	5.5	5.8	7.1	6.2	5.8	8.6 H

Source: MCHP RHA Indicators Atlas 2019

Child Mortality

Definition

The average annual number of deaths amongst children, aged 1 to 19 years, per 1,000, for a five-year time period.

Why is this indicator important?

Similar to infant mortality, child mortality is an important indicator of overall population health and the well-being of a society over time. This is a health equity indicator as it is largely driven by social determinants of health and helps to inform planning of appropriate upstream interventions.

Provincial Key Findings

- In Manitoba, 472 children aged 1-19 died in 2012-2016.
- Mortality rates were considerably higher for rural compared to urban children.
- For Manitoba, and for all regions, injury and poisoning was the most common cause of mortality for children.

Regional Key Findings

- In Interlake-Eastern, 51 children aged 1-19 died in 2012-2016 at a rate of 0.35 per 1,000 children.
- Child mortality rates for Interlake-Eastern have remained above the Manitoba average.
- In Interlake-Eastern, over 75% of all child mortality was a result of an injury or poisoning.
- Due to small numbers the other most frequent causes have been suppressed together to protect the privacy of patients.

Figure 3.6. Child Mortality Rates by RHA, 2007-2011(T1) and 2012-2016 (T2)

Age and sex adjusted average annual rate of deaths per 1,000 residents per year, age 1-19



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	PMH	SH-SS	MB	IERHA	NRHA
T2 COUNT	174	50	79	472	51	94
T2 RATE	0.22	0.26	0.30	0.31	0.35	0.76 H
T1 RATE	0.21	0.39 L	0.26	0.32	0.33	0.89 H

Source: MCHP RHA Indicators Atlas 2019

Potential Years of Life Lost (PYLL)—All Deaths

Definition

The life lost when a person dies between the age of 1 to 74 years. For each death, the PYLL value is calculated as the difference (in years) between age at death and 75 years of age. Average annual rates are calculated per 1,000 populations, for a five-year time period.

Why is this indicator important?

PYLL is more sensitive to deaths at younger ages than other mortality indicators.

Provincial Key Findings

- Manitoba experienced a reduction of PYLLs, from 54.11 to 52.25 PYLLs per 1,000 population aged 1 to 74.
- Injury, cancer, circulatory, digestive, and respiratory diseases resulted in the largest number of PYLL in the province over a five-year time period.
- Income: In rural settings, low-income residents’ overall potential years of life lost was 2.3 times higher than that of highest income residents.



Figure 3.7. Potential Years of Life Lost by RHA, 2007-2011 (T1) and 2012-2016 (T2)
Age- and sex-adjusted average annual rate of PYLL per 1,000 residents (aged 1-74)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	PMH	MB	IERHA	NRHA
T2 COUNT	37,007	163,408	40,289	315,700	33,708	32,157
T2 RATE	44.8	45.2	49.5	52.3	55.7	110.8 H
T1 RATE	41.8	47.2	57.8	54.1	57.2	108.1 H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- The number of PYLL by Interlake-Eastern residents in 2012-2016 was 33,708 years in total.
- Due to the larger population in the South Zone, this zone represents the largest proportion of PYLL in the Interlake-Eastern but at the lowest rate at 37.5 life years lost per 1,000 residents aged 0 to 74.
- It is important to note that there are varying PYLL rates across the districts and this is reflected in the district disparity ratio highlighted in **Table 3.7**. For instance, the PYLL are 5.8 times greater in Northern Remote compared to Stonewall/Teulon.
- The most frequent cause of PYLL in the Interlake-Eastern is injury and poisoning, which represented 11,123 PYLL (**Table 3.8**).

Table 3.7. Potential Years of Life Lost—All Deaths by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)

	T2		T1	
	Count	Rate	Rate	
Manitoba	315,700	52.3	54.1	

	T2		T1	
	Count	Rate	Rate	
IERHA	33,708	55.7	57.2	

South Zone	11,354	37.5	38.6	
Stonewall/Teulon	3,378	29.4	30.6	
Springfield	2,486	34.4	41.8	
Wpg Beach/St. Andrews	3,500	38.3	39.1	
St. Clements	1,990	60.1	55.5	

North Zone	7,581	96.2	H	80.9	
Eriksdale/Ashern	2,360	91.2		68.0	
Fisher/Peguis	2,295	92.5		69.2	
Powerview/Pine Falls	2,926	110.6		105.7	

East Zone	4,728	45.0	41.2	
Whiteshell	748	37.9	46.8	
Beausejour	1,979	38.6	41.3	
Pinawa/Lac du Bonnet	2,001	64.9	35.7	

Northern Remote	2,292	169.9	H	242.9	H
Northern Remote	2,292	169.9	H	242.9	H

West Zone	4,137	48.7	54.6	
Arborg/Riverton	954	37.0	59.6	
St. Laurent	1,299	50.2	42.5	
Gimli	1,884	58.0	56.5	

Selkirk Zone	3,616	64.1	72.4	
Selkirk	3,616	64.1	72.4	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	7.9
	T2 Disparity	5.8
	Change	-2.1↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Table 3.8. Most Frequent Causes of PYLL for IERHA Zone Findings, 2007-2016 (T1) and 2012-2016 (T2)

	T2		T1
	Count	Rate	Rate
Injury and Poisoning	11,123	21.8	21.9
Cancer	9,569	14.0	15.4
Circulatory	5,916	8.8	9.8
Digestive	1,649	2.6	2.4
Respiratory	1,205	1.7	1.9

Source: MCHP RHA Indicators Atlas 2019



Potential Years of Life Lost—Unintentional Injuries

Definition

The PYLL for all unintentional injuries, for example falls, motor vehicle accidents, or drowning per 1,000 population aged 1 to 74 years, for a five-year time period. Note that the data source and years differs from PYLL – all deaths presented above.

Why is this indicator important?

Unintentional injuries contribute significantly to PYLL and can be used to help identify the need for injury prevention strategies.

Provincial Key Findings

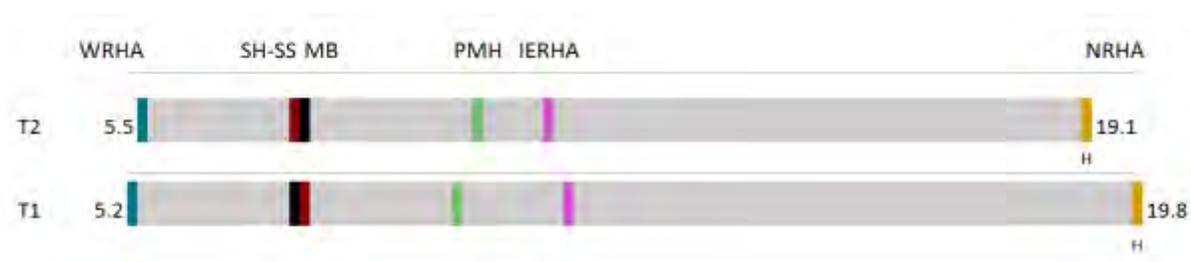
- In Manitoba, PYLL caused by unintentional injuries were 7.8 PYLLs per 1,000 population aged 1 to 74 years. It remained stable over time for Manitoba and all regions.

Regional Key Findings

- In Interlake-Eastern, 5,975 PYLL were a result of unintentional injuries in 2012-2016.

Figure 3.8. Potential Years of Life Lost (PYLL) due to Unintentional Injury by RHA, 2006/07-2010/11 (T1) and 2011/12-2015/16 (T2)

Age/Sex Adjusted PYLL Rates, per 1,000 (1 to 74 years and older)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	PMH	IERHA	NRHA
T2 COUNT	17,962	6,449	44,662	7,566	5,975	6,710
T2 RATE	5.5	7.6	7.8	10.3	11.3	19.1 H
T1 RATE	5.2	7.9	7.8	10.0	11.7	19.8 H

Source: MHSAL IMA 2018

Potential Years of Life Lost — Suicide

Definition

The PYLL for all suicides per 1,000 population aged 1 to 74 years, for a five-year time period. Note that the data source and years differ from PYLL all deaths presented above.

Why is this indicator important?

Suicide is one of the main causes of premature death. There is potential to positively affect society overall through strengthening mental health awareness, early identification of suicidal thoughts, and timely referral to appropriate supports.

Provincial Key Findings

- In Manitoba, PYLLs caused by suicide increased from 4.9 to 5.6 PYLLs per 1,000 population.
- PYLLs due to suicide in Northern were the highest in both time periods and they were significantly higher than the provincial average in both periods.

Regional Key Findings

- In Interlake-Eastern, PYLLs caused by suicide increased from 7.0 to 7.2 PYLLs per 1,000 population.
- This rate represents a total of 3,548 years of potential life lost due to to suicide.

Figure 3.9. Potential Years of Life Lost (PYLL) due to Suicide, 2011/12 (T1) and 2016/17 (T2)

Age/Sex Adjusted PYLL Rates, per 1,000 (1 to 74 years and older)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	PMH	MB	IERHA	NRHA
T2 COUNT	2,465	12,451	3,564	27,455	3,548	5,427
T2 RATE	2.7	3.9	4.7	4.9	7.2	15.6 H
T1 RATE	1.8	3.5	4.0	4.3	7.0	13.3 H

Source: MHSAL IMA 2018

Potentially Avoidable Deaths

Definition

The average annual rate of avoidable deaths before age 75, per 1,000 populations (aged 0-74), for a five-year time period. Avoidable deaths include those that could be avoided through primary prevention efforts, such as lifestyle modifications, immunizations, and health promotion initiatives.

Why is this indicator important?

Potentially avoidable deaths provide insight on the effectiveness of disease prevention policies, health promotion, and health care in preventing premature deaths.

Provincial Key Findings

- The number of potentially avoidable deaths in Manitoba was 13,699 in 2012-2016. The rate of potentially avoidable deaths significantly decreased over time from 2.3 to 2.1 per 1,000 residents 75 years of age and younger.
- Income: Low-income residents' rate of potentially avoidable deaths was about 2.2 times higher than that of highest income residents.



Figure 3.10. Potentially Avoidable Death Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2)

Age- and sex-adjusted average annual rate of avoidable death before age 75 per 1,000 residents under age 75



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	PMH	MB	IERHA	NRHA
T2 COUNT	1,539	7,272	1,856	13,699	1,587	1,074
T2 RATE	1.74 L	1.98 L-	2.08 -	2.11 -	2.15 -	3.83 H-
T1 RATE	1.84 L	2.16 L	2.34	2.33	2.48	4.22 H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern saw a statistically significant decrease in avoidable deaths.

- **Table 3.9.** shows the number of potentially avoidable deaths in Interlake-Eastern was 1,587 in 2012-2016.
- Selkirk, North, and Northern Remote zones have rates of potentially avoidable deaths significantly higher than the provincial rate of 2.1 per 1,000 residents.
- Based on the results presented in **Table 3.9**, it is evident that variation in potentially avoidable deaths exists among districts within Interlake-Eastern and this is reflected in the district disparity ratio. Although disparity has narrowed over time, residents living in Northern Remote are 4.6 times more likely to die from a potentially avoidable cause than residents living in Springfield.

Table 3.9. Potentially Avoidable Deaths—IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)

	T2			T1	
	Count	Rate		Rate	
Manitoba	13,699	2.11	-	2.33	

	T2			T1	
	Count	Rate		Rate	
IERHA	1,587	2.15	-	2.48	

South Zone	550	1.62	L-	2.02	L
Springfield	114	1.45	L	1.66	L
St. Clements	85	1.60	-	2.36	
Stonewall/Teulon	170	1.65	L-	2.11	
Wpg Beach/St. Andrews	181	1.72		2.04	

North Zone	312	3.39	H	3.88	H
Eriksdale/Ashern	98	2.96	H	3.59	H
Fisher/Peguis	98	3.19	H	3.40	H
Powerview/Pine Falls	116	4.13	H	4.79	H

East Zone	244	1.74	L	1.81	L
Beausejour	80	1.60		2.09	
Pinawa/Lac du Bonnet	120	1.77		1.63	L
Whiteshell	44	1.96		1.80	

Northern Remote	72	6.62	H	8.12	H
Northern Remote	72	6.62	H	8.12	H

West Zone	229	2.22		2.33	
Arborg/Riverton	47	1.82		2.53	
Gimli	101	2.05		1.99	
St. Laurent	81	2.92	H	2.72	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	5.0
	T2 Disparity	4.6
	Change	-0.4↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

Selkirk Zone	180	3.29	H	3.53	H
Selkirk	180	3.29	H	3.53	H

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Unintentional Injury Causes of Death

Definition

The number of deaths due to unintentional injury, per 1,000 population, for a five-year time period.

Why is this indicator important?

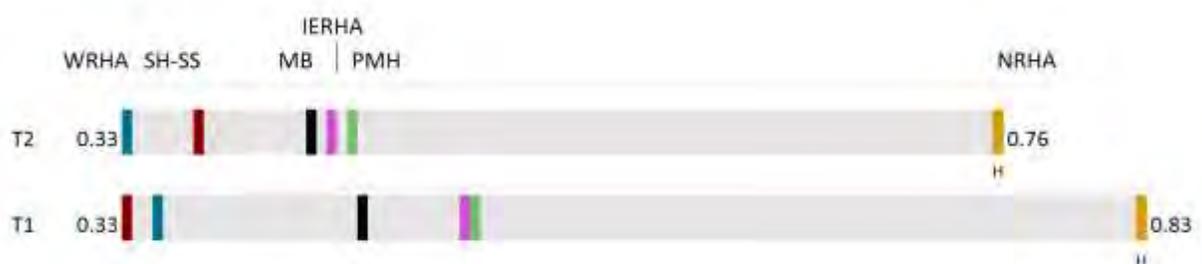
This indicator focuses on the accidental causes of death such as motor vehicle accidents, drowning, falls, burns, and poisonings. Unintentional injuries are one of the leading causes of death in Canada and worldwide.

Provincial Key Findings

- In Manitoba, 2,774 unintentional injuries occurred in 2012-2016. The rate of deaths due to unintentional injury decreased over time from 0.45 to 0.42 per 1,000 residents, but the decrease was not statistically significant.
- Income: Low-income residents' rate of unintentional injury causing death was 2.2 times higher than that of highest income residents.



Figure 3.11. Average Annual Unintentional Injury Causing Death Rates by RHA, 2007-2011(T1) and 2012-2016(T2)
Age & Sex Adjusted, per 1,000



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	IERHA	PMH	NRHA
T2 COUNT	1,356	338	2,774	295	471	240
T2 RATE	0.33	0.37	0.42	0.43	0.44	0.76 H
T1 RATE	0.35	0.33	0.45	0.50	0.50	0.83 H

Source: MCHP RHA Indicators Atlas 2019

Regional Findings

- In Interlake-Eastern, there were a total of 295 unintentional injuries causing death in 2012-2016.
- Although not statistically significant, the majority of districts saw decreases in deaths due to unintentional injuries.
- The district disparity ratio indicates there were significant narrowing of rates over time between our highest and lowest performing districts.

Table 3.10. Unintentional Injury Causes of Death by IERHA Zone & District Findings 2011-2013 (T1) and 2014-2016 (T2)

	T2		T1	
	Count	Rate	Rate	
Manitoba	2,774	0.42	0.45	

	T2		T1	
	Count	Rate	Rate	
IERHA	295	0.43	0.50	

South Zone				
	91	0.29	0.37	
Springfield	18	0.29	0.46	
Wpg Beach/St. Andrews	25	0.33	0.40	
Stonewall/Teulon	33	0.35	0.45	
St. Clements	15	0.39	0.54	

North Zone				
	64	0.58	0.62	
Fisher/Peguis	16	0.56	0.68	
Eriksdale/Ashern	23	0.70	0.65	
Powerview/Pine Falls	25	1.00	H 1.12	H

East Zone				
	43	0.28	0.30	
Pinawa/Lac du Bonnet	15	0.31	0.38	
Beausejour	19	0.40	0.38	
Whiteshell	9	0.49	0.70	

Northern Remote				
	19	1.78	H 2.84	H
Northern Remote	19	1.78	H 2.84	H

West Zone				
	41	0.31	0.28	
Gimli	12	0.29	0.49	
Arborg/Riverton	13	0.48	0.24	
St. Laurent	16	0.69	0.44	

Selkirk Zone				
	37	0.58	0.63	
Selkirk	37	0.58	0.63	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	12.0
	T2 Disparity	6.1
	Change	-5.8↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

CLOSER LOOK... MORTALITY DISTRICT DISPARITY OVERVIEW

DO HEALTH INEQUITIES EXIST WITHIN INTERLAKE-EASTERN?... Yes. Health inequities are reflected in differences in length of life, quality of life, rates of diseases, disability, death, and access to treatment, for example. Table 11 summarizes all of the mortality indicators and we have learned that disparities among districts are improving over time. Although differences do exist among districts, the data suggests that inequities related to mortality are narrowing which is a good news story for Interlake-Eastern.

Table 3.11. Summary of Mortality District Disparities within IERHA.

Indicator:	Time period District Disparity Ratio	Change Over Time	What did we learn?
Female Life Expectancy	T1 = 1.3 T2 = 1.2	↓ -0.1	Gap narrowed slightly. Female life expectancy in Northern Remote is more than 10 years shorter compared to other districts.
Male Life Expectancy	T1 = 1.2 T2 = 1.2	=	No change in disparity. Male life expectancy in Northern Remote is more than 15 years shorter compared to other districts.
Total Morality Rates	T1 = 3.7 T2 = 2.9	↓ -0.8	Gap narrowed slightly. Residents in Northern Remote are 2.9 times more likely to die in a given year than residents in other districts.
Premature Mortality Rates	T1 = 4.5 T2 = 4.0	↓ -0.5	Gap narrowed slightly. Residents in Northern Remote are four times more likely to die prematurely than residents in other districts.
Potential Years of Lost Life	T1 = 7.9 T2 = 5.8	↓ -2.1	Gap narrowed significantly. The disparity narrowed by 26% between T1 and T2.
Potentially Avoidable Deaths	T1 = 5.0 T2 = 4.6	↓ -0.4	Gap narrowed slightly. Residents in Northern Remote are 4.6 times more likely to die to a potentially prevention cause than residents in other districts.
Unintentional Injury Causes of Death	T1 = 12.0 T2 = 6.1	↓ -5.8	Gap narrowed significantly. The disparity narrowed by 49% between T1 and T2.

Cancers

Cancer Incidence — All Cancers

Definition

The number of diagnosed new cases of all invasive cancers per 100,000 population, for a two-year time period.

Why is this indicator important?

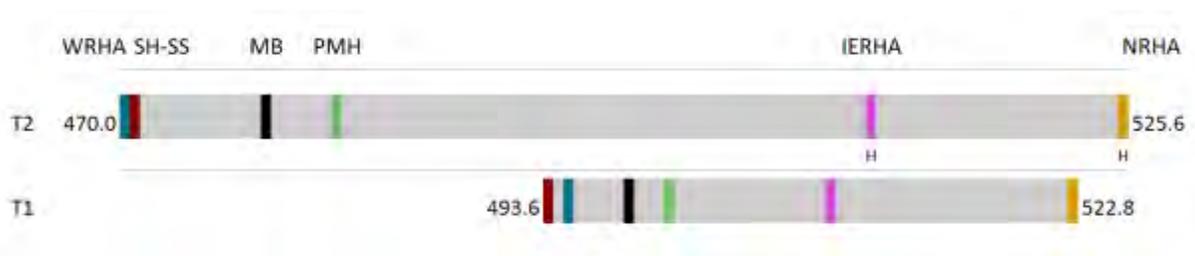
Annual statistics on cancer incidence are an important part of predicting future utilization of cancer care services and can provide insight into the effectiveness of and access to screening programs.

Provincial Key Findings

- The age-standardized overall invasive cancer incidence rate in Manitoba did not change much over time, from 498.2 cases per 100,000 residents to 478.4 cases per 100,000 residents.
- In both Interlake-Eastern and Northern RHAs, the rates were significantly higher than the Manitoba rate in 2014-2016.
- Age and Sex: The incidence rate was higher among residents aged 75+ and males.

Figure 3.12. All Invasive Cancers – Incidence rate by RHA 2011-13 (T1) and 2014-16 (T2)

Age-standardized incidence rates per 100,000 resident



H/L Significantly higher or lower than the MB average for that time period.

	WRHA	SH-SS	MB	PMH	IERHA	NRHA
T2 COUNT	11,073	2,517	19,422	2,860	2,272	720
T2 RATE	470.0	470.9	478.4	482.3	511.8 H	525.6 H
T1 RATE	494.9	493.6	498.2	500.8	509.2	522.8

Source: Cancer Care Manitoba 2019

Regional key findings

- In Interlake-Eastern there were a total of 2,272 cancer incidences (new cases) over a two-year time period.
- **Table 3.12.** shows that overall cancer incidence for Interlake-Eastern residents has increased from 509.2 to 511.8 per 100,000 residents, which is significantly higher than the Manitoba rate.
- In 2014-2016 both the West (541.6) and North (551.4) zones of Interlake-Eastern had cancer incidence rates significantly higher than the Manitoba rate (478.4).

Table 3.12. Cancer Incidence — All cancers by IERHA Zone findings, 2011-2013 (T1) and 2014-2016 (T2)

	T2		T1			T2		T1		
	Count	Rate		Rate		Count	Rate		Rate	
Manitoba	19,442	478.4		498.2						
					IERHA	2,272	511.8	H	509.2	
South Zone	966	500.7		496.5	Selkirk Zone	194	470.9		525.3	
East Zone	430	506.6		462.0	North Zone	297	551.4	H	578.4	H
West Zone	356	541.6	H	527.4	Northern Remote	29	581.4		618.7	

Source: CancerCare Manitoba 2019



Cancer Incidence—Top 4 Diagnoses

Definition

The number of diagnosed new cases of breast, prostate, lung, and colorectal cancer per 100,000 populations, for a two-year time period.

Why is this indicator important?

Specifying the cancer site allows for more accurate prediction of future utilization of treatment services.

Provincial Key Findings

- Of the top four cancers, the age-standardized incidence rate for 2014-2016 was 61.9/100,000 (count=2,504) for colorectal cancer, 62.7/100,000 (count=2,530) for breast cancer, 67.7/100,000 (count=2,778) for lung and bronchus cancer and 51.8/100,000 (count=2,145) for prostate cancer.
- Age and Sex: The cancer incidence rate was higher among residents aged 75+ for all top 4 diagnoses. The incidence rates were higher in males than females for colorectal and lung and bronchus cancers.

Regional Key Findings

- In 2014-2016 the top cancer diagnosis in Interlake-Eastern was lung and bronchus, followed by prostate, colorectal, and breast.
- The 2014-2016 data demonstrate that Interlake-Eastern experienced an increase in both lung and bronchus, and prostate cases and a decrease in colorectal and breast cases.
- Compared to the Manitoba data presented in **Table 3.13**, Interlake-Eastern residents experience a higher rate of incidence for new cases in each of the top four cancer groups per 100,000 residents, although only prostate were found to be significantly different than the provincial rate.

Table 3.13. Cancer Incidence – Top 4 Diagnoses Interlake-Eastern, 2011-2013 (T1) and 2014-2016 (T2)

	Interlake-Eastern				Manitoba		
	T2		T1	T2		T1	
	Count	Rate	Rate	Count	Rate	Rate	
Lung and bronchus	312	68.5	67.6	2,778	67.7	69.4	
Prostate	313	66.6	60.7	2,145	51.8	51.1	
Colorectal	284	65.9	74.1	2,504	61.9	66.8	
Breast	286	64.7	64.5	2,530	62.7	69.9	

Source: CancerCare Manitoba 2019

Cancer Mortality — All & Top 4

Definition

This indicator measures the rate of death for breast, prostate, lung and bronchus, and colorectal cancers, per 100,000 populations, for a two-year time period.

Why is this indicator important?

Site specific cancer mortality statistics provide insight into the treatment success for cancer at a site specific level.

Provincial Key Findings

- Age-standardized mortality rates for all invasive cancers have been fairly stable in Manitoba since 2011.
- Age and Sex: The cancer mortality rate was higher among residents aged 75+ for all top four diagnoses. The mortality rates for colorectal, and lung and bronchus cancers were higher for males than females.

Regional Key Findings

- In Interlake-Eastern, a total of 942 people died of cancer in 2014-2016.
- Similar to the provincial key findings, the age-standardized mortality rates among Interlake-Eastern have remained stable over time.
- Table 3.15 shows that the mortality rates for each of the top four cancers are slightly higher for Interlake-Eastern residents compared to the provincial rates, but none show any statistical significant differences.

Table 3.14. Cancer Mortality – Top Four Diagnoses IERHA, 2011-2013 (T1) and 2014-2016 (T2)

	Interlake-Eastern				Manitoba		
	T2		T1	T2		T1	
	Count	Rate	Rate	Count	Rate	Rate	
Lung and bronchus	248	55.3	47.7	2,039	50.0	49.6	
Colorectal	106	25.4	24.1	1,005	25.0	25.4	
Prostate	66	16.8	16.0	542	13.6	12.3	
Breast	69	16.3	16.8	591	14.7	14.2	

Source: Cancer Care Manitoba 2019

Cancer Late Stage Diagnosis

Definition

The percent of all cancer patients diagnosed at a later stage (IV), for a two-year time period.

Why is this indicator important?

In late-stage diagnoses, cancer has already spread to other parts of the body and has a significantly worse outcome than cancer diagnosed during earlier stages. Data on late-stage cancer diagnosis helps to identify where to focus cancer awareness campaigns, screening programs and how to improve access to diagnostic tests.

Provincial Key Findings

- The proportion of cancer patients who were diagnosed at stage 4 of their cancer has remained relatively stable throughout the province with 20.8% (count=3,963) in 2011-2013 and 20.9% (count=4,064) in 2014-2016.
- Age and Sex: The proportion of cancer patients who were diagnosed at stage 4 was higher in males and patients aged 50+.

Figure 3.13. Percent of all Invasive Cancers diagnosed at Stage IV, by RHA, 2011-2013 (T1) and 201-2016 (T2)



H/L Significantly higher or lower than the MB average for that time period.

	SH-SS	WRHA	MB	PMH	IERHA	NRHA
T2 COUNT	489	2,300	4,064	610	493	172
T2 PERCENT	19.4%	20.8%	20.9%	21.3%	21.7%	23.9%
T1 PERCENT	19.7%	21.1%	20.8%	20.9%	19.9%	22.9%

Source: CancerCare Manitoba 2019

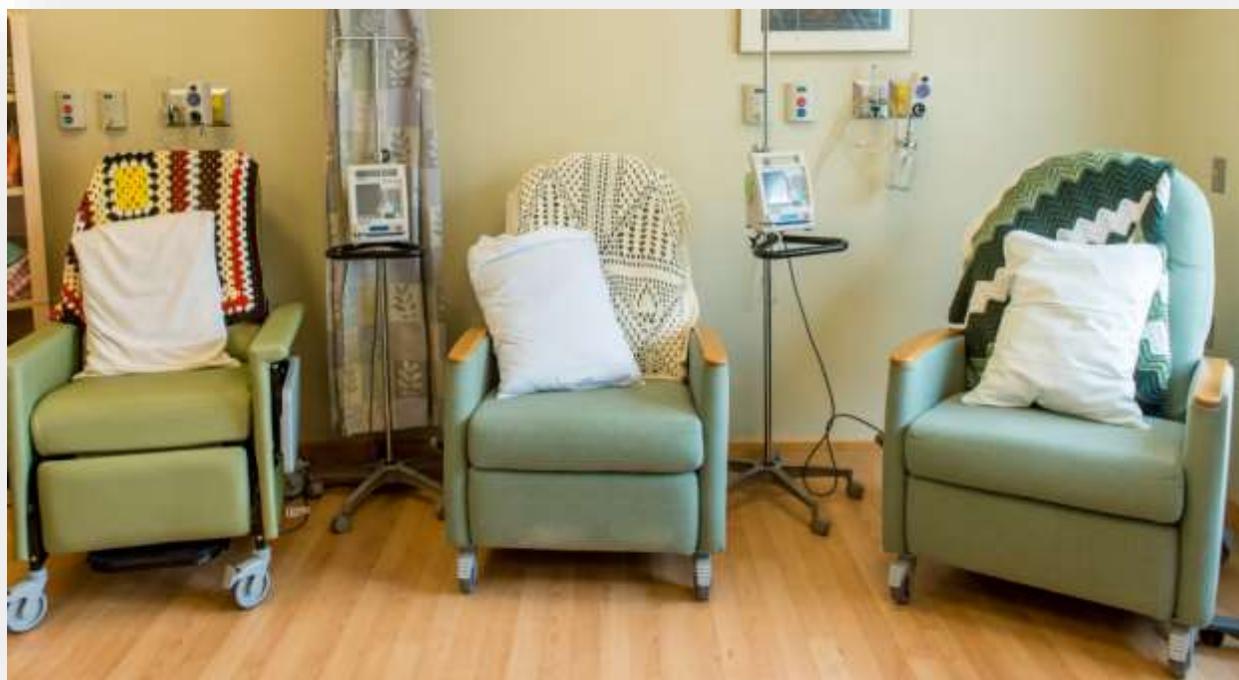
Regional Key Findings

- In Interlake-Eastern, there were a total of 493 individuals with late stage (stage IV) cancer in 2014-2016.
- At the zone level, late stage diagnosis ranged from a low of 19.0% (South Zone) to a high of 27.0% (West Zone).
- Although, statistical significance testing was not performed on this set of data, it is important to note that the majority of the zones experienced an increase in individuals being diagnosed with late stage cancer compared to early data in T1 as shown in **Table 3.15**.

Table 3.15. Cancer Stage 4 Diagnosis by IERHA Zone Findings, 2011-2013 (T1) and 2014-2016 (T2)

	T2		T1			T2		T1	
	Count	Percent		Percent		Count	Percent		Percent
Manitoba	4,064	20.9%		20.8%	IERHA	493	21.7%		19.9%
South Zone	184	19.0%		19.7%	Selkirk Zone	50	25.8%		24.7%
East Zone	93	21.6%		16.3%	L	North Zone	64	21.5%	20.8%
West Zone	96	27.0%	H	21.3%	Northern Remote	6	20.7%		11.5%

H/L Significantly higher or lower than the MB average for that time period.
Source: CancerCare Manitoba 2019



Cancer Survival—All & Top 4

Definition

The percent of residents still alive five years after a cancer diagnosis for breast, prostate, lung and bronchus, or colorectal cancer, for a five-year time period.

Why is this indicator important?

Data on cancer survival can be used to assess the effectiveness of cancer treatment and prevention strategies. Site specific data on cancer survival can be used to assess the effectiveness of cancer treatment and prevention strategies.

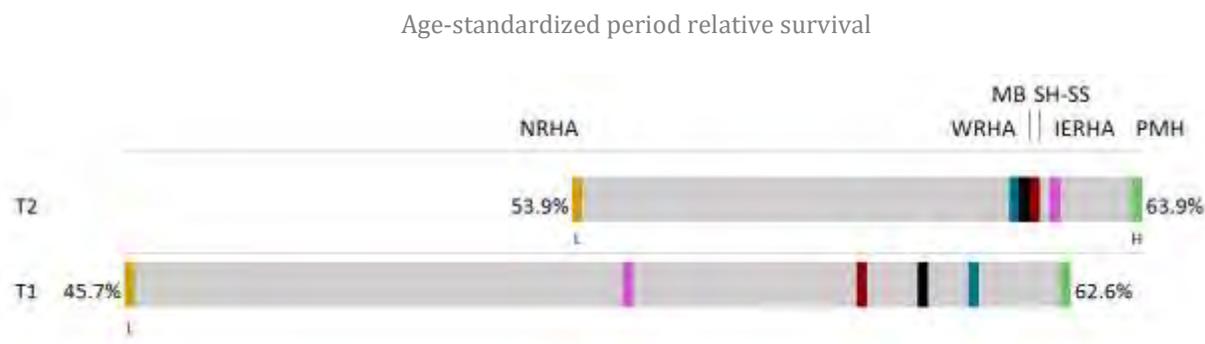
Provincial Key Findings

- Cancer survival rates have remained relatively stable in the province (60.0% in 2007-2011 compared to 62.0% in 2012-2016).
- Age and Sex: Cancer survival rate was high among cancer patients in the age group of 15-44 and females.

Regional Key Findings

- The age-standardized 5-year relative survival has improved over time for Interlake-Eastern to 62.3% from 54.7%.
- **Figure 3.14.** shows that Interlake-Eastern relative survival rates are similar to the provincial averages for each of the top four diagnosis groups.

Figure 3.14. Cancer Survival for all Invasive Cancers by RHA observed years 2007-2011, with follow-up to 2011 (T1) and observed years 2012-2016, with follow-up to 2016 (T2)



H/L Significantly higher or lower than the MB average for that time period.

Table 3.16. Cancer Survival – Five-Year Relative Survival Rate, 2007-2011 (T1) and 2012-2016 (T2)

	Interlake-Eastern		Manitoba	
	T2	T1	T2	T1
	Percent	Percent	Percent	Percent
Overall Total Relative Survival	62.3%	54.7%	62.0%	60.0%
Lung and bronchus	19.6%	*	23.1%	20.3%
Colorectal	67.2%	*	65.0%	64.5%
Prostate	88.6%	*	91.1%	86.3%
Breast	86.7%	*	88.0%	87.5%

*Data not available or potentially unstable during the reporting time frame. Source: CancerCare Manitoba 2019



CLOSER LOOK... AT THE CANCER NAVIGATION TEAM IN IERHA



Pictured above: Cancer navigation (CN) team on a facility visit to Eriksdale Hospital (left to right, Donna Anderson (CN), Brindy Bishop (Eriksdale Nurse), Sheryl McLeod (Eriksdale Nurse), Michelle Rosentreter (CN), and Marcia Garvie (CN)).

Cancer navigation services in the Interlake-Eastern consists of nurse navigators, psychosocial oncology clinician and a community engagement liaison. Each member has specialized training in cancer care and work closely with health care teams to assist in coordinating care and diagnostic workup for those with cancer.

The goal of cancer navigation is to support cancer patients and to improve each cancer patient's journey. Navigators can support patients and families from the time of a clinical suspicion of cancer through the diagnostic period and follow through treatment. In 2018-19, nearly 400 patients in Interlake-Eastern were supported by the cancer navigation team.



Cardiovascular

Hypertension Prevalence

Definition

The percent of residents, aged 19 and older, diagnosed with hypertension (high blood pressure), for a one-year time period.

Why is this indicator important?

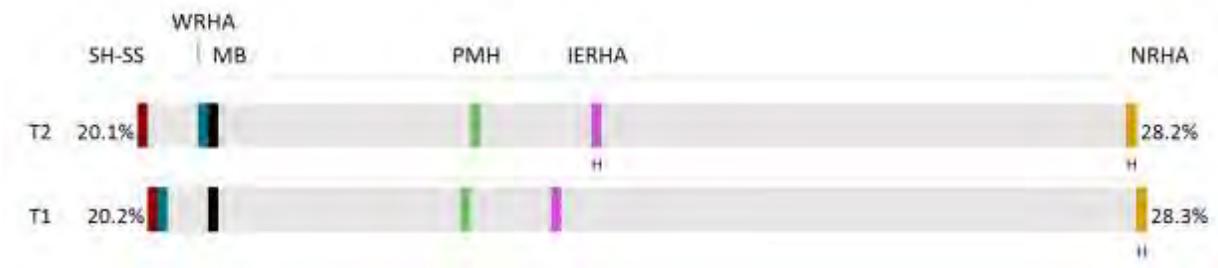
Hypertension is a risk factor for a number of cardiovascular conditions. Accurate assessment of the hypertension burden helps to guide prevention efforts and treatment choices, which may lead to reductions in heart-related morbidity and mortality.

Provincial Key Findings

- In Manitoba, 291,507 residents were diagnosed with high blood pressure in 2016/17. Hypertension prevalence in the province remained steady at 20.7% over time.
- Income: The hypertension prevalence among low-income residents was about 1.2 times higher than that of highest income residents in 2016/2017.



Figure 3.15. Prevalence of Hypertension by RHA, 2011/12 (T1) and 2016/17 (T2)
Age- and sex-adjusted percent of residents aged 19+ diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	MB	PMH	IERHA	NRHA
T2 COUNT	26,699	125,460	219,507	31,977	25,134	9,392
T2 PERCENT	20.1%	20.7%	20.7%	22.8%	23.8% H	28.2% H
T1 PERCENT	20.2%	20.2%	20.7%	22.8%	23.5%	28.3% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern had a significantly higher percentage of residents diagnosed with hypertension compared to provincial average.
- A total of 25,134 residents in Interlake-Eastern were diagnosed during a one-year period.
- Selkirk (26.9%), North (25.5%) and Northern Remote (29.2%) zones all experience hypertension rates significantly higher than the provincial average of 20.7%.
- Over time, the majority of districts showed little to no improvement, with the exception of Arborg/Riverton District where rates decreased significantly.

Table 3.17. Hypertension Prevalence by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1		
	Count	Percent		Percent	
Manitoba	219,507	20.7%		20.7%	

	T2		T1		
	Count	Percent		Percent	
IERHA	25,134	23.8%	H	23.5%	

South Zone	10,487	20.8%		20.2%	
Springfield	2,183	19.2%	L	18.3%	L
Wpg Beach/St. Andrews	3,252	21.3%		21.0%	
Stonewall/Teulon	3,381	21.3%		20.5%	
St. Clements	1,671	22.0%		21.9%	

East Zone	4,605	21.1%		21.2%	
Whiteshell	661	20.3%		21.9%	
Pinawa/Lac du Bonnet	2,113	20.6%		21.4%	
Beausejour	1,831	22.9%		21.4%	

West Zone	3,611	22.1%		23.1%	H
Arborg/Riverton	806	20.2%	-	23.4%	H
Gimli	1,779	22.2%		22.8%	H
St. Laurent	1,026	24.6%	H	24.4%	H

Selkirk Zone	2,625	26.9%	H	26.2%	H
Selkirk	2,625	26.9%	H	26.2%	H

North Zone	3,440	25.5%	H	25.6%	H
Fisher/Peguis	1,075	24.1%	H	24.5%	H
Eriksdale/Ashern	1,294	26.0%	H	24.7%	H
Powerview/Pine Falls	1,071	27.4%	H	29.0%	H

Northern Remote	366	29.2%	H	28.2%	H
Northern Remote	366	29.2%	H	28.2%	H

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	1.6	
	T2 Disparity	1.5	
	Change	-0.1↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Ischemic Heart Disease Prevalence

Definition

The percent of residents, aged 19 and older, diagnosed with ischemic heart disease (IHD), for a five-year time period.

Why is this indicator important?

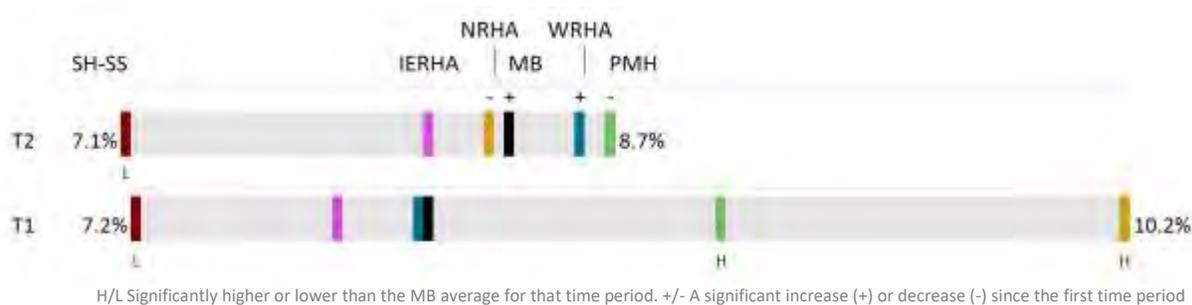
IHD (also known as coronary artery disease) is a major cause of death and disability in Canada. IHD prevalence helps to gain insight into the success of prevention, program planning and IHD management efforts.

Provincial Key Findings

- In Manitoba, 82,339 residents were diagnosed with IHD in 2012/13-2016/17. The prevalence has significantly increased in the province from 8.1 to 8.3%.
- IHD prevalence varied across the province with the highest prevalence in Prairie Mountain Health (8.7%) and the lowest prevalence in Southern Health-Santé Sud (7.1%) in 2012/13-2016/17.
- Income: The prevalence of IHD among low-income residents was 1.5 times greater than that of highest income residents in 2012/13-2016/17.



Figure 3.16. Prevalence of Ischemic Heart Disease by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)
Age- and sex-adjusted percent of residents aged 19+ diagnosed with disorder



	SH-SS		IERHA		NRHA		MB		WRHA		PMH	
T2 COUNT	9,458		8,908		2,539		82,339		47,935		13,094	
T2 PERCENT	7.1%	L	8.1%		8.3%	-	8.3%	+	8.6%	+	8.7%	-
T1 PERCENT	7.2%	L	7.8%		10.2%	H	8.1%		8.1%		9.0%	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern saw nearly 9,000 residents diagnosed with IHD over a five-year time period.
- Across the region, some zones experienced rates below the provincial rate (South, East and West zones) and other zones were above the provincial rate (Selkirk and Northern zones).
- The geographic disparity ratio indicates that differences do exist among different districts and over time there has been little change. Residents in Powerview/Pine Falls are twice as likely to experience a heart attack than those living in Arborg/Riverton.

Table 3.18. IHD Prevalence by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2			T1	
	Count	Percent		Percent	
Manitoba	82,339	8.3%	+	8.1%	

	T2			T1	
	Count	Percent		Percent	
IERHA	8,908	8.1%		7.8%	

South Zone	3,629	7.7%	L	7.4%	L
Springfield	695	8.4%		8.7%	
Stonewall/Teulon	1,179	9.4%	H	8.7%	
Wpg Beach/St. Andrews	1,170	10.7%	H	9.6%	H
St. Clements	585	10.8%	H	10.5%	H

North Zone	1,252	9.6%	H	9.6%	H
Fisher/Peguis	347	10.5%	H	10.1%	H
Eriksdale/Ashern	475	11.3%	H	9.8%	H
Powerview/Pine Falls	430	14.8%	H-	17.7%	H

East Zone	1,620	7.4%	L	7.2%	L
Whiteshell	217	8.5%		8.7%	
Pinawa/Lac du Bonnet	769	9.3%		10.3%	H
Beausejour	634	9.9%	H+	8.1%	

Northern Remote	91	11.0%		12.4%	H
Northern Remote	91	11.0%		12.4%	H

West Zone	1,208	7.1%	L	7.5%	
Arborg/Riverton	224	6.6%		7.6%	
Gimli	627	9.2%		10.2%	H
St. Laurent	357	10.6%	H	10.3%	H

Selkirk Zone	1,108	13.0%	H+	11.2%	H
Selkirk	1,108	13.0%	H+	11.2%	H

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	2.3
	T2 Disparity	2.2
	Change	-0.1↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Heart Attack Incidence Rate

Definition

The annual rate of death or hospitalization due to acute myocardial infarction (AMI) (or heart attack) per 1,000 population, aged 40 and older, for a five-year time period.

Why is this indicator important?

Heart attacks are one of the leading causes of death in Manitoba. Understanding AMI rates, in combination with other cardiovascular indicators, is important in the planning of public awareness campaigns and health promotion interventions, as well as the allocation of resources in response to the demands on acute care services.

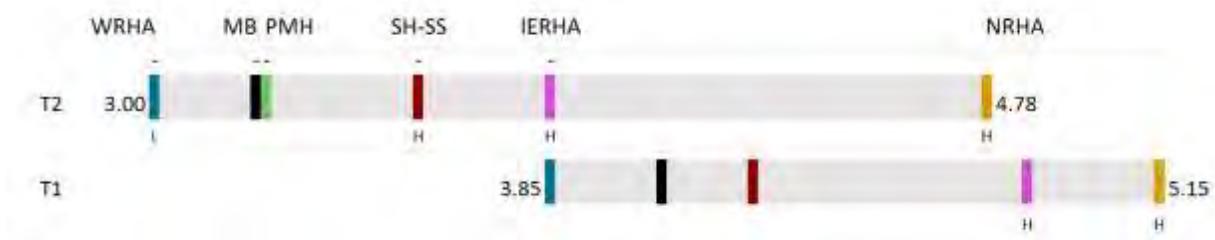
Provincial Key Findings

- About 10,235 adults in Manitoba received a new diagnosis of heart attack in 2012-2016. The heart attack rate has declined significantly over time, from 4.08 to 3.24 events per 1,000 residents aged 40 and older.
- The heart attack rate has declined in all regions over time.
- Income: The incidence rate of AMI (heart attacks) among the low-income residents was 1.7 times higher than that of highest income residents in 2012-2016.



Figure 3.17. Heart Attack (AMI) Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2)

Age- and sex-adjusted average annual rate of death or hospitalization for AMI per 1,000 residents aged 40+



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	PMH	SH-SS	IERHA	NRHA
T2 COUNT	5,366	10,235	1,577	1,470	1,304	438
T2 RATE	3.00 L-	3.24 -	3.24 -	3.58 H-	3.86 H-	4.78 H
T1 RATE	3.85	4.08	4.28	4.28	4.87 H	5.15 H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern, although above the provincial average, did experience a significant decrease in the number of residents suffering from a heart attack.
- Between 2012-2016 a total of 1,304 Interlake-Eastern residents had a death or hospitalization due to heart attack.
- **Table 3.19.** shows South, East and North zones all saw significant decreases in rates over time.
- The geographic disparity ratio indicates that there was no widening or narrowing in disparity between the two time periods.

Table 3.19. Heart Attack Incidence Rate by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)

	T2		T1		
	Count	Rate		Rate	
Manitoba	10,235	3.24	-	4.08	

	T2		T1		
	Count	Rate		Rate	
IERHA	1,304	3.86	H-	4.87	H

South Zone					
	Count	Rate		Rate	
South Zone	491	3.43	-	4.64	
Stonewall/Teulon	155	3.36	-	5.39	H
Wpg Beach/St. Andrews	145	3.43	-	4.50	
Springfield	109	3.54		3.85	
St. Clements	82	3.93		5.01	

North Zone					
	Count	Rate		Rate	
North Zone	192	4.74	H-	5.83	H
Fisher/Peguis	54	4.25	-	6.41	H
Eriksdale/Ashern	72	4.65		5.04	
Powerview/Pine Falls	66	5.92	H	6.93	H

East Zone					
	Count	Rate		Rate	
East Zone	216	3.23	-	3.98	
Pinawa/Lac du Bonnet	83	2.64		3.56	
Whiteshell	28	2.82		3.11	
Beausejour	105	4.41		5.22	

Northern Remote					
	Count	Rate		Rate	
Northern Remote	11	3.76		4.59	
Northern Remote	11	3.76		4.59	

West Zone					
	Count	Rate		Rate	
West Zone	236	4.46	H	5.19	H
Arborg/Riverton	56	4.45		4.95	
St. Laurent	59	4.55		5.32	
Gimli	121	4.70	H	5.60	H

Selkirk Zone					
	Count	Rate		Rate	
Selkirk Zone	158	5.07	H	6.29	H
Selkirk	158	5.07	H	6.29	H

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	2.2
	T2 Disparity	2.2
	Change	0
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Congestive Heart Failure Prevalence

Definition

The percent of residents, aged 40 and older, diagnosed with congestive heart failure (CHF), for a three-year time period.

Why is this indicator important?

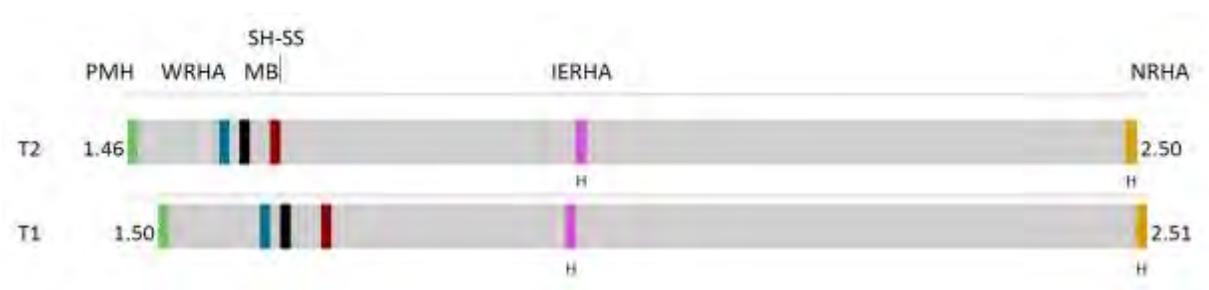
Cardiovascular disease, including CHF, is the leading cause of death in Manitoba. Understanding CHF prevalence is important in the planning of public education and health promotion initiatives, as well as allocation of resources in response to symptom severity, reserved prognosis and high costs of treatment.

Provincial Key Findings

- 10,461 adults aged 40 years and older in Manitoba lived with diagnosed CHF in 2014/15-2016/17. The prevalence of CHF in the province remained stable in both time periods.
- In Interlake-Eastern and Northern RHAs, the prevalence of CHF was significantly higher than the provincial prevalence during both time periods.

Figure 3.18. Congestive Heart Failure Prevalence by RHA, 2011/12 (T1) and 2016/17 (T2)

Age- and sex-adjusted average annual rate of death or hospitalization for AMI per 1,000 residents aged 40+



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	PMH	WRHA	MB	SH-SS	IERHA	NRHA
T2 COUNT	1,478	5,959	10,461	1,325	1,247	386
T2 PERCENT	1.46%	1.57%	1.59%	1.62%	1.93% H	2.50% H
T1 PERCENT	1.50%	1.61%	1.63%	1.67%	1.93% H	2.51% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Rates for CHF in Interlake-Eastern have remained stable over time.
- A total of 1,247 residents in Interlake-Eastern were diagnosed with CHF during the most recent time period, which represents nearly 2% of the population aged 40 and older.
- The geographic disparity ratio indicates that there are differences in rates for CHF depending on where you live, but the good news is that Interlake-Eastern saw a narrowing over time between our highest and lowest performing districts.

Table 3.20. CHF Prevalence by IERHA Zone & District Findings, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)

	T2		T1	
	Count	Percent	Percent	
Manitoba	10,461	1.59%	1.63%	

	T2		T1	
	Count	Percent	Percent	
IERHA	1,247	1.93%	1.93%	H

South Zone		440	1.62%	1.67%	
Springfield	78	1.48%	1.41%		
Wpg Beach/St. Andrews	125	1.74%	1.74%		
Stonewall/Teulon	159	1.83%	2.16%		H
St. Clements	78	2.24%	1.66%		

North Zone		169	2.15%	H	2.25%	H
Powerview/Pine Falls	40	2.08%	2.72%			H
Fisher/Peguis	52	2.29%	1.61%			
Eriksdale/Ashern	77	2.66%	3.01%	H		H

East Zone		216	1.60%	1.75%	
Whiteshell	25	1.47%	1.12%		
Pinawa/Lac du Bonnet	93	1.59%	1.60%		
Beausejour	98	2.15%	2.69%		H

Northern Remote		13	2.98%	3.69%	H
Northern Remote	13	2.98%	3.69%		H

West Zone		200	1.85%	1.74%	
Gimli	92	1.81%	1.77%		
Arborg/Riverton	47	1.97%	1.80%		
St. Laurent	61	2.60%	2.29%	H	

Selkirk Zone		209	3.06%	H	2.62%	H
Selkirk	209	3.06%	2.62%	H		H

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	3.3
	T2 Disparity	2.1
	Change	-1.2↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Stroke Rate

Definition

The number of hospitalizations or deaths due to stroke, per 1,000 residents, aged 40 and older, for a five-year time period.

Why is this indicator important?

Stroke is one of the leading causes of adult disability and death. Stroke rates, along with other cardiovascular indicators, describe levels of cardiovascular health in the population.

Provincial Key Findings

- There were 7,857 strokes among Manitoba residents in 2012-2016. The stroke event rate in the province decreased from 2.69 to 2.48 strokes per 1,000 residents aged 40+ over time.
- Stroke event rates varied across the province, with the highest event rate in the Northern RHA (4.68 events per 1,000 residents) and the lowest event rate in Prairie Mountain Health (2.13 events per 1,000 residents).
- In three regions (Prairie Mountain Health, Winnipeg Regional Health Authority, and Interlake-Eastern Regional Health Authority), stroke event rates declined significantly between 2007-2011 and 2012-2016.

Figure 3.19. Stroke Rate by RHA, 2007-2011 (T1) and 2012-2016 (T2)

Age- and sex-adjusted average annual rate of death or hospitalization for stroke per 1,000 residents aged 40+



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	PMH	SH-SS	WRHA	MB	IERHA	NRHA
T2 COUNT	1076	921	4494	7857	816	357
T2 RATE	2.13	2.31	2.43	2.48	2.56	4.68
T1 RATE	2.52	2.45	2.65	2.69	2.84	4.56

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- During the most recent five-year period, there were a total of 816 hospitalizations or deaths due to stroke, which is significantly lower than the previous reporting period.
- The East Zone experienced a significant decrease from 2.93 per 1,000 residents to 1.98.
- The geographic disparity ratio presented in Table 21 shows significant improvements/narrowing of disparity between our highest and lowest performing districts.

Table 3.21. Stroke Rate by IERHA Zone & District Findings, 2007-2011 (T1) and 2012-2016 (T2)

	T2			T1	
	Count	Rate		Rate	
Manitoba	7,857	2.48	-	2.69	

	T2			T1	
	Count	Rate		Rate	
IERHA	816	2.56	-	2.84	

South Zone					
	Count	Rate		Rate	
Stonewall/Teulon	100	2.23		2.51	
Wpg Beach/St. Andrews	92	2.53	+	1.71	L
Springfield	71	2.64		2.41	
St. Clements	60	3.33		3.40	

North Zone					
	Count	Rate		Rate	
Eriksdale/Ashern	44	2.86		2.87	
Powerview/ Pine Falls	33	3.30		3.29	
Fisher/Peguis	51	4.33	H	4.18	H

East Zone					
	Count	Rate		Rate	
Pinawa/Lac du Bonnet	58	1.93		2.46	
Beausejour	46	1.95	-	3.50	
Whiteshell	22	2.39		3.09	

Northern Remote					
	Count	Rate		Rate	
Northern Remote	19	8.22	H	13.66	H
Northern Remote	19	8.22	H	13.66	H

West Zone					
	Count	Rate		Rate	
St. Laurent	24	1.92		2.56	
Gimli	56	2.14		2.37	
Arborg/Riverton	40	3.06		3.23	

Selkirk Zone					
	Count	Rate		Rate	
Selkirk	100	2.88		3.40	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	8.0
	T2 Disparity	4.3
	Change	-3.7↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

CLOSER LOOK... MANAGING HEART HEALTH

The chronic disease program is made up of chronic disease nurses and registered dietitians who focus on the prevention and management of hypertension and high cholesterol. This program can provide basic education and support with heart health including information about cholesterol, hypertension, target numbers, blood pressure monitoring, complications of high blood pressure and high cholesterol and how to avoid them. Guidance about the treatments that include healthy eating, smoking cessation, and cholesterol and blood pressure medications is also provided.

You can see a chronic disease nurse or registered dietitian regarding diabetes, high blood pressure, high cholesterol or for healthy eating information with a referral from your provider or by self-referral. Contacting the nurse or dietitian in your area directly or call toll-free 1 (877) 979-WELL (9355).



Diabetes

Diabetes Incidence

Definition

The average number of residents newly diagnosed with diabetes (Type 1 and 2) per 100 person years, for a three-year time period.

Why is this indicator important?

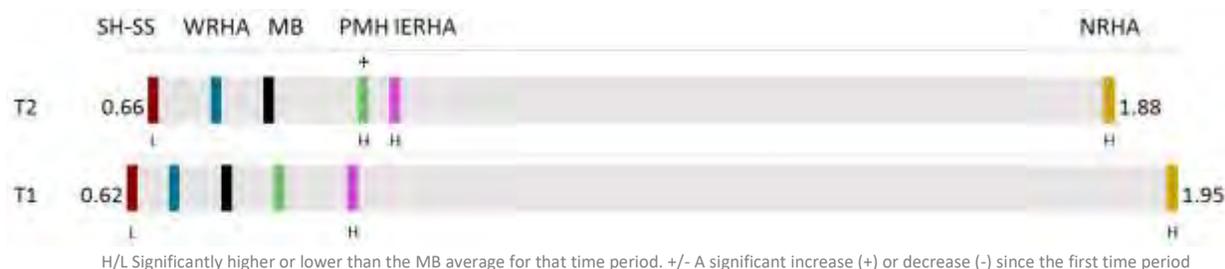
Diabetes is a significant public health issue. Diabetes incidence provides perspective on the number of new cases of diabetes and can help focus prevention and management efforts going forward.

Provincial Key Findings

- In 2014/15-2016/17, 25,603 Manitobans were newly diagnosed with diabetes.
- Diabetes incidence increased over time in most regions.
- The incidence rates were significantly higher than the provincial rate during both time periods in Interlake-Eastern as well as the Northern RHA.
- Income: The diabetes incidence among low-income residents was about 2.2 times higher than that of highest income residents in 2014/15-2016/17.



Figure 3.20. Incidence of Diabetes by RHA, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)
Age- and sex-adjusted incidence rate per 100 person-years for residents (all ages)



	SH-SS	WRHA	MB	PMH	IERHA	NRHA
T2 COUNT	2,847	13,901	25,603	3,599	3,044	2,052
T2 RATE	0.66 L	0.74	0.80	0.92 H+	0.97 H	1.88 H
T1 RATE	0.62 L	0.69	0.74	0.81	0.91 H	1.95 H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern's rates for new diagnosis of diabetes are significantly higher than the provincial average.
- There were a total of 3,044 residents newly diagnosed with diabetes over a 3-year period in Interlake-Eastern.
- The majority of districts have experienced slight increases in new incidences of diabetes with the exception of Powerview/Pine Falls, Fisher/Peguis, and Northern Remote districts which all saw statistically significant decreases in rates over time.
- The decrease in rates at the district level is reflected in the geographic district disparity ratio highlighted below in **Table 3.22**, from 8.2 (in T1) to 4.7 (in T2), resulting in a narrowing of disparity within Interlake-Eastern.

Table 3.22. Diabetes Incidence by IERHA Zone & District Findings, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)

	T2		T1		
	Count	Rate		Rate	
Manitoba	25,603	0.80		0.74	

	T2		T1		
	Count	Rate		Rate	
IERHA	3,044	0.97	H	0.91	H

South Zone	1,180	0.70	L+	0.61	L
Springfield		0.60	L	0.49	L
Stonewall/Teulon	353	0.67	L	0.61	
Wpg Beach/St. Andrews	385	0.75		0.65	
St. Clements	197	0.77		0.63	

North Zone	575	1.47	H	1.65	H
Powerview/Pine Falls	150	1.24	H-	1.70	H
Fisher/Peguis	196	1.51	H-	1.89	H
Eriksdale/Ashern	229	1.60	H	1.36	H

East Zone	537	0.83		0.74	
Whiteshell	80	0.77		0.69	
Pinawa/Lac du Bonnet	233	0.77		0.65	
Beausejour	224	0.88		0.84	

West Zone	386	0.83		0.74	
Arborg/Riverton	79	0.62		0.71	
Gimli	171	0.78		0.65	
St. Laurent	136	1.09	H	0.86	

Selkirk Zone	261	0.96		0.82	
Selkirk	261	0.96		0.82	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	8.2	
	T2 Disparity	4.7	
	Change	-3.5↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Diabetes Prevalence

Definition

The percent of residents (all ages) diagnosed with and treated for diabetes (Type 1 and 2), for a three-year time period.

Why is this indicator important?

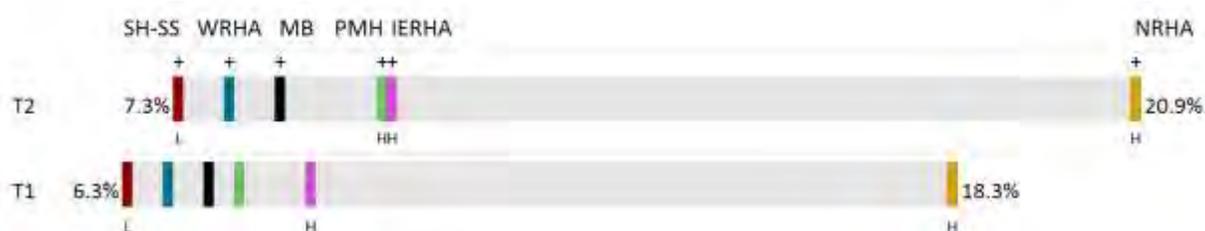
Diabetes can lead to serious complications (such as cardiovascular disease, vision loss, kidney failure, nerve damage or amputation) and premature death. As the Canadian population continues to grow and age, the number of Canadians living with diabetes is also expected to continue to increase.^{xxvi}

Provincial Key Findings

- In 2014/15-2016/17, about 120,201 Manitobans aged 19 and older were living with diagnosed diabetes. Diabetes prevalence increased significantly over time in the province, from 7.6% to 8.6%.
- In all five regions, the prevalence of diabetes increased significantly over time.
- The prevalence in Interlake-Eastern and Northern RHAs was consistently higher than the prevalence of diabetes in Manitoba in both time periods.
- Income: The diabetes prevalence among low-income residents was 2.2 times higher than that of highest income residents in 2014/15-2016/17.



Figure 3.21. Prevalence of Diabetes by RHA, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)



Age- and sex-adjusted percent of residents (all ages) diagnosed with disorder

H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	MB	PMH	IERHA	NRHA
T2 COUNT	13,103	65,004	120,201	17,593	14,040	9,733
T2 PERCENT	7.3% L+	7.9% +	8.6% +	10.1% H+	10.3% H+	20.9% H+
T1 PERCENT	6.3% L	7.0%	7.6%	8.1%	9.1% H	18.3% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- In Interlake-Eastern, just over one in 10 residents are diagnosed with diabetes.
- Five of the six zones in Interlake-Eastern experienced statistically significant increases in diabetes prevalence with the exception of Northern Remote Zone which remained stable over time.
- Although Northern Remote Zone did not experience any significant increases in rates, it has the highest percentage of residents living with diabetes at 32.5%.
- The geographic disparity ratio indicates that diabetes prevalence rates have narrowed slightly over time. The narrowing of disparity is being driven by increases in diabetes across all districts (such as, Springfield, St. Clements, Whiteshell, etc.) and not necessarily by decreasing rates in districts with higher rates of prevalence.

Table 3.23. Diabetes Prevalence by IERHA Zone & District Findings, 2009/10-2011/12 (T1) and 2014/15-2016/17 (T2)

	T2			T1	
	Count	Percent		Percent	
Manitoba	120,201	8.6%	+	7.6%	

	T2			T1	
	Count	Percent		Percent	
IERHA	14,040	10.3%	H+	9.1%	H

South Zone					
	Count	Percent		Percent	
Springfield	937	6.0%	L+	4.9%	L
Stonewall/Teulon	1,633	7.5%	L	6.7%	
Wpg Beach/St. Andrews	1,578	7.6%	L+	5.8%	L
St. Clements	863	8.3%	+	6.9%	

East Zone					
	Count	Percent		Percent	
Pinawa/Lac du Bonnet	1,025	8.0%	+	6.4%	
Beausejour	928	8.5%		7.7%	
Whiteshell	392	9.1%	+	7.6%	

West Zone					
	Count	Percent		Percent	
Arborg/Riverton	418	7.6%		6.9%	
Gimli	754	7.5%	+	6.3%	L
St. Laurent	569	10.4%	+	7.7%	

Selkirk Zone					
	Count	Percent		Percent	
Selkirk	1,314	10.4%	H+	8.1%	

North Zone					
	Count	Percent		Percent	
Eriksdale/Ashern	1,000	16.0%	H+	12.8%	H
Powerview/Pine Falls	914	16.5%	H	16.8%	H
Fisher/Peguis	1,062	17.3%	H	15.8%	H

Northern Remote					
	Count	Percent		Percent	
Northern Remote	653	32.5%	H	33.8%	H

IERHA DISTRICT DISPARITY RATIO					
	T1 Disparity	6.9			
	T2 Disparity	5.4			
	Change	-1.5↓			
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>					

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Lower Limb Amputation Due to Diabetes

Definition

The percent of residents with diabetes, aged 19 and older, who had a lower limb amputation either below or including the knee, for a five-year time period.

Why is this indicator important?

Individuals with diabetes are more likely to be hospitalized with a non-traumatic lower limb amputation than the non-diabetic population^{xxvii}. Lower limb amputations amongst diabetics are an indication of poor disease management and can lead to increased morbidity and mortality. There is a strong relationship between lower limb amputation due to diabetes and overall health status of vulnerable populations. This indicator helps to plan focused upstream education and equitable access to disease prevention efforts.

Provincial Key Findings

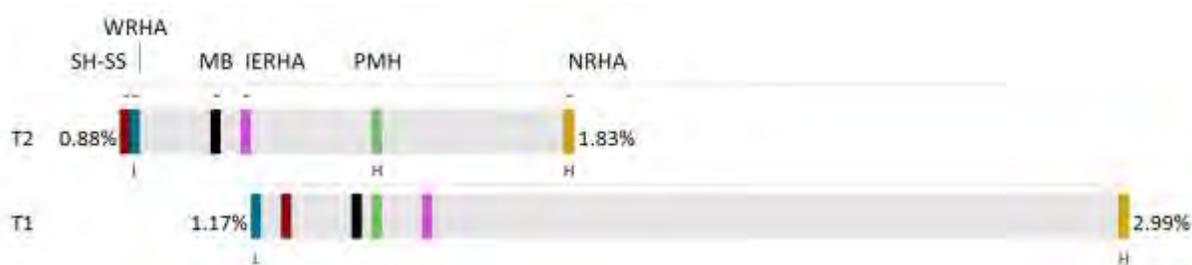
- Over the past five years, 1,197 Manitobans aged 19 and older with diabetes had lower limb amputation.
- The percentage of amputations declined significantly over time in all regions except Prairie Mountain Health, where the percentage remained the same.
- Income: The percentage of lower limb amputations due to diabetes among low-income residents was 3.8 times higher than that of highest income residents in 2012/13-2016/17.



Rural Quintiles

T2 3.8x

Figure 3.22. Lower Limb Amputations due to Diabetes by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)
Age- and sex-adjusted percent of residents with diabetes aged 19+ who had an amputation



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	MB	IERHA	PMH	NRHA
T2 COUNT	107	538	1,197	157	235	142
T2 PERCENT	0.88%	0.91% L-	1.09%	1.16%	1.42% H	1.83% H-
T1 PERCENT	1.23%	1.17% L	1.39%	1.54%	1.42%	2.99% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- During the most recent five-year time period, a total of 157 Interlake-Eastern residents had a lower limb amputation, which is significantly lower than the previous time period.
- The majority of zones remained stable over time, with the exception of the North Zone where rates decreased significantly from 3.3% to 2.3%.
- The geographic disparity ratio indicates that Interlake-Eastern has not experienced any changes in disparity over time. Residents living in Fisher/Peguis are nearly five times more likely to have a lower limb amputation than those living in Stonewall/Teulon.

Table 3.24. Lower Limb Amputation Due to Diabetes by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2			T1	
	Count	Percent		Percent	
Manitoba	1,197	1.09%	-	1.39%	
IERHA	157	1.16%	-	1.54%	
South Zone	36	0.75%		0.91%	
Stonewall/Teulon	9	0.55%		0.86%	
Springfield	6	0.70%		S	
Wpg Beach/St. Andrews	12	0.79%		1.48%	
St. Clements	9	1.10%		S	
East Zone	19	0.83%		1.03%	
Pinawa/Lac du Bonnet	9	0.90%		0.88%	
Beausejour	S			1.44%	
Whiteshell	S			S	
West Zone	18	1.01%		0.95%	
St. Laurent	6	1.11%		S	
Gimli	11	1.36%		1.44%	
Arborg/Riverton	S			S	
Selkirk Zone	13	1.02%		1.51%	
Selkirk	13	1.02%		1.51%	
North Zone	62	2.30%	H-	3.26%	H
Eriksdale/Ashern	18	2.02%		3.62%	H
Powerview/Pine Falls	22	2.25%	H-	4.11%	H
Fisher/Peguis	22	2.65%	H	1.88%	
Northern Remote	9	1.73%		2.17%	
Northern Remote	9	1.73%		2.17%	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	4.8	
	T2 Disparity	4.8	
	Change	0	
Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Diabetes Care - Eye Exams

Definition

The percent of residents with diabetes, aged 19 and older, who had an eye exam in a given year, as defined by a visit to an ophthalmologist or an optometrist.

Note: Eye exam rates may be underestimated in Manitoba. Services provided by general practitioners and family physicians may not be included, as there is no specific tariff for this service. Furthermore, although all residents with diabetes qualify for annual eye exams without having to pay for the service, some may not indicate their diabetic status to the provider, in which case the provider may bill the patient directly. If that occurs, there would be no record of the visit in medical claims data.

Why is this indicator important?

Diabetic eye problems (such as diabetic retinopathy, cataract, and glaucoma) are common complications of diabetes and may lead to visual loss or even blindness. The Canadian Association of Optometrists recommends that individuals with diabetes should see their optometrists for an eye examination when they are first diagnosed and at minimum, once a year after. More frequent eye exams may be recommended^{xxviii}.

Provincial Key Findings

- The percentage of adults with diabetes in Manitoba who had an eye examination increased significantly over time, from 38.3% to 41.7%.
- Rates for residents of the Northern RHA may be under-estimated because the Manitoba Retinal Screening Vision Program affects these rates - services from nurse screeners are not documented into the medical claims system.
- Income: In rural settings, the percentage of eye exams among low-income residents was 0.9 times lower than that of highest income residents.



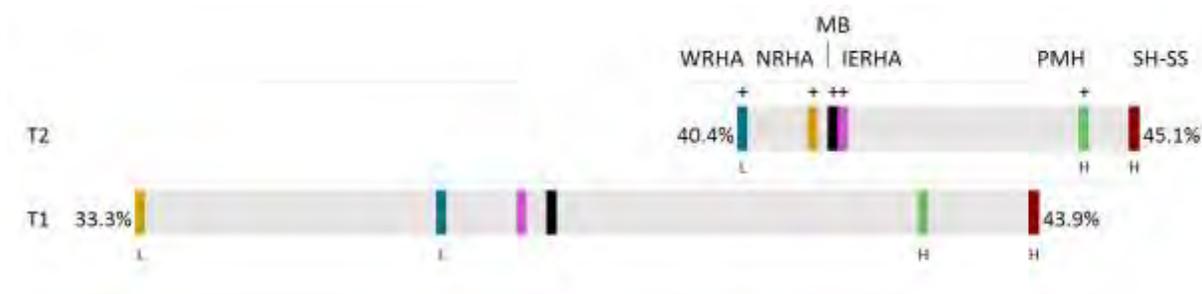
Rural Quintiles

T2

0.9x

Figure 3.23. Diabetes Care: Eye Examinations by RHA, 2011/12 (T1) and 2016/17 (T2)

Crude percent of residents (age 19+) with diabetes who had an eye exam



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA		NRHA		MB		IERHA		PMH		SH-SS	
T2 COUNT	26,292		4,026		50,112		5,857		7,831		5,909	
T2 PERCENT	40.5%	L+	41.4%	+	41.7%	+	41.7%	+	44.5%	H+	45.1%	H
T1 PERCENT	37.0%	L	33.3%	L	38.3%		37.9%		42.6%	H	43.9%	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- 41.7% of Interlake-Eastern residents diagnosed with diabetes had an eye care exam within a one-year time period, which is significantly higher than the previous reporting period.
- Four of the six zones experienced statistically significant increases in eye care exams.
- Selkirk is the only zone to experience rates significantly lower than the Manitoba average for eye care exams.
- The geographic disparity ratio tells us that little disparity exists for this measure; therefore, regardless where you live, residents with diabetes tend to access ophthalmologists or optometrists at similar rates.

Table 3.25. Diabetes Care: Eye Examinations by IERHA Zone & District (age 19+), 2011/12 (T1) and 2016/17 (T2)

	T2			T1	
	Count	Percent		Percent	
Manitoba	50,112	41.7%	+	38.3%	

South Zone	2,168	43.3%	+	38.7%	
Wpg Beach/St. Andrews	708	44.9%		39.9%	
Springfield	414	44.2%		40.4%	
Stonewall/Teulon	715	43.8%	+	38.6%	
St. Clements	331	38.4%		34.3%	

East Zone	1,010	43.1%	+	39.1%	
Pinawa/Lac du Bonnet	465	45.4%		42.4%	
Beausejour	387	41.7%	+	32.8%	
Whiteshell	158	40.3%		46.2%	

West Zone	706	40.6%		42.8%	H
Gimli	359	47.6%		46.0%	H
Arborg/Riverton	165	39.5%		46.3%	
St. Laurent	182	32.0%	L	35.5%	

Selkirk Zone	468	35.6%	L	33.3%	
Selkirk	468	35.6%	L	33.3%	

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	T2			T1	
	Count	Percent		Percent	
IERHA	5,857	41.7%	+	37.9%	

North Zone	1,216	40.9%	+	35.2%	
Fisher/Peguis	501	47.2%	+	41.2%	
Eriksdale/Ashern	387	38.7%	+	29.2%	L
Powerview/Pine Falls	328	35.9%		34.5%	

Northern Remote	289	44.3%	+	37.2%	
Northern Remote	289	44.3%	+	37.2%	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	1.6	
	T2 Disparity	1.5	
	Change	-0.1↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

Source: MCHP RHA Indicators Atlas 2019

CLOSER LOOK... MANAGING DIABETES

The chronic disease program is made up of chronic disease nurses and registered dietitians who focus on the prevention and management of diabetes. This program can provide basic education and support with diabetes including blood sugar meters and testing, explaining, and evaluating the different factors that can affect glucose levels. Treatments for diabetes include healthy eating, physical activity, and diabetes medications. Program staff help people match these treatments to their work and lifestyle schedules and they provide support when starting or adjusting insulin. They also educate about the complications of diabetes related to heart, eye, and kidney health and how to avoid them. Diabetic foot exams and circulation testing are also part of the care provided.

People can see a chronic disease nurse or registered dietitian for information on diabetes, high blood pressure, high cholesterol and for healthy eating recommendations through a referral from a provider or by self-referral. Contact the nurse or dietitian in your area directly or call toll-free 1 (877) 979-WELL (9355).

Injury

Injury Hospitalization - Intentional

Definition

The number of residents who stayed in hospital at least one day with a primary diagnosis of intentional injury (e.g. self-inflicted, assault) per 1,000 populations, for a one-year time period.

Why is this indicator important?

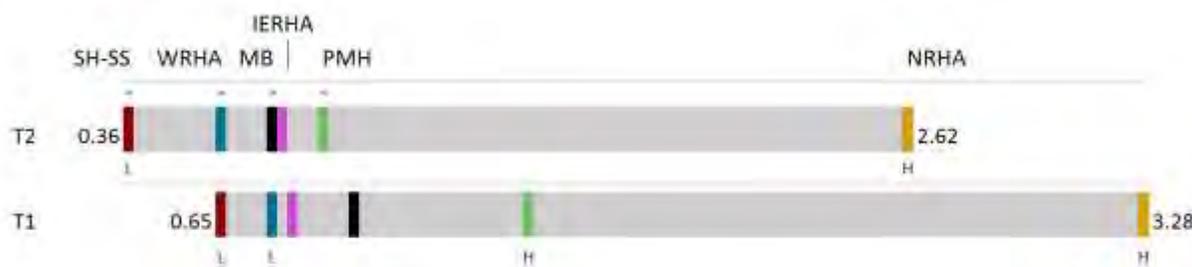
This indicator helps us to understand the effectiveness of intentional injury public awareness efforts and informs program planning and resource allocation.

Provincial Key Findings

- There were 1,015 intentional injury hospitalizations in 2016-2017.
- Income: Income disparity is large for this indicator. In rural settings, hospitalization due to intentional injuries among low-income residents was 8.6 times higher than that of highest income residents in 2016-2017.



Figure 3.24. Intentional Injury Hospitalization Rates by RHA, 2011/12 (T1) and 2016/17 (T2)
Age/Sex Adjusted Rates, per 1,000 residents



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS		WRHA		MB		IERHA		PMH		NRHA	
T2 COUNT	66		480		1,015		94		146		200	
T2 RATE	0.36	L-	0.65	-	0.80	-	0.82		0.94	-	2.62	H
T1 RATE	0.65	L	0.81	L	1.04		0.87		1.54	H	3.28	H

Source: MHSAL IMA 2018

Regional Key Findings

- Hospitalizations for intentional injuries has remained stable over time for Interlake-Eastern residents.
- Both North (2.66) and Northern Remote zones (4.04) have rates significantly higher than the Manitoba average of 0.8 for intentional injury hospitalizations per 1,000.

Table 3.26. Injury Hospitalization (Intentional) by IERHA Zone Finding, 2011/12 (T1) and 2016/17 (T2)

	T2		T1	
	Count	Rate	Rate	
Manitoba	1,015	0.80	-	1.04
IERHA	94	0.82		0.87
South Zone	15	0.31		0.42
East Zone	s			0.98
West Zone	6	0.53		s
Selkirk Zone	11	1.42		0.77
North Zone	44	2.66	H	2.26
Northern Remote	14	4.04	H	4.05

H/L Significantly higher or lower than the MB average for that time period. (s) indicated data suppressed due to small numbers.

Source: MHSAL IMA 2019

Injury Hospitalization - Unintentional

Definition

The number of residents who stayed in hospital at least one day with a primary diagnosis of unintentional injury (e.g. falls, motor vehicle accidents, drowning) per 1,000 population, for a one-year time period.

Why is this indicator important?

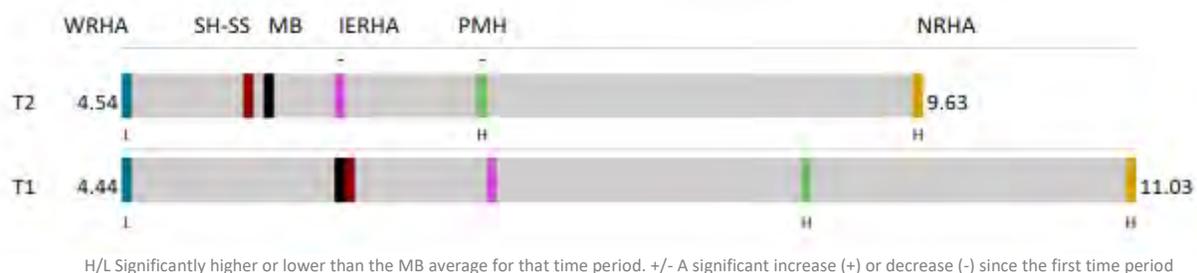
Measuring unintentional injury hospitalization rates helps to understand the adequacy and effectiveness of prevention efforts.

Provincial Key Findings

- There were 7,449 unintentional injury hospitalizations in 2016-2017. The age-standardized unintentional injury hospitalization rate decreased slightly in the province, from 5.90 to 5.42 per 1,000 residents.
- Two regions (Prairie Mountain Health and Interlake-Eastern Regional Health Authority) saw significant decreases in their rates of unintentional injury hospitalizations over time.
- Falls were the most frequent cause of injury hospitalization in all RHAs in both time periods.
- Income: In rural settings, hospitalization rates due to unintentional injuries among low-income residents were 1.9 times higher than that of highest income residents.



Figure 3.25. Unintentional Injury Hospitalization Rates by RHA, 2011/12 (T1) and 2016/17 (T2)
Age/Sex Adjusted Rates, per 1,000 residents



	WRHA	SH-SS	MB	IERHA	PMH	NRHA
T2 COUNT	3,738	971	7,449	763	1,298	512
T2 RATE	4.54 L	5.32	5.42	5.89 -	6.78 H-	9.63 H
T1 RATE	4.44 L	5.97	5.90	6.90	8.91 H	11.03 H

Source: MHSAL IMA 2018

Regional Key Findings

- During the most recent reporting period, a total of 763 residents from Interlake-Eastern were hospitalized for unintentional injuries.

- At the zone level, West experienced a statistically significant decrease at from 7.53 to 5.16 hospitalizations per 1,000 residents.
- North Zone (8.49) and Northern Remote Zone (15.0) have rates significantly higher than the Manitoba (5.42) average for unintentional injury hospitalizations.
- A total of 434 Interlake-Eastern residents fell during the one-year reporting time period, which accounted for nearly 50% of injury related hospitalizations (**Table 3.27.**)

Table 3.27. Injury Hospitalization (Unintentional) by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1			T2		T1	
	Count	Rate		Rate		Count	Rate		Rate
Manitoba	7,449	5.42		5.90	IERHA	763	5.89	-	6.90
South Zone	291	5.07		6.04	Selkirk Zone	74	5.57		6.10
East Zone	115	4.78		5.64	North Zone	146	8.49	H	8.58
West Zone	103	5.16	-	7.53	Northern Remote	35	15.0	H	15.33

H/L Significantly higher or lower than the MB average for that time period.

+/- A significant increase (+) or decrease (-) since the first time period

Source: MHSAL IMA 2019

Table 3.28. Most Frequent Causes for Injury Hospitalization, for IERHA, 2011/12 (T1) and 2016/17 (T2)

	T2		T1
	Count	Percentage	Percentage
Fall	434	47.6%	52.2%
Poisoning	75	8.2%	9.3%
Suffocation	71	7.8%	-
Occupant, MVA	64	7.0%	6.5%
Struck by or against	53	5.8%	6.8%

+/- A significant increase (+) or decrease (-) since the first time period

Source: MHSAL IMA 2019

Hip Fracture Hospitalization Rate

Definition

The rate of individuals admitted to an acute care hospital with a hip fracture, per 100,000 populations, aged 65 and older, for a five-year time period.

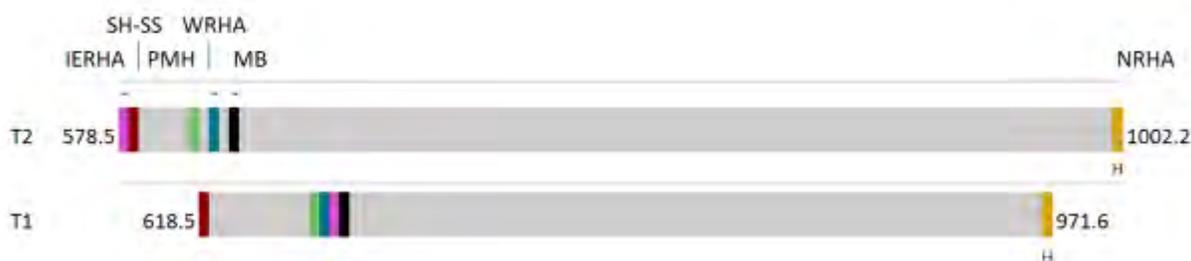
Why is this indicator important?

Hip fractures are associated with high morbidity and mortality rates in older adults. Individuals with hip fractures are at significantly increased risk for further fractures.

Provincial Key Findings

- There were 5,637 Manitobans admitted to an acute care hospital with a hip fracture in 2012/13-2016/17.
- The rates have significantly decreased in Winnipeg RHA and Interlake-Eastern over time.
- Northern RHA had the highest rates in both time periods. The rates also were significantly higher than the provincial average.

Figure 3.26. Hip Fracture Hospitalization Rate by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)
Age- and sex-adjusted rate per 100,000 residents (65 years and older)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	IERHA	SH-SS	PMH	WRHA	MB	NRHA				
T2 COUNT	478	643	927	3,295	5,637	159				
T2 RATE	578.5	-	584.0	612.3	621.6	-	627.9	-	1,002.2	H
T1 RATE	673.0	-	618.5	664.1	667.9	-	674.0	-	971.6	H

Source: MHSAL IMA 2019

Regional Key Findings

- Interlake-Eastern had the lowest hip fracture hospitalization rate across the province between 2012-2017.
- Rates have decreased significantly over time from 673.0 to 578.5 per 100,000 residents.
- Although not statistically significant, the majority of zones in Interlake-Eastern saw lower rates of hip fracture hospitalizations, with exception of the West Zone which increased slightly.
- The geographic disparity has narrowed over time from 4.8 to 1.7. Therefore, it appears that we see less variability in hip fracture hospitalization rates across the region.

Table 3.29. Hip Fracture Rate by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2		T1	
	Count	Rate	Rate	
Manitoba	5637	627.9	-	674.0

	T2		T1	
	Count	Rate	Rate	
IERHA	478	578.5	-	673.0

South Zone	173	579.4		652.7
St. Clements	20	519.3		834.5
Springfield	34	553.5		594.1
Wpg Beach/St. Andrews	45	573.5		562.8
Stonewall/Teulon	74	613.5		676.7

North Zone	55	563.0		683.3
Powerview/Pine Falls	13	541.4		501.0
Fisher/Peguis	17	544.7		925.2
Eriksdale/Ashern	25	587.4		591.3

East Zone	82	496.4		662.2
Pinawa/Lac du Bonnet	33	443.6		586.0
Beausejour	36	530.3		763.0
Whiteshell	13	562.7		599.8

Northern Remote	s			2,395.5	H
Northern Remote	s			2,395.5	H

West Zone	92	632.7		595.8
Gimli	37	505.3		659.6
St. Laurent	25	744.4		564.5
Arborg/Riverton	30	775.0		509.4

Selkirk Zone	72	624.3		758.5
Selkirk	72	624.3		758.5

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	4.8	
	T2 Disparity	1.7	
	Change	-3.0↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

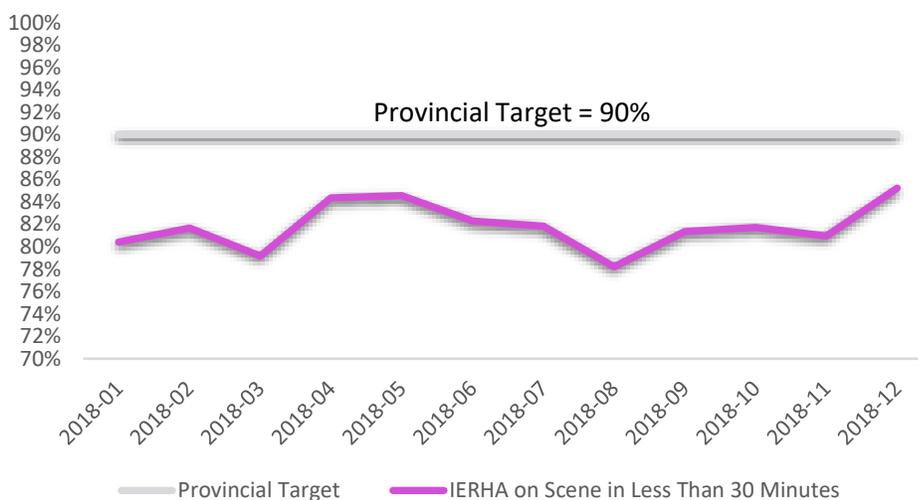
Source: MHSAL IMA 2018

CLOSER LOOK... EMERGENCY MEDICAL SERVICES RESPONSES

Emergency Medical Services (EMS) response times are compared with provincial standard measures. The measures look at the proportion of EMS calls received and the response time taken to arrive on scene.

In 2018, nearly 82% of all primary EMS calls received were responded to in 30 minutes or less (see **Figure 3.27**). There are approximately 35 ambulances in operation within 18 EMS stations in IERHA borders.

Figure 3.27. Percentage of 2018 EMS Primary Call Response Times
EMS Calls Responded to in 30 Minutes or Less



Source: IERHA (2019), MTCC Special Data Run

Mental Illness

Mood & Anxiety Disorders

Definition

The percent of residents (aged 18+) diagnosed with mood and anxiety disorders, for a five-year time period.

Why is this indicator important?

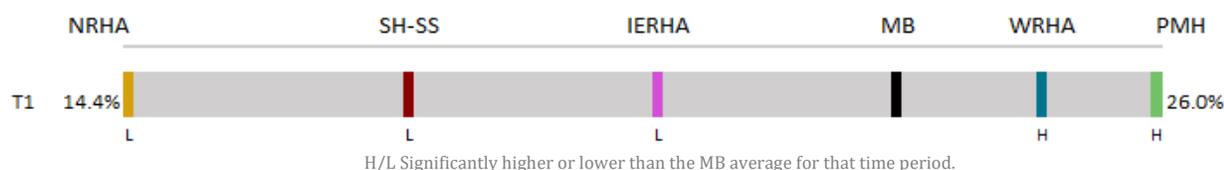
Mood and anxiety disorders frequently coexist with other chronic diseases and/or conditions. For example, the early onset of depressive and anxiety disorders is associated with an increased risk of developing heart disease, asthma, arthritis, chronic back pain, and chronic headaches in adults.^{xxix}

Provincial Key Findings

- There were 228,982 Manitobans diagnosed with mood and anxiety disorders.
- The rate was lower in Southern Health-Santé Sud, Interlake-Eastern and Northern; however, it was significantly higher than the provincial average in Prairie Mountain Health and in the Winnipeg health region.
- A higher prevalence of mood and anxiety disorders was found in urban areas compared to rural areas.

Figure 3.28. Prevalence of Mood and Anxiety Disorders among Adults by RHA, 2010/11 – 2014/15 (T1)

Age- and sex-adjusted percent of adults (aged 18+ years) diagnosed with disorder in five-year time period



	NRHA	SH-SS	IERHA	MB	WRHA	PMH
T1 COUNT	7,148	23,814	20,287	228,982	142,171	34,287
T1 PERCENT	14.4% L	17.7% L	20.4% L	23.2%	24.7% H	26.0% H

Source: MCHP Mental Illness Among Adult Manitobans 2018

Regional Key Findings

- From 2010-2015, approximately one in five residents over the age of 18 were diagnosed with a mood and anxiety disorder, which total 20,287 residents.
- 11 of the 15 districts in Interlake-Eastern have rates of mood and anxiety disorders significantly lower than the provincial average of 23.2%.

Table 3.30. Mood & Anxiety Disorders by IERHA Zone & District Findings, 2010/11 – 2014/15 (T1)

	T1		
	Count	Percent	
Manitoba	228,982	23.2%	

	T1		
	Count	Percent	
IERHA	20,287	20.4%	L

South Zone			
Springfield	2,032	18.4%	L
Stonewall/Teulon	2,944	19.4%	L
Wpg Beach/St. Andrews	2,770	20.0%	L
St. Clements	1,452	21.5%	

North Zone			
Powerview/Pine Falls	1,304	29.9%	H
Fisher/Peguis	791	16.6%	L
Eriksdale/Ashern	1,011	19.7%	L

East Zone			
Whiteshell	468	16.7%	L
Pinawa/Lac du Bonnet	1,378	20.1%	L
Beausejour	1,470	20.7%	L

Northern Remote			
Northern Remote	227	10.8%	L

West Zone			
Arborg/Riverton	468	12.5%	L
Gimli	1,170	22.6%	
St. Laurent	612	17.9%	L

Selkirk Zone			
Selkirk	2,190	26.8%	H

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP Mental Illness Among Adult Manitobans 2018

Dementia Prevalence

Definition

The percent of residents, aged 55 and older, diagnosed with dementia for a five-year time period.

Why is this indicator important?

Dementia refers to symptoms and signs associated with a progressive deterioration of cognitive functions that affects many Canadians' daily activities.^{xxx} Prevalence estimates are useful to better understand the burden of this disease in the community.

Provincial Key Findings

- There were 34,912 Manitobans diagnosed with dementia. The diagnostic prevalence of dementia for adults aged 55+ in Manitoba was 10.3% in 2010/11-2014/15.
- The rate was significantly lower in Prairie Mountain Health and Interlake-Eastern than the Manitoba average.
- Income: In rural settings, the dementia prevalence among low-income residents was 1.2 times higher than that of highest income residents.



Figure 3.29. Prevalence of Dementia among Adults by RHA, 2010/11 – 2014/15 (T1)

Age- and sex-adjusted percent of adults (aged 55+ years) diagnosed with disorder in five-year time period



	PMH	IERHA	NRHA	SH-SS	MB	WRHA
T1 COUNT	5,073	2,785	565	4,191	34,912	20,952
T1 PERCENT	8.8% L	8.9% L	8.9%	10.0%	10.3%	10.7% H/L

Source: MCHP Mental Illness Among Adult Manitobans 2018

Regional Key Findings

- In Interlake-Eastern, 2,785 residents aged 55 and older were diagnosed with dementia between 2010-2015.
- Selkirk had the highest prevalence at 14.1% compared to Northern Remote having the lowest at 5.03.

Table 3.31. Dementia Prevalence by IERHA Zone & District Findings, 2010/11 – 2014/15 (T1)

	T1			
	Count	Percent		
Manitoba	34,912	10.3%		
IERHA	2,785	8.9%		L
South Zone				
Springfield	166	6.6%		L
Stonewall/Teulon	366	8.1%		L
Wpg Beach/St. Andrews	220	6.9%		L
St. Clements	116	7.2%		L
North Zone				
Powerview/Pine Falls	73	7.4%		
Fisher/Peguis	66	5.4%		L
Eriksdale/Ashern	158	8.8%		
East Zone				
Whiteshell	77	8.2%		
Pinawa/Lac du Bonnet	236	7.8%		L
Beausejour	232	9.4%		
West Zone				
Arborg/Riverton	114	8.0%		
Gimli	272	9.6%		
St. Laurent	125	9.1%		
Selkirk Zone				
Selkirk	551	14.1%		H

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP Mental Illness Among Adult Manitobans 2018

Antidepressant Prescription

Definition

The percent of residents with a physician diagnosis of depression, plus a new prescription for antidepressants filled within two weeks, and who had at least the recommended follow-up of three subsequent physician visits within four months, for a five-year time period.

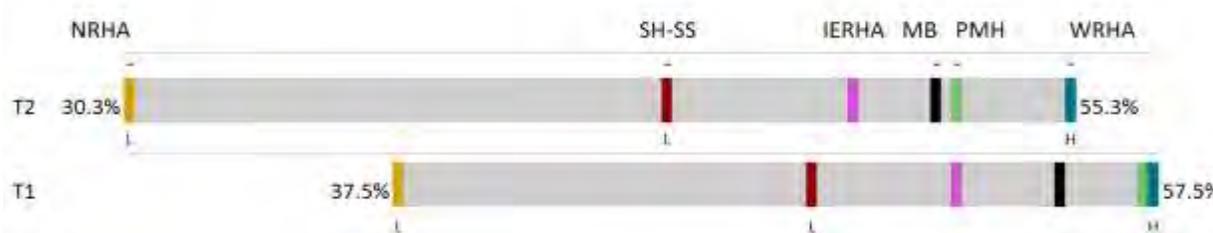
Why is this indicator important?

Regular follow-up after initial diagnosis of depression is essential to track patient response to antidepressant medication and modify treatment if necessary. Antidepressants may not have a clinical effect for some time after initiation of therapy and patients with major depression are at risk for suicide. Antidepressant prescription follow-up is a quality of care indicator and an important part of a treatment regime.

Provincial Key Findings

- About 13,717 residents with a diagnosis of depression had a new prescription for antidepressants in 2012/13—2016/17. The rate of antidepressant prescription follow-up decreased significantly over time, from 54.9% to 51.7%. Rates decreased in all regions, though the decrease in Interlake-Eastern was not statistically significant.
- Winnipeg RHA had the highest rates, while Northern RHA had the lowest rates in the province. The rates in Northern RHA should be interpreted with caution because many residents receive much of their primary care from nurses in local nursing stations. This care is not captured in the medical claims data system.

Figure 3.30. Antidepressant Prescription Follow-up by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)
Crude percent of new depression patients who received 3+ physician visits in four months



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA	SH-SS	IERHA	MB	PMH	WRHA
T2 COUNT	350	1,676	1,413	13,717	2,140	8,092
T2 PERCENT	30.3% L-	44.7% L-	49.7%	51.7% -	52.4% -	55.3% H-
T1 PERCENT	37.5% L	48.5% L	52.3%	54.9%	57.2%	57.5% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Although not statistically significant, rates for antidepressant prescription follow-up decreased over time from 52.3% to 49.7% for those with a diagnosis of depression.
- At the zone level, rates ranged from a low of 27.1% (Northern Remote Zone) to a high of 53.4% (West Zone).
- Some level of disparity remains at the district level, which indicates that some areas in Interlake-Eastern have better rates for antidepressant prescription follow-up compared to others.

Table 3.32. Antidepressant Prescription by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2		T1
	Count	Percent	Percent
Manitoba	13,717	51.7%	54.9%

	T2		T1
	Count	Percent	Percent
IERHA	1,413	49.7%	52.3%

South Zone		682	50.2%	54.2%
St. Clements	88	43.1%	56.3%	
Springfield	152	49.4%	57.4%	
Wpg Beach/St. Andrews	198	50.3%	51.2%	
Stonewall/Teulon	244	53.9%	53.4%	

East Zone		235	52.5%	53.9%
Pinawa/Lac du Bonnet	81	49.4%	51.6%	
Beausejour	126	53.9%	55.4%	
Whiteshell	28	56.0%	55.8%	

West Zone		142	53.4%	52.3%
Arborg/Riverton	32	45.1%	43.3%	
St. Laurent	44	53.7%	58.4%	
Gimli	66	58.4%	56.2%	

Selkirk Zone		168	50.3%	44.2%
Selkirk	168	50.3%	44.2%	

North Zone		173	44.5%	50.6%
Fisher/Peguis	46	38.7%	32.5%	
Eriksdale/Ashern	54	43.2%	45.5%	
Powerview/Pine Falls	73	50.3%	65.1%	

Northern Remote		13	27.1%	27.6%
Northern Remote	13	27.1%	27.6%	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	2.4
	T2 Disparity	2.2
	Change	-0.2↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Suicide Rates

Definition

The average annual rate for which suicide was listed as the cause of death, per 1,000 population, aged 10 and older, for a five-year time period.

Why is this indicator important?

High rates of suicide are an important indication of the mental health of communities and underlying trauma. Suicide rates are one indication of the effectiveness of mental health prevention and promotion initiatives.

Provincial Key Findings

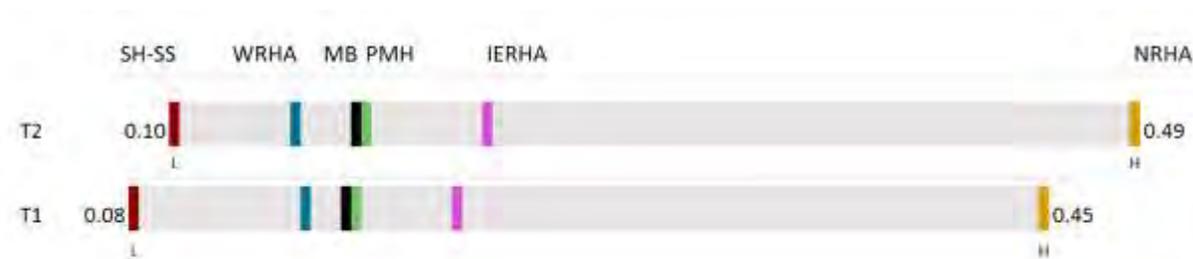
- About 993 suicides took place in Manitoba in 2012-2016. The suicide death rate in the province increased slightly over time; however, the increase was not statistically significant.
- The suicide rates decreased slightly in Winnipeg RHA, while the rates increased slightly in other RHAs, but none of these were significant.
- Northern RHA had significantly higher suicide rates, while Southern Health-Santé Sud had significantly lower suicide rates than the MB average in 2007-2011 and 2012-2016.
- Income: Suicide rates among low-income residents were 2.3 times higher than that of highest income residents in 2012/13-2016/17.



Rural Quintiles

T2 2.3

Figure 3.31. Average Annual Suicide Rates by RHA, 2007-2011(T1) and 2012-2016(T2)
Age & Sex Adjusted, per 1,000 age 10+



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS	WRHA	MB	PMH	IERHA	NRHA
T2 COUNT	83	503	993	136	118	139
T2 RATE	0.10 L	0.15	0.17	0.18	0.23	0.49 H
T1 RATE	0.08 L	0.15	0.17	0.17	0.21	0.45 H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- From 2012-2016 a total of 118 individuals died by suicide in Interlake-Eastern.
- Rates in the North and Northern Remote zones are significantly higher than the Manitoba average.
- Over time, suicide rates at the zone level have remained stable with no significant increases or decreases.

Table 3.33. Suicide Rates by IERHA Zone Findings, 2007-2011(T1) and 2012-2016(T2)

	T2		T1	
	Count	Rate	Rate	
Manitoba	993	0.17	0.17	

	T2		T1	
	Count	Rate	Rate	
IERHA	118	0.23	0.21	

South Zone	33	0.13		0.12	
East Zone	14	0.16		0.21	
West Zone	17	0.24		0.14	

Selkirk Zone	14	0.31		0.22	
North Zone	29	0.37	H	0.28	
Northern Remote	11	0.84	H	1.25	H

H/L Significantly higher or lower than the MB average for that time period.

Source: MCHP RHA Indicators Atlas 2019



CLOSER LOOK... INTO MENTAL HEALTH SERVICES AVAILABLE IN IERHA

Did you know the region has Mental Health Liaison Nurses (MHLNs)?

MHLNs are located at Selkirk Regional Health Centre (SRHC) to provide a comprehensive mental health assessment for individuals that present to the emergency department (ED) with mental health concerns.

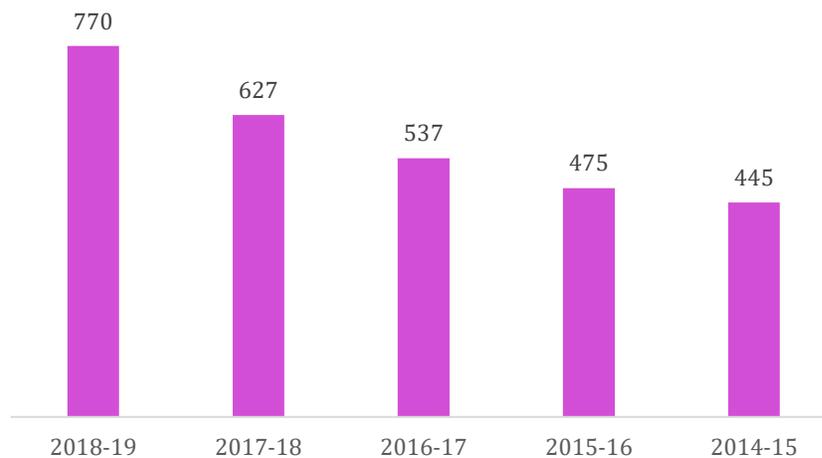
The target population for this service is individuals in “urgent/emergent need” of mental health services who are unable to wait for service in the community.

In 2018-19 a total of 770 ED assessments (includes both new assessments and reassessments) were completed by the MHLN. Only 9% of assessments required further involuntary psychiatric assessment, therefore demonstrating that least restrictive services are recommended and provided to individuals. **Figure 3.32.** demonstrates the annual growth of this program at SRHC.

In addition to providing services at SRHC the MHLN also provides telephone consultation services (MHLN to nurse or MHLN to Physician) to three additional EDs in the region (Pine Falls, Arborg, and Pinawa).

In 2018-19 rural EDs had over 50 telephone consultations with the MHLN for discussions regarding resources and interventions.

Figure 3.32. Annual ED Assessments at SRHC by MHLNs, 2014-15 to 2018-19.



Source: IERHA (2019), MHLN Annual Statistical Report

Mental health staff in Interlake-Eastern RHA have compiled a number of helpful and valuable mental health tools and resources. These are accessible on Interlake-Eastern RHA’s website. Visit ierha.ca and click on “Care in Your Community” and “Mental Health”.

Musculoskeletal

Arthritis Prevalence

Definition

The percent of residents, aged 19 and older, diagnosed with arthritis (rheumatoid or osteoarthritis), for a two-year time period.

Why is this indicator important?

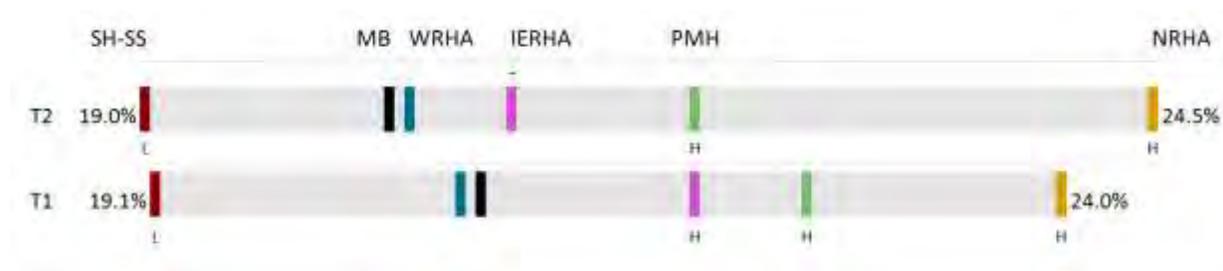
Arthritis is a chronic condition that seriously affects quality of life, functional independence, and physical ability of many Manitobans.

Provincial Key Findings

- There were 213,054 Manitobans with a diagnosis of arthritis in 2015/16-2016/17. The prevalence of arthritis in Manitoba decreased slightly from 20.9% to 20.4% although the decrease was not of statistical significance.
- The prevalence also decreased in most RHAs, though only the decrease in Interlake-Eastern was statistically significant.

Figure 3.33. Prevalence of Arthritis by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

Age- and sex-adjusted percent of residents aged 19+ diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS		MB		WRHA		IERHA		PMH		NRHA	
T2 COUNT	26,121		213,054		124,475		21,994		29,921		10,304	
T2 PERCENT	19.0%	L	20.4%		20.4%		21.0%	-	22.0%	H	24.5%	H
T1 PERCENT	19.1%	L	20.9%		20.8%		22.0%	H	22.6%	H	24.0%	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Arthritis prevalence has decreased significantly in Interlake-Eastern from 2010 to 2017.
- Both East and West zones of Interlake-Eastern experienced significant decreases over time, and interestingly, Arborg/Riverton was found to have one of the smallest percentages of residents with a diagnosis of arthritis across the entire province.
- The geographic disparity ratio shown below in **Table 3.34**. indicates that disparity does exist between districts in Interlake-Eastern and over time there has only been a slight narrowing of disparity. Those living in Powerview/Pine Falls are twice as likely to have arthritis than residents living in Arborg/Riverton.

Table 3.34. Arthritis Prevalence by IERHA Zone & District Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

	T2		T1		
	Count	Percent		Percent	
Manitoba	213,054	20.4%		20.9%	

	T2		T1		
	Count	Percent		Percent	
IERHA	21,994	21.0%	-	22.0%	H

South Zone	9,687	20.4%		20.9%	
Stonewall/Teulon	2,984	20.0%	-	21.6%	
Wpg Beach/St. Andrews	2,861	20.7%		20.9%	
Springfield	2,296	21.1%		20.2%	
St. Clements	1,546	22.2%	H	22.6%	

North Zone	3,499	26.8%	H-	29.3%	H
Fisher/Peguis	1,044	23.5%	H	24.2%	H
Eriksdale/Ashern	1,280	27.6%	H	27.6%	H
Powerview/Pine Falls	1,175	30.1%	H-	37.8%	H

East Zone	3,962	21.5%	-	23.0%	H
Pinawa/Lac du Bonnet	1,693	21.0%	-	24.0%	H
Whiteshell	623	21.9%		22.3%	
Beausejour	1,646	22.2%	H	22.6%	

West Zone	2,441	17.9%	L-	19.7%	
Arborg/Riverton	475	13.0%	L-	17.7%	L
Gimli	1,239	19.7%		20.8%	
St. Laurent	727	20.4%		20.5%	

Selkirk Zone	2,151	24.4%	H	23.7%	H
Selkirk	2,151	24.4%	H	23.7%	H

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	2.7	
	T2 Disparity	2.3	
	Change	-0.4↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Osteoporosis Prevalence

Definition

The percent of residents, aged 50 and older, diagnosed with osteoporosis, for a one-year time period.

Why is this indicator important?

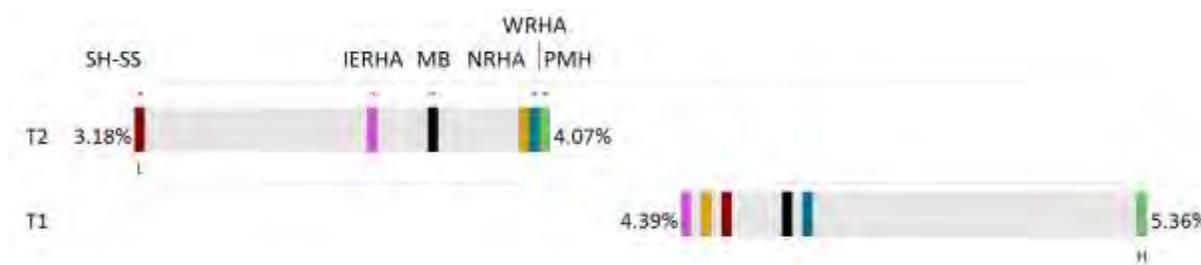
Osteoporosis is a disease that leads to a reduction in bone density and causes bones to become weak and more likely to fracture. The most common injuries associated with osteoporosis are fractures of the wrist, spine, and hip. Osteoporosis prevalence provides valuable insight for planning patient education regarding preventive measures and treatment options to reduce fractures and hospitalizations, and improve quality of life.

Provincial Key Findings

- 17,104 Manitobans were diagnosed with osteoporosis in 2016/17. The prevalence of osteoporosis in Manitoba decreased significantly from 4.60% to 3.83%. The prevalence also decreased in all regions, though the decrease in Northern RHA was not statistically significant.
- Osteoporosis prevalence for Southern Health-Santé Sud was significantly lower than the provincial average in 2016/17, while the prevalence for Prairie Mountain Health was significantly higher than the provincial average in 2011/12.

Figure 3.34. Prevalence of Osteoporosis by RHA, 2011/12 (T1) and 2016/17 (T2)

Age- and sex-adjusted percent of residents aged 50+ diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	SH-SS		IERHA		MB		NRHA		WRHA		PMH	
T2 COUNT	1,635		1,626		17,104		450		10,721		2,600	
T2 PERCENT	3.2%	L-	3.7%	-	3.8%	-	4.0%		4.1%	-	4.1%	-
T1 PERCENT	4.5%		4.4%		4.6%		4.4%		4.7%		5.4%	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- During the most recent time period, Interlake-Eastern was found to have a significantly lower percentage of residents diagnosed with osteoporosis.
- South and West zones experienced statistically significant decreases in prevalence over time.

- Although osteoporosis prevalence has trended down in Interlake-Eastern, the geographic disparity ratio indicates that there has been a slight widening in disparity between our lowest (Arborg/Riverton = 2.1%) and highest districts (Eriksdale/Ashern = 4.7%).

Table 3.35. Osteoporosis Prevalence by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)

	T2			T1	
	Count	Percent		Percent	
Manitoba	17,104	3.8%	-	4.6%	

	T2			T1	
	Count	Percent		Percent	
IERHA	1,626	3.7%	-	4.4%	

South Zone					
	Count	Percent		Percent	
South Zone	674	3.8%	-	4.6%	
St. Clements	86	3.2%		4.1%	
Springfield	137	3.6%		4.0%	
Stonewall/Teulon	230	3.9%	-	5.4%	
Wpg Beach/St. Andrews	221	4.2%		4.5%	

East Zone					
	Count	Percent		Percent	
East Zone	337	3.9%		4.7%	
Pinawa/Lac du Bonnet	170	3.8%	-	5.3%	
Beausejour	122	3.9%		3.5%	
Whiteshell	45	4.0%		5.3%	

West Zone					
	Count	Percent		Percent	
West Zone	225	3.4%	-	4.4%	
Arborg/Riverton	34	2.1%	L	3.2%	
St. Laurent	56	3.5%		4.7%	
Gimli	135	3.8%		4.7%	

Selkirk Zone					
	Count	Percent		Percent	
Selkirk Zone	188	4.2%		4.2%	
Selkirk	188	4.2%		4.2%	

North Zone					
	Count	Percent		Percent	
North Zone	195	4.1%		4.4%	
Fisher/Peguis	49	3.1%		3.0%	
Powerview/Pine Falls	57	4.4%		4.6%	
Eriksdale/Ashern	89	4.7%		5.5%	

Northern Remote					
	Count	Percent		Percent	
Northern Remote	7	2.1%		4.0%	
Northern Remote	7	2.1%		4.0%	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	1.8
	T2 Disparity	2.2
	Change	0.4 ↑
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

CLOSER LOOK... AT IERHA'S REHABILITATION UNIT

Located in the Beausejour Health Centre, the rehabilitation unit is the designated intensive inpatient rehabilitation site for residents in Interlake-Eastern. Rehab is completed in an inpatient setting with the goal for the patient to return to living in their home community. Together with rehab staff, patients and their families are involved in setting individualized goals for their rehabilitation and recovery.

Here are some quotes shared by patients from the "Rehab Wall of Fame":



"Therapy works, prove that it works with your own hard work and determination. Thank you to the rehab staff, great work."

"Miracles do happen."

"The rehab staff are knowledgeable, caring and amazing individuals. Together they form a team that creates magic and miracles. Thanks ever so much for all of your help."

Renal

Chronic Kidney Disease Prevalence

Definition

The percent of residents, aged 18 years and older, diagnosed with chronic kidney disease (CKD).

Why is this indicator important?

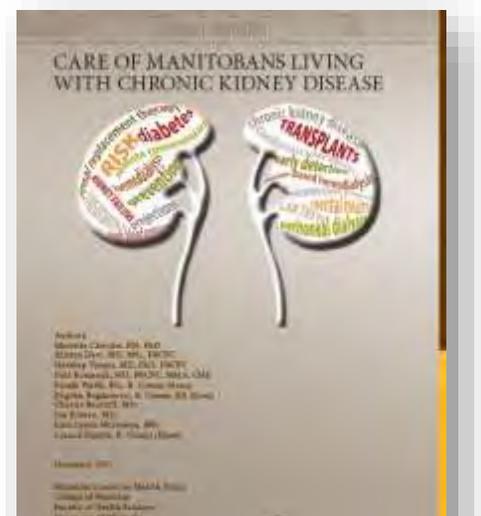
CKD often starts slowly and develops without symptoms over a number of years, sometimes leading to serious damage before diagnosis. Understanding how many residents live with CKD and where they live helps with program planning and resource allocation. Appropriate care can slow the progression of the disease, reduce complications, and enhance quality of life.

Provincial Key Findings

- In 2012, the prevalence of adult CKD in Manitoba with laboratory data was 10% (n=37,534).
- Age and Sex: The renal disease prevalence among residents aged 65+ was more than seven times higher than residents aged 18-44. The prevalence was 1.5 times higher in females than in males.
- The prevalence of CKD in the Northern RHA and remote communities was significantly higher than the provincial average.

Regional Key Findings

- 9.6% of residents aged 18 and older in Interlake-Eastern were diagnosed with chronic kidney disease in 2012.



To learn more about Chronic Kidney Disease including ESKD in Manitoba visit: <http://is.gd/ChronicKidneyDisease>

Figure 3.35. Prevalence of Adults with Chronic Kidney Disease by RHA, March 31, 2012

Age and Sex Adjusted Percent of Residents, Age 18+, Lab Data Only



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	PMH	SH-SS	IERHA	MB	WRHA	NRHA
T1 COUNT	730	1,964	3,262	37,534	30,084	1,491
T1 PERCENT	4.4% L	6.9%	9.6%	10.4%	11.0%	15.5% H

Source: MCHP Care of Manitobans Living with Chronic Kidney Disease 2015

End Stage Kidney Disease

Definition

The number of residents with end stage kidney disease (ESKD) per 1,000 population. ESKD is based on a patient's use of renal replacement therapies (dialysis or kidney transplant).

Why is this indicator important?

ESKD is increasing in Canada and Manitoba has the highest rate of kidney disease in the country. ESKD is a serious chronic condition because of associated high mortality, negative affect on quality of life, and high cost of kidney transplants. Diabetes is the most common cause of ESKD so it is important to address comorbidities in prevention education, treatment options, and resource allocation.

Provincial Key Findings

- There were 1,833 residents diagnosed with ESKD in Manitoba in 2012 (1.45 per 1,000 residents).
- ESKD prevalence increased in all regions over time from 2007 to 2012.
- In Manitoba, 1,236 residents with ESKD had dialysis in 2012 and 597 residents with ESKD had a kidney transplant.

Regional Key Findings

- Rates of treatment for ESKD in Interlake-Eastern were not found to be statistically significantly higher or lower than the Manitoba average.
- 206 residents in Interlake-Eastern had renal replacement therapy which includes both dialysis and kidney transplantation during the most recent time period.

Figure 3.36. End Stage Kidney Disease Prevalence by RHA, 2007 Q2 (T1) and 2012 Q2 (T2)



	SH-SS	PMH	MB	WRHA	IERHA	NRHA
T2 COUNT	180	200	1,833	1,066	206	181
T2 RATE	0.99	1.21	1.45	1.47	1.68	2.43
T1 RATE	0.83	1.00	1.22	1.26	1.37	1.90

Source: MCHP Care of Manitobans Living with Chronic Kidney Disease 2015

Observed and Projected End Stage Kidney Disease

Definition

The observed (2004-2012 (Q2)) and projected (2012 (Q3)-2024) number of residents living with end stage kidney disease (ESKD), by treatment type.

Why is this indicator important?

Manitoba has the highest prevalence of ESKD in Canada and current projections predict a significant increase by 2024. ESKD projections help to plan prevention initiatives, deliver coordinated health care services and allocate appropriate resources to meet the service demand.

Provincial Key Findings

- The number of Manitobans with ESKD will increase by 68% between 2012 and 2024. The projections estimate that 3,077 people will require renal replacement therapy (RRT) in 2024 (Table 35).
- The highest increases are projected in the Southern Health-Santé Sud and Northern RHA.
- Age: ESKD patients aged 65+ on hemodialysis will increase by 89% by 2024. In the younger age groups, the need for hemodialysis will see increases of 50% (0 to 44 years) and 65% (45 to 64).

Table 3.36. Observed and Projected Number of Patients with ESKD by RHA, 2012 and 2024.

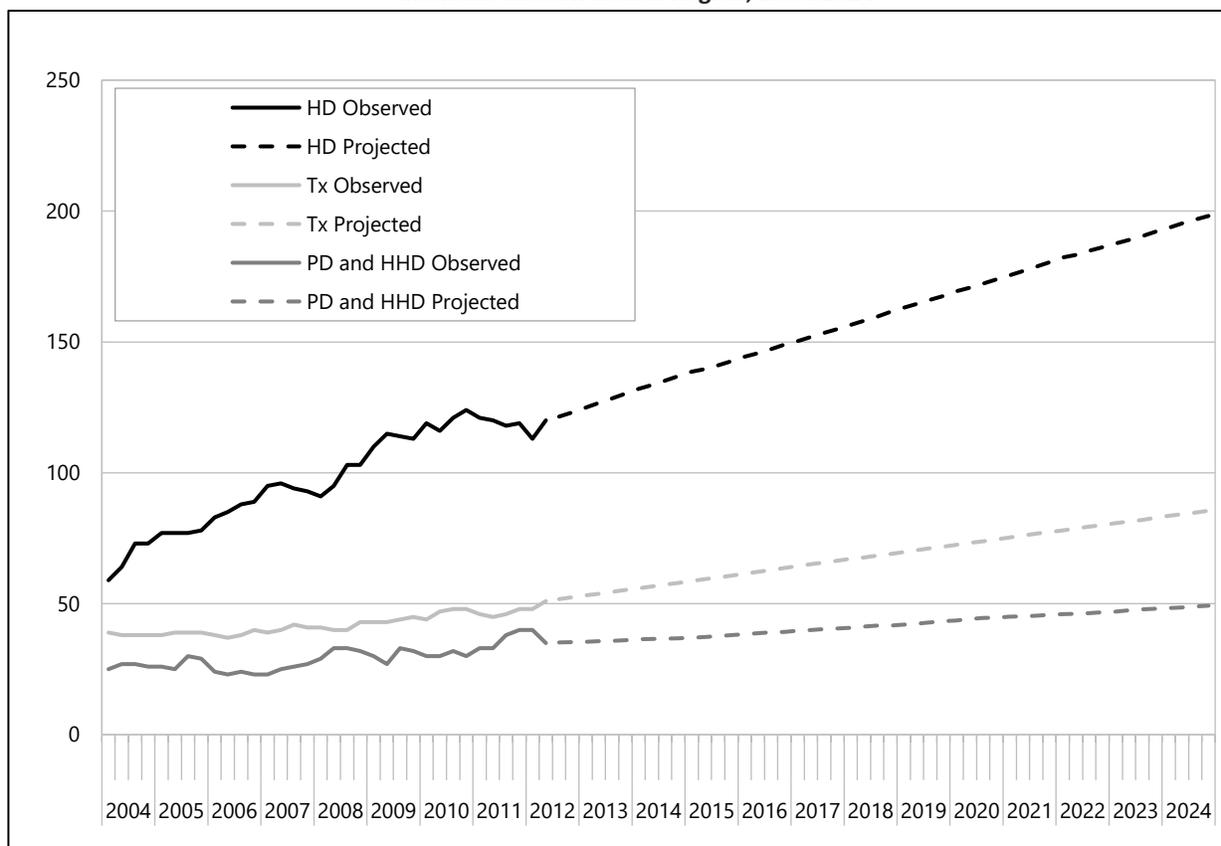
	WRHA	SH-SS	PMH	NRHA	IERHA	MB
Observed ESKD (2012)	1,066	180	200	181	206	1,833
Projected ESKD (2024)	1,769	323	328	325	333	3,077

Source: MCHP Care of Manitobans Living with Chronic Kidney Disease 2015

Regional Key Findings

- By 2024 it is projected that a total of 333 Interlake-Eastern residents will require RRT.
- The projection also estimates that our region will see an increase of 62% in ESKD between 2012 to 2024, which is slightly below the Manitoba average of 68%.
- **Figure 3.37.** shows the projected number of residents in Interlake-Eastern over 12 years who will require centre-based hemodialysis, kidney transplant, and peritoneal dialysis and home dialysis.
- It is projected that in 2024: 198 residents will require centre-based hemodialysis (= to 5.4% annual increase), 86 residents will require a kidney transplant (= 5.8% annual increase), and 49 residents will require peritoneal dialysis and home dialysis (=3.3% annual increase).

Figure 3.37. Observed and Projected Number of Patients with End Stage Kidney Disease by Treatment Type in Interlake-Eastern Health Region, 2004-2024



HD = Centre-based Hemodialysis, Tx = Kidney Transplant, PD &HHD = Peritoneal dialysis and home dialysis

Source: MCHP Care of Manitobans Living with Chronic Kidney Disease 2015

CLOSER LOOK... LOCAL RENAL HEALTH CENTRES IN IERHA

Accessing hemodialysis services in Interlake-Eastern Regional Health Authority (IERHA) is done through the Manitoba Renal Program, located at the Health Sciences Centre in Winnipeg, Manitoba. Patients who have been diagnosed with kidney failure are referred to the Manitoba Renal Program via their primary care provider. Patients who require hemodialysis treatment can request treatment occur in a centre in or near their home community. If they meet the criteria/stability for a rural hemodialysis site, they can be placed on a wait list.

IERHA has six Local Renal Health Centres (LRHC). They are located in the following areas:

- Ashern
- Berens River
- Gimli
- Hodgson
- Pine Falls
- Selkirk



Pictured above: Selkirk Regional Health Centre's new dialysis unit that opened in June 2017.

Respiratory

Total Respiratory Morbidity (TRM) Prevalence

Definition

The percent of residents diagnosed with a respiratory disease (asthma, chronic or acute bronchitis, emphysema, or chronic airway obstruction).

Why is this indicator important?

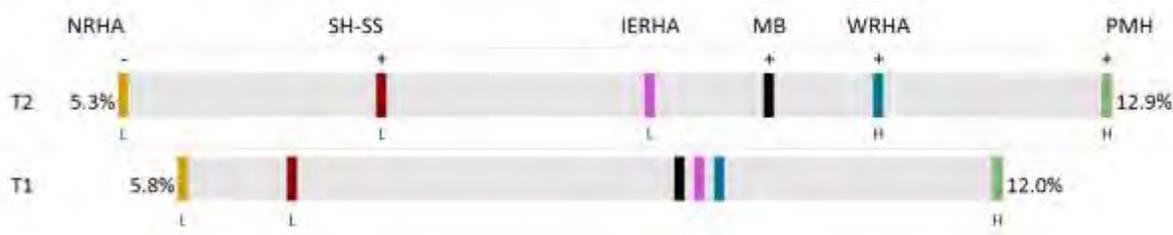
TRM is a good overall measure of the proportion of the population that experiences breathing issues. Understanding prevalence helps to plan prevention efforts, coordinate services between community and acute care, and provide effective supports to enhance quality of life.

Provincial Key Findings

- 143,607 Manitoba residents were diagnosed with a respiratory disease in 2016/17. Total respiratory morbidity prevalence significantly increased in Manitoba, from 9.6% to 10.3%. The increase was also significant in Southern Health-Santé Sud, Winnipeg health region, and Prairie Mountain, but there was a significant decrease in Northern RHA.
- There was a big variation in prevalence in both time periods. Rates were the lowest in Northern RHA.

Figure 3.38. Prevalence of Total Respiratory Morbidity by RHA, 2011/12 (T1) and 2016/17 (T2)

Age- and sex-adjusted percent of residents (all ages) diagnosed with disorder



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA	SH-SS	IERHA	MB	WRHA	PMH
T2 COUNT	3,829	14,679	12,632	143,607	88,789	23,371
T2 PERCENT	5.3% L-	7.3% L+	9.4% L	10.3% +	11.1% H+	12.9% H+
T1 PERCENT	5.8% L	6.6% L	9.8%	9.6%	9.9%	12.0% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern had a total of 12,632 residents diagnosed with a respiratory disease in 2016-2017, which represents 9.4% of residents.

- Total respiratory morbidity prevalence at the regional level is very complex. Some areas within Interlake-Eastern have rates well below the provincial average and other areas, such as Selkirk, are significantly higher.
- Over time some areas of Interlake-Eastern, such as Powerview/Pine Falls, have seen declining rates and other areas, such as Winnipeg Beach/St. Andrews, have experienced increasing rates.
- The geographic disparity ratio indicates that within the districts in Interlake-Eastern, we experience a disproportion of residents being diagnosed with respiratory diseases with the lowest prevalence at 3.0% (Northern Remote) and the highest at 12.3% (Selkirk) during the most recent time period.

Table 3.37. Total Respiratory Morbidity Prevalence by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)

	T2			T1	
	Count	Percent		Percent	
Manitoba	143,607	10.3%	+	9.6%	

	T2			T1	
	Count	Percent		Percent	
IERHA	12,632	9.4%	L	9.8%	

South Zone	5,950	9.5%	L+	8.7%	L
Springfield	1,331	8.6%	L+	6.5%	L
Wpg Beach/St. Andrews	1,702	9.3%	L+	8.5%	L
St. Clements	884	9.3%	+	8.3%	L
Stonewall/Teulon	2,033	10.0%		10.1%	

North Zone	1,950	9.7%	-	11.7%	H
Fisher/Peguis	464	6.5%	L	6.9%	L
Eriksdale/Ashern	702	10.4%		11.3%	H
Powerview/Pine Falls	784	12.3%	H-	17.3%	H

East Zone	1,913	8.4%	L	9.0%	
Whiteshell	281	7.3%	L	6.8%	L
Pinawa/Lac du Bonnet	723	7.9%	L	8.6%	
Beausejour	909	9.1%	L	10.0%	

Northern Remote	108	3.0%	L	3.9%	L
Northern Remote	108	3.0%	L	3.9%	L

West Zone	1,327	7.9%	L-	10.1%	
Arborg/Riverton	252	4.8%	L-	9.9%	
Gimli	642	9.3%		9.9%	
St. Laurent	433	9.5%		10.4%	

Selkirk Zone	1,384	12.3%	H	11.4%	H
Selkirk	1,384	12.3%	H	11.4%	H

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	4.4	
	T2 Disparity	4.1	
	Change	-0.3↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Asthma Prevalence for Children

Definition

The percent of residents, aged five to 19 years, diagnosed with asthma, over a two-year time period.

Why is this indicator important?

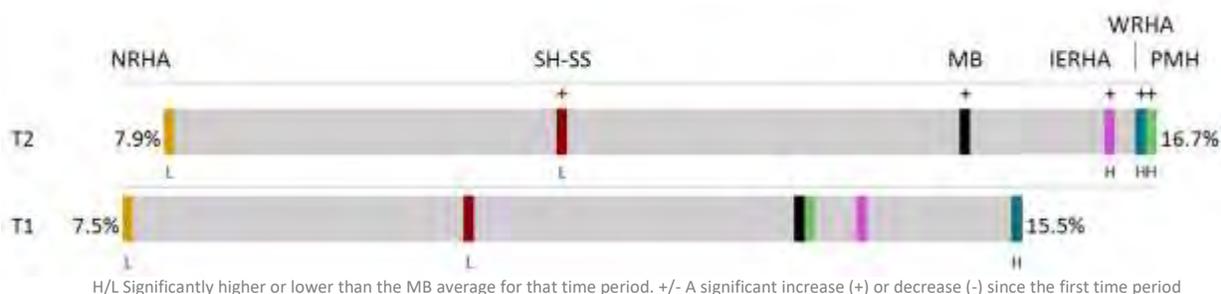
Asthma is the most common chronic disease in children.^{xxxi} Timely and appropriate education and treatment help children and their families living with asthma learn how to manage the condition effectively.

Provincial Key Findings

- There were 38,424 children aged five to 19 years diagnosed with asthma in 2015/16-2016/17. The prevalence of asthma for children in Manitoba increased significantly over time from 13.6% to 15.1%. Rates also increased in all regions, though the increase in Northern RHA was not statistically significant.
- In both time periods, rates in Northern RHA and Southern Health-Santé Sud were significantly lower than the provincial average, while those in Winnipeg were significantly higher.
- Asthma prevalence rates for children were higher for urban residents than rural, this may mean people residing in urban areas have a higher rate of visits to physicians and nurse practitioners.

Figure 3.39. Asthma Prevalence by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

Age- and sex-adjusted average annual percent of residents aged 5-19



	NRHA		SH-SS		MB		IERHA		WRHA		PMH	
T2 COUNT	1,680		5,085		38,424		3,738		22,037		5,325	
T2 PERCENT	7.9%	L	11.4%	L+	15.1%	+	16.4%	H+	16.7%	H+	16.7%	H+
T1 PERCENT	7.5%	L	10.6%	L	13.6%		14.1%		15.5%	H	13.7%	

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Asthma rates for children aged five to 19 have increased significantly in Interlake-Eastern over the previous time period, from 14.1% to 16.4%.
- All zones in Interlake-Eastern have experienced increasing rates in asthma among children.
- Selkirk Zone has the highest prevalence of children aged five to 19 diagnosed with asthma across all Manitoba at a rate of 24.1%.
- The geographic disparity ratio indicates that within districts in Interlake-Eastern we are seeing a growing gap between our highest and lowest districts over time.
- It is increasing rates in the southern areas of Interlake-Eastern that are driving this gap in disparity.

Table 3.38. Asthma Rate for Children by IERHA Zone & District Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

	T2			T1	
	Count	Percent		Percent	
Manitoba	38,424	15.0%	+	13.6%	

	T2			T1	
	Count	Percent		Percent	
IERHA	3,738	16.4%	H+	14.1%	

South Zone		1,704	16.8%	H+	13.8%	
Springfield	412	15.1%	+	11.6%		
Stonewall/Teulon	530	15.5%	+	13.1%		
St. Clements	262	18.6%	H	16.1%		
Wpg Beach/St. Andrews	500	19.0%	H+	15.7%		

North Zone		756	16.7%		15.8%	H
Fisher/Peguis	183	10.9%	L	11.5%		
Eriksdale/Ashern	224	17.5%		19.3%		H
Powerview/Pine Falls	349	22.4%	H+	16.7%		H

East Zone		459	15.0%		13.4%	
Whiteshell	75	12.6%		12.7%		
Pinawa/Lac du Bonnet	129	14.2%		12.2%		
Beausejour	255	16.3%		14.4%		

West Zone		332	14.1%		12.5%	
Arborg/Riverton	98	9.4%	L	10.9%		
Gimli	106	15.9%		13.6%		
St. Laurent	128	19.4%	+	13.8%		

Selkirk Zone		400	24.1%	H+	19.7%	H
Selkirk	400	24.1%	H+	19.7%		H

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	2.9	
	T2 Disparity	3.2	
	Change	0.3↑	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Asthma Care: Controller Medication Use

Definition

The percent of residents (all ages) diagnosed with asthma receiving medication recommended for long-term control of their disease.

Why is this indicator important?

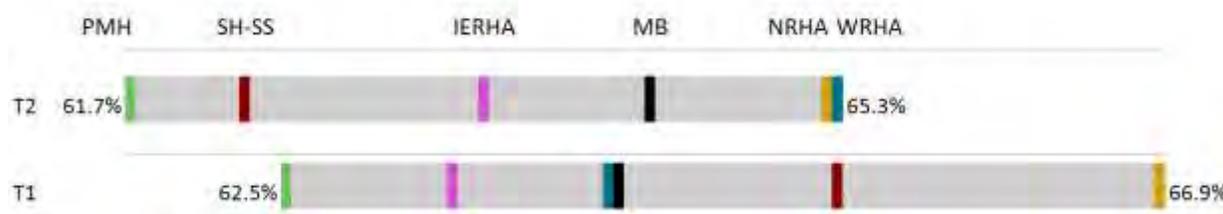
Asthma controller medications control the inflammation in the airways and prevent asthma symptoms.^{xxxii}

Provincial Key Findings

- There were 25,107 Manitobans diagnosed with asthma receiving medication in 2012/13-2016/17. The rates of asthma care in Manitoba remained stable at 64% over time. This stability was reflected in all regions.

Figure 3.40. Asthma Care by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

Crude percent of residents with asthma receiving at least one prescription for inhaled steroids



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	PMH	SH-SS	IERHA	MB	NRHA	WRHA
T2 COUNT	3,218	2,716	2,652	25,107	1,503	14,813
T2 PERCENT	61.7%	62.3%	63.5%	64.3%	65.2%	65.3%
T1 PERCENT	62.5%	65.2%	63.3%	64.1%	66.9%	64.1%

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Rates for asthma medication use within Interlake-Eastern (63.5%) were found to be comparable to the provincial average (64.3%).
- Over time, rates of asthma medication use for long-term control has remained stable across all Interlake-Eastern zones and districts.
- This stabilization of asthma care is evident in the geographic disparity ratio highlighted below in **Table 3.39**, where there has been no change over time between the highest and lowest districts.

Table 3.39. Controller Medication Use by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2		T1	
	Count	Percent	Percent	
Manitoba	25,107	64.3%	64.1%	

	T2		T1	
	Count	Percent	Percent	
IERHA	2,652	63.5%	63.3%	

South Zone		1,069	65.2%		64.1%	
St. Clements	183	61.0%		60.0%		
Wpg Beach/St. Andrews	344	63.7%		61.2%		
Springfield	208	65.6%		67.8%		
Stonewall/Teulon	334	69.2%		66.4%		

East Zone		410	65.7%		68.4%	
Pinawa/Lac du Bonnet	144	64.2%		58.7%		
Beausejour	186	66.2%		75.1%		
Whiteshell	80	67.2%		74.3%		

West Zone		289	63.2%		61.7%	
Gimli	118	62.8%		56.6%		
Arborg/Riverton	71	63.4%		60.4%		
St. Laurent	100	63.7%		68.9%		

Selkirk Zone		309	63.3%		56.2%	
Selkirk	309	63.3%		56.2%		

North Zone		519	58.6%		63.2%	
Eriksdale/Ashern	139	52.9%		59.8%		
Fisher/Peguis	130	53.9%		62.7%		
Powerview/Pine Falls	250	65.5%		67.1%		

Northern Remote		56	69.1%		69.4%	
Northern Remote	56	69.1%		69.4%		

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	1.3	
	T2 Disparity	1.3	
	Change	0	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

CLOSER LOOK... THE COPD SYSTEM OF CARE PROJECT

Interlake-Eastern Regional Health collaborated with WRHA, PMH and the Canadian Foundation for Healthcare Improvements (CFHI) to implement the “INSPIRED” COPD (Chronic Obstructive Pulmonary Disease) System of Care in Selkirk. While patients have always felt very supported in hospitals this “system” teaches them how to help themselves and gives support resources in the community.

The strategy of change brought:

- Continuity of care from hospital to home transitions
- Individualized, coordinated, self-managed care
- Liaison and partnership building with community health-care support services

The stories from our patients are testament to the value of this program:

“A COPD patient who had been living with the disease for years was in hospital. She felt a lot of anxiety around self-management, and described how it felt to be at home, unable to breathe. The hospital respiratory therapist educated her on her disease, and gave her strategies to help herself. This also included an action plan that could be shared with her primary caregiver. Prior to discharge, she was provided with a folder of COPD education and community resources including the contact number of a chronic disease nurse who would be in contact post discharge. The patient felt a tremendous sense of relief and was very appreciative of having a system of care in place that addresses the many facets of COPD management. She indicated she hadn’t recognized there was more to managing COPD than taking prescriptions.”

Communicable Diseases: Sexually Transmitted Infections

Chlamydia Rates

Definition

The number of reported cases of chlamydia per 100,000 population.

Why is this indicator important?

Chlamydia is the most common bacterial sexually transmitted infection (STI). Symptoms usually begin two to six weeks after infection but are often overlooked. Left untreated, chlamydia can lead to painful health problems and infertility. It can also be transmitted from mother to child during childbirth. Timely access to health information, and early diagnoses and treatment, will help prevent many complications associated with this infection.

Provincial Key Findings

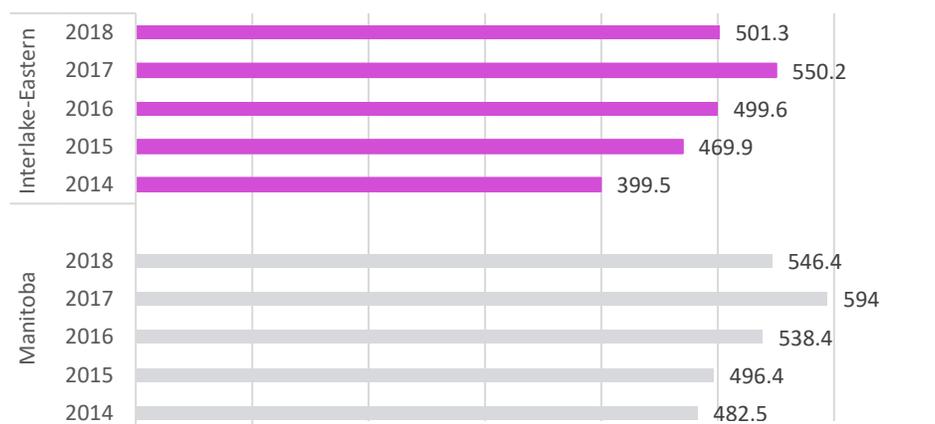
- In 2018, the crude rate of reported chlamydia infections in Manitoba were 546.4 cases per 100,000.

Regional Key Findings

- The number of reported chlamydia infections in 2018 for Interlake-Eastern was 501.3 cases per 100,000 population.
- Over the five-year reporting period, cases of chlamydia have increased by 25% in Interlake-Eastern.

Figure 3.41. Crude Rate of Reported Chlamydia Infections, 2014-2018

Rate per 100,000



Source: MHSAL EpiVIEW 2018

Gonorrhea Rates

Definition

The number of reported cases of gonorrhea per 100,000 population.

Why is this indicator important?

Gonorrhea, commonly referred to as the 'Clap', is on the rise in Canada and can cause very serious complications when left untreated. Gonorrhea can be cured with the right medication; however, it is becoming increasingly resistant to antibiotics. Gonorrhea can lead to pelvic inflammatory disease in women and infertility in both women and men. Understanding gonorrhea incidence helps to plan public awareness campaigns to promote safer sex and regular screening. Timely access to early diagnoses and treatment will prevent many complications associated with this infection.

Provincial Key Findings

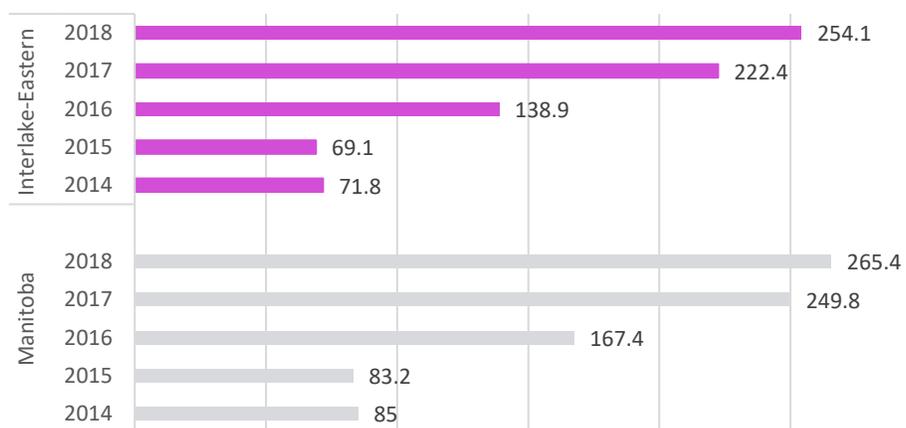
- In 2018, the crude rate of reported gonorrhea infections in Manitoba was 265.4 cases per 100,000 compared to 85 cases in 100,000 in 2014.
- This significant increase represents a 212% increase in gonorrhea infections over five years in Manitoba.

Regional Key Findings

- The number of reported gonorrhea infections in 2018 for Interlake-Eastern was 254.1 cases per 100,000 population.
- Over the five-year reporting period, cases of gonorrhea have increased by 253% in Interlake-Eastern, which is slightly higher than the provincial increase.

Figure 3.42. Crude Rate of Reported Gonorrhea Infections, 2014-2018

Rate Per 100,000



Source: MHSAL EpiVIEW 2018

HIV Rates

Definition

The rate of new HIV cases reported per 100,000 population.

Why is this indicator important?

HIV is a retro virus that attacks the immune system and can cause a number of serious health problems and opportunistic infections. It is most commonly transmitted through sexual activity and sharing of needles and drug equipment. Timely access to early diagnoses and treatment helps people with HIV live longer, healthier lives and reduces the risk of HIV transmission. HIV is a measure of equity because vulnerable populations and those living in poverty are disproportionately at risk. Understanding HIV incidence helps to plan public awareness campaigns to promote safer sex and drug use, and allocate resources to support appropriate access to testing and treatment.

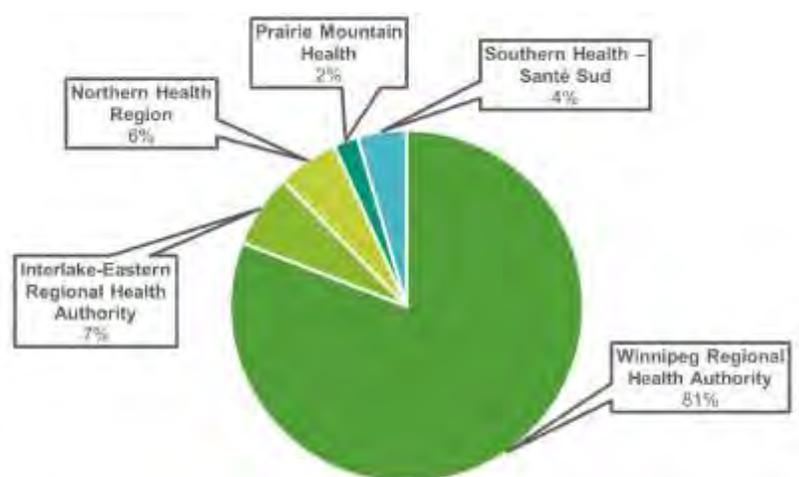
Provincial Key Findings

- There were 89 new positive HIV cases reported in 2017. This is a decrease of 20 cases compared to the 109 new HIV cases in 2016.
- The majority of new HIV cases reported reside in Winnipeg Regional Health Authority, with six or fewer infections arising in each of the other Regional Health Authorities.

Regional Key Findings

- In 2017, Interlake-Eastern residents made up 7% of the new HIV positive cases.

Figure 3.43. Proportion of new HIV cases in Manitoba by RHA, 2017



Source: Manitoba Health, 2017 Annual Statistical Update



To learn more about HIV in Manitoba visit: <https://www.gov.mb.ca/health/publichealth/surveillance/hiv aids/docs/dec2017.pdf>

To view all years HIV reports visit: <https://www.gov.mb.ca/health/publichealth/surveillance/hiv aids/index.html>

Syphilis Rates

Definition

The number of reported cases of syphilis per 100,000 population.

Why is this indicator important?

Syphilis is a bacterial infection, usually spread by sexual contact. It can have very serious complications if left untreated but it is simple to cure with the right treatment. Manitoba has seen clustered outbreaks of this infection in recent years. Timely access to health information, and early diagnoses and treatment, will help prevent many complications associated with this infection.

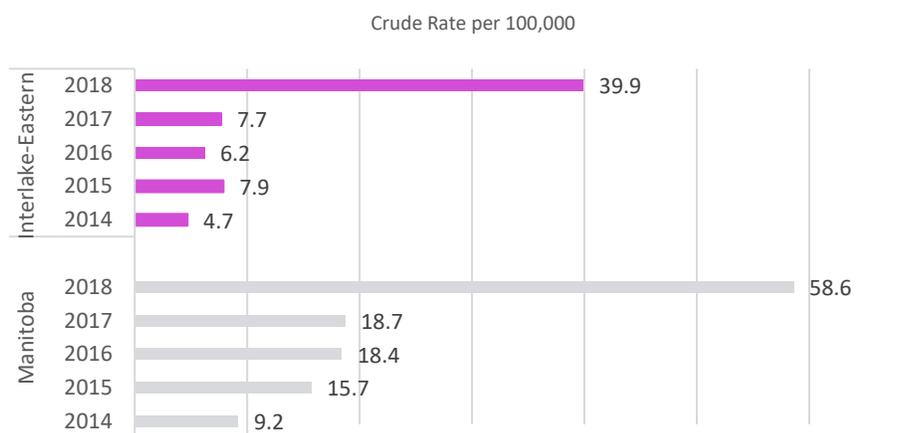
Provincial Key Findings

- In 2018, the crude rate of reported syphilis infections in Manitoba was 58.6 cases per 100,000 compared to only 9.2 cases in 100,000 in 2014.
- This significant increase represents a 537% increase in syphilis infections over five years in Manitoba.

Regional Key Findings

- The number of reported syphilis infections in 2018 for Interlake-Eastern was 39.9 cases per 100,000 population.
- Over the five-year reporting period, cases of syphilis have increased by 749% in Interlake-Eastern, which is higher than the provincial increasing rate.

Figure 3.44. Crude rate of reported Syphilis infections calendar years 2014 to 2018



Source: MHSAL EpiVIEW 2018

CLOSER LOOK... REACHING OUT

SEXUALLY TRANSMITTED BLOOD BORNE INFECTIONS (STBBI)

A large outbreak of syphilis continues in Manitoba with the case count for 2018 being the highest on record. As a result, instances of HIV/syphilis co-infections are also increasing. Testing is critical to reduce the risk of long-term health effects from sexually transmitted blood borne infections (STBBI) and to prevent their continued transmission. Since its early days, the public health program and its practitioners have been positioned to respond to public health threats by treating people where they are. For instance, public health nurses have long been visiting people's homes to ensure treatment of communicable diseases, such as tuberculosis. Public health nurses' mobility means they can go into the community and attend public events to offer information on STBBI and provide testing on-site.



Pictured: public health nurses Marcy Timchishen and Susan Stevenson at Arborg's rodeo.

CHAPTER 4:

HOW WELL DOES OUR HEALTH SYSTEM
MEET THE POPULATION'S NEEDS?



Table of Contents

CHAPTER 4: HOW WELL DOES OUR HEALTH SYSTEM MEET THE POPULATION’S NEEDS? _____	218
Tables and Figures _____	218
At A Glance: How Well Does Our Health System Meet the Population’s Needs? _____	220
Chapter 4 Key Findings _____	221
Primary Health Care _____	222
Physician Use _____	222
Use of Physicians and Nurse Practitioners _____	222
Ambulatory Visits to Physicians and Nurse Practitioners _____	224
Location Visits to Physicians or Nurse Practitioner _____	227
Ambulatory Consultation _____	228
Majority of Care—Continuity _____	230
Ambulatory Care Sensitive Conditions (ACSC) Hospitalization Rates _____	232
Benzodiazepine Overprescribing Community-Dwelling Older Adults (75+) _____	234
Access to a Regular Health Care Provider _____	237
Type of Place for Minor Health Problem (Primary Care) _____	238
Reasons for No Regular Health Care Provider _____	240
Wait Time for Minor Health Problem _____	242
Coordination Between Health Professionals and Other Providers _____	243
Acute Care _____	245
Use of Hospitals _____	245
Inpatient Hospitalization Rate _____	247
Hospital Days for Acute Care _____	250
Where Residents Were Hospitalized: Hospital Location _____	253
Hospital Days for Alternate Level of Care Stays _____	254
Hospital Catchment: Where Patients Using RHA Hospitals Came From _____	256
Hospital Readmission Rates _____	257
Caesarean Section _____	259
Vaginal Birth after Caesarean Section (VBAC) _____	261
Canadian Patient Experience Survey—Inpatient Care _____	263
Home Care _____	266

Home Care Regional Prevalence _____	266
Duration of Care: How Long On Average People Receive Health Care Aid/Home Support Worker Services _____	268
Wait Time from Intake to First Visit _____	269
Personal Care Homes _____	270
Residents in Personal Care Homes _____	270
Level of Care on Admission to Personal Care Homes _____	272
Median Wait Times for Personal Care Home Admission _____	273
Benzodiazepine overprescribing—Personal Care Homes (75+) _____	276

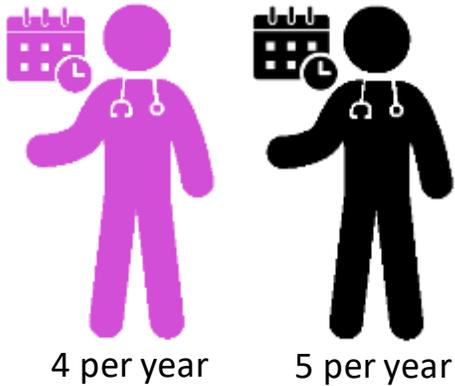
Tables and Figures

Figure 4.1. Use of Physicians by RHA, 2011/12 (T1) and 2016/17 (T2)	222
Table 4.1. Use of Physicians by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2).....	223
Figure 4.2. Ambulatory Visit Rate by RHA, 2011/12 (T1) and 2016/17 (T2).....	224
Table 4.2. Physician Visits (Ambulatory) by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2).....	225
Table 4.3. Most Frequent Causes for Physician (Ambulatory) Visits by IERHA, 2011/12 (T1) and 2016/17 (T2) .	226
Figure 4.3. Location of Visits to Family Practitioners and Nurse Practitioners by RHA, 2011/12 (T1) and 2016/17 (T2).....	227
Figure 4.4. Percentage of Ambulatory Consultation by RHA, 2011/12 (T1) and 2016/17 (T2)	228
Table 4.4. Ambulatory Consultation Rate by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2).....	229
Figure 4.5. Majority of Care by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)	230
Table 4.5. Majority of Care—Continuity by IERHA Zone Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2).....	231
Figure 4.6. Hospitalization Rate Ambulatory Care Sensitive Conditions by RHA, 2011/12 (T1) and 2016/17 (T2).....	232
Table 4.6. ACSC Hospitalization Rates by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)	233
Figure 4.7. Benzodiazepine Prescribing for Community-Dwelling Older Adults by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	234
Table 4.7. Benzodiazepine Overprescribing – Community (75+) by IERHA Zone Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	235
Figure 4.8. Access to a Regular Health Care Provider by RHA, CCHS 2015-2016	237
Figure 4.9. Type of Place for Minor Health Problem by RHA, CCHS 2015-2016	239
Figure 4.10. Reasons for No Regular Health Care Provider by RHA, CCHS 2015-2016	241
Figure 4.11. Wait Time for Minor Health Problem by RHA, CCHS 2015-2016.....	242
Figure 4.12. Coordination between health care providers reported as 'Excellent/Very Good'	243
Table 4.8 IERHA Annual CTAS, 2016-2019	244
Figure 4.13. Use of Hospitals by RHA, 2011/12 (T1) and 2016/17 (T2)	245
Table 4.9. Use of Hospitals by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)	246
Figure 4.14. Inpatient Hospitalization by RHA, 2011/12 (T1) and 2016/17 (T2)	247
Table 4.10. Inpatient Hospitalization Rate by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)..	248
Table 4.11. Most Frequent Causes of Hospitalizations, 2007-2011 (T1) & 2012-2016 (T2)	249
Figure 4.15. Hospital Days for Acute Stays (Excluding Newborns) by RHA, 2011/12 (T1) and 2016/17 (T2)	250
Table 4.12. Hospital Days for Acute Care (Excluding Newborns) by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)	251
Table 4.13. Most Frequent Causes of Hospital Days, 2007-2011 (T1) & 2012-2016 (T2)	252
Figure 4.16. Hospital Location: Where Residents Went for Hospitalization, by RHA, 2011/12 (T1) and 2016/17 (T2).....	253

Figure 4.17. Hospital Days for ALC Stays (Excluding Newborns) by RHA, 2011/12 (T1) and 2016/17 (T2).....	254
Table 4.14. Hospital Days—Hospital Days for Alternate Level of Care Stays (Excluding Newborns) by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)	255
Figure 4.18. Hospital Catchment: Where Patients Using RHA Hospitals Came From, 2011/12 and 2016/17	256
Figure 4.19. Hospital Readmission by RHA, 2011/12 (T1) and 2016/17 (T2)	257
Table 4.15. Hospital Readmission Rates (Unplanned) by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)	258
Figure 4.20. Caesarean Section Rate by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)	259
Table 4.16. Caesarean Section by IERHA Zone & District Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)	260
Figure 4.21. Vaginal Birth After Prior Caesarean Section by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	261
Table 4.17. Vaginal Birth After Caesarian Section by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)	262
Figure 4.22. Overall hospital experience, Manitoba and IERHA, 2017-18.....	263
Figure 4.23. Canadian Patient Experience Survey—Inpatient Care by IERHA Findings, 2017-18	264
Table 4.18. Bed Occupancy Data by Facility, 2018-19 and 2017-18	265
Table 4.19. Overall Home Care Prevalence 2013/14-2014/15	266
Figure 4.24. Home Care Prevalence by IERHA, 2013-14-2014-15	267
Figure 4.25. Episode length (Number of Days) for HCA/HSW by Health Region, 2013/14-2014/15.....	268
Figure 4.26. Residents in Personal Care Homes by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2).....	270
Table 4.20 Residents in Personal Care Homes by IERHA Zone Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)	271
Figure 4.27. Level of Care on Admission to PCH for Residents Age 75+ by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)	272
Figure 4.28. Median Waiting Times for Personal Care Home Admission from Hospital by RHA, 2010/11-2011/12 and 2015/16-2016/17	273
Figure 4.29. Median Waiting Times for Personal Care Home Admission from the Community by RHA, 2010/11-2011/12 and 2015/16-2016/17	274
Table 4.21. Median Wait Times for Personal Care Home Admission by IERHA Zone Findings, 2010/11-2011/12 and 2015/16-2016/17	275
Figure 4.30. Crude Proportion of PCH older adults with Inappropriate Benzodiazepine Rx by RHA.....	276
Table 4.22. Benzodiazepine overprescribing—Personal Care Homes (75+) by IERHA Zone Findings.....	277

At A Glance: How Well Does Our Health System Meet the Population's Needs?

Physician Visits



Wait Time for Minor Health Care Problem



2-3 Days



Same Day

Percent of Residents Admitted into Hospital



6.2%



5.8%

Alternate Level of Care (ALC) Days per 1,000 Population



164.6



191.7



● Interlake-Eastern
● Manitoba

Chapter 4 Key Findings

Primary Health Care:

- Interlake-Eastern residents are more likely to travel further from home to see a physician/nurse practitioner
- 75% of residents have had the majority of the care from the same provider
- Decrease in patients hospitalized for ambulatory care sensitive conditions

Personal Care Home:

- Decrease in the percentage of residents aged 75+ in personal care homes
- Significantly longer wait times in hospital and community for personal care home (PCH) admission in Interlake-Eastern

Home Care:

- Over 4,300 residents received home care services
- Average duration for home care services totals 709 days

Acute Care:

- Decrease in inpatient hospitalizations over time
- Pregnancy and birth is the leading reason for hospitalization but circulatory diseases make up the largest percentage of hospital days
- Over 50% of residents hospitalized in Winnipeg hospitals
- West Zone experienced a significant increase in alternate level of care (ALC) days



Primary Health Care

Physician Use

Use of Physicians and Nurse Practitioners

Definition

The percent of residents who received at least one ambulatory visit in a fiscal year. Ambulatory visits include all contact with physicians and nurse practitioners (NP), except during inpatient hospitalization and emergency department visits.

Why is this indicator important?

Regular examinations and consultations are important to help identify risk factors and problems before they become serious. When conditions are identified early, treatments are usually much more effective. Understanding how many people see a physician or nurse practitioner may help to identify access barriers to services and reflects the effectiveness of the primary care system.

Provincial Key Findings

- In 2016/17, 78.7% of Manitoba residents saw a physician at least once.
- The proportion of Manitobans with at least one physician visit in a year slightly decreased over time, but the change was not statistically significant. This trend was observed across all regions.
- Residents in Northern RHA had significantly lower rate than the provincial average in both time periods. However, it is because many residents receive their primary care from nurses in local nursing station. These visit records are not captured in the medical claim data system.

Figure 4.1. Use of Physicians by RHA, 2011/12 (T1) and 2016/17 (T2)



adjusted percent of residents with at least one ambulatory visit per year (to any physician)

H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA		SH-SS		IERHA		PMH		MB		WRHA	
T2 COUNT	47,460		149,798		101,307		135,770		1,072,087		636,040	
T2 PERCENT	65.9%	L	77.2%		78.1%		78.6%		78.7%		81.4%	
T1 PERCENT	68.8%	L	77.6%		80.2%		80.3%		79.9%		81.7%	

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- A total of 78.1% of Interlake-Eastern residents had at least one visit with a physician or NP over a one-year time period.
- West and North zones both experienced a significant decrease in visits while the other zones remained stable.
- Northern Remote residents had the lowest visit rates, with 60.3% of residents having at least one visit to a physician or NP. Limitation of data sources linked with nursing stations may be a contributing factor to lower physician and NP visits within the district.
- The district disparity for physician and nurse practitioner visits has remained stable over time. The ratio suggests that regardless where residents live within Interlake-Eastern there appears to be minimal difference in the use of physicians and NPs.

Table 4.1. Use of Physicians by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1	
	Count	Percent	Percent	
Manitoba	1,072,087	78.7%	79.9%	

	T2		T1	
	Count	Percent	Percent	
IERHA	101,307	78.1%	80.2%	

South Zone	48,333	80.7%	80.4%	
Stonewall/Teulon	15,688	80.2%	81.7%	
Wpg Beach/St. Andrews	13,706	79.9%	79.4%	
Springfield	11,851	79.4%	77.3%	
St. Clements	7,088	79.1%	76.0%	

North Zone	14,184	72.7%	-	79.5%	
Powerview/Pine Falls	4,851	77.8%	-	85.2%	
Eriksdale/Ashern	4,828	74.3%		77.9%	
Fisher/Peguis	4,505	64.9%	L-	73.5%	

East Zone	16,812	77.1%	79.3%	
Pinawa/Lac du Bonnet	6,787	79.1%	80.2%	
Beausejour	7,392	77.1%	78.6%	
Whiteshell	2,633	71.3%	L	74.3%

Northern Remote	2,145	60.3%	L	60.9%	L
Northern Remote	2,145	60.3%	L	60.9%	L

West Zone	11,278	71.0%	L-	76.8%	
Gimli	5,153	79.1%		79.9%	
St. Laurent	3,192	73.9%		75.9%	
Arborg/Riverton	2,933	57.8%	L-	72.1%	L

Selkirk Zone	8,555	80.9%	82.3%	
Selkirk	8,555	80.9%	82.3%	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	1.4
	T2 Disparity	1.4
	Change	0
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Ambulatory Visits to Physicians and Nurse Practitioners

Definition

The average number of visits to physicians and nurse practitioners (NP) per resident in a given year. Ambulatory visits include all contact with physicians and nurse practitioners: office visits, walk-in clinics, home visits, personal care home visits, visits to outpatient departments and prenatal visits. Exclusions include inpatient hospitalization and emergency department visits.

Why is this indicator important?

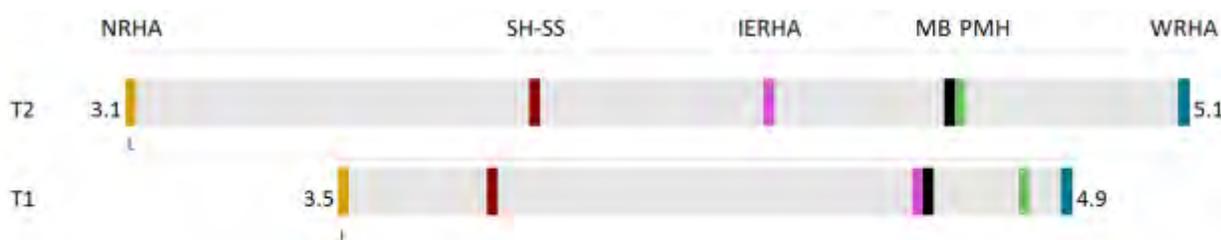
Ambulatory visit rates may reveal issues related to access to primary care, and how well the health-care system manages ongoing care for patients outside the hospital setting, especially for individuals living with a chronic condition(s). This measure provides insight into whether a region is moving towards a primary care centered model that focuses on appropriate resources and supports in the community and reduces unnecessary hospitalizations.

Provincial Key Findings

- There was an average of five visits to physicians per Manitoba resident in 2016/17. The rate remained stable over time.
- Winnipeg RHA and Southern Health-Santé Sud experienced small rate increases while other RHAs had small decreases but none of the changes were significant.
- The most frequent causes for ambulatory visits in 2016/17 were: circulatory (10.05%), health status and contact (9.52%), respiratory (9.44%), mental illness (9.38%), and musculoskeletal (8.70%).
- The most frequent causes varied across the regions.

Figure 4.2. Ambulatory Visit Rate by RHA, 2011/12 (T1) and 2016/17 (T2)

Age and sex adjusted rate of ambulatory visits to all physicians per resident



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA	SH-SS	IERHA	MB	PMH	WRHA
T2 COUNT	208,501	747,581	573,982	6,299,699	821,641	3,936,761
T2 RATE	3.1 L	3.9	4.3	4.6	4.6	5.1
T1 RATE	3.5 L	3.8	4.6	4.6	4.8	4.9

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- In 2016/17, Interlake-Eastern residents visited a physician or NP on average 4.3 times per year, which is down slightly from 4.6 in 2011/12.
- West Zone averages 3.7 visits and Northern Remote averages 2.7 visits, which are both significantly lower than the provincial average of 4.6.
- The North Zone saw a significant decrease in visits over time from an average of five visits per year down to 3.8 visits.
- Residents living in Selkirk are twice as likely to visit a doctor or NP than residents living in Arborg/Riverton.
- The most frequent causes for physician visits has remained stable over time, with circulatory system making up the largest percentage of visits at 12.0% (Table 4.2.).

Table 4.2. Physician Visits (Ambulatory) by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1		
	Count	Rate	Rate		
Manitoba	6,299,699	4.6	4.6		
IERHA	573,982	4.3	4.6		
South Zone	271,375	4.6	4.5		
Stonewall/Teulon	87,583	4.6	5.0		
Springfield	65,603	4.5	3.9		
St. Clements	40,332	4.5	4.0		
Wpg Beach/St. Andrews	77,857	4.4	4.3		
North Zone	75,137	3.8	5.0		
Powerview/Pine Falls	28,589	4.6	6.6	-	H
Eriksdale/Ashern	26,796	4.1	4.7		
Fisher/Peguis	19,752	2.9	3.8	L-	
East Zone	100,397	4.5	4.8		
Beausejour	42,908	4.7	5.1		
Pinawa/Lac du Bonnet	42,400	4.5	4.8		
Whiteshell	15,089	4.1	4.2		
West Zone	65,118	3.7	4.3	L	
Gimli	34,649	4.7	5.0		
St. Laurent	18,110	3.9	4.1		
Arborg/Riverton	12,359	2.3	3.7	L-	
Selkirk Zone	54,007	4.9	5.0		
Selkirk	54,007	4.9	5.0		
IERHA DISTRICT DISPARITY RATIO					
		T1 Disparity	2.3		
		T2 Disparity	2.1		
		Change	-0.2↓		
Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.					

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Table 4.3. Most Frequent Causes for Physician (Ambulatory) Visits by IERHA, 2011/12 (T1) and 2016/17 (T2)

	T2		T1
	Count	Percentage	Percentage
Circulatory	69,243	12.0%	10.8%
Musculoskeletal	55,292	9.6%	10.2%
Health Status and Contact	52,168	9.1%	9.2%
Mental Illness	48,560	8.4%	8.0%
Respiratory	45,755	7.8%	9.0%

Source: MCHP RHA Indicators Atlas 2019

Location Visits to Physicians or Nurse Practitioner

Definition

The percent of visits by residents of each RHA to general or family physicians or nurse practitioners (NP): within the patient’s RHA district; elsewhere in their RHA; in another RHA or in Winnipeg.

Why is this indicator important?

Where residents access primary care provides valuable insight regarding challenges related to availability and accessibility of services, which helps to plan and allocate resources appropriately.

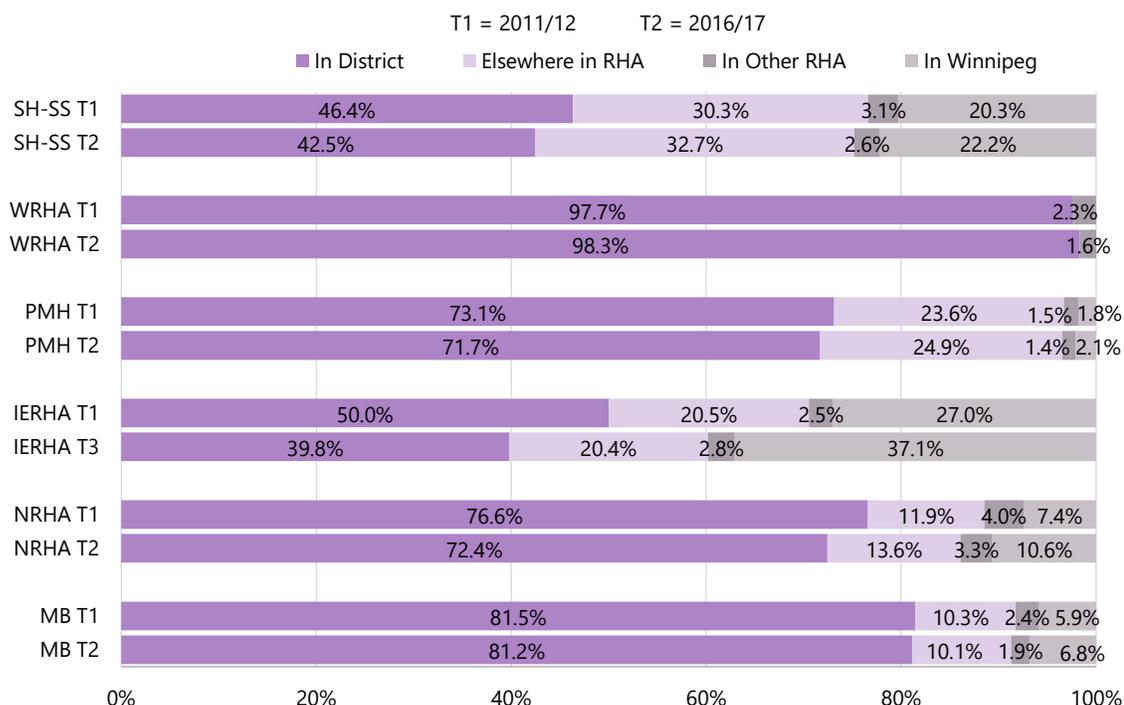
Provincial Key Findings

- The location of visits to GPs in Manitoba was stable over time. More than 80% of all visits to GPs occurred in the district where the resident lived.
- In 2016/17, the location of visits to GPs varied dramatically across all RHAs. Over 98% of WRHA residents’ GP visits were within their WRHA district while residents in Southern Health-Santé Sud and Interlake–Eastern RHA were more likely to travel to visit a GP as fewer than 50% of their visits were within their district in their RHA and a large portion of visits occurred in Winnipeg.

Regional Key Findings

- In 2016/17, 60% of Interlake-Eastern residents visited a physician or NP within the region, which is down slightly from 70% in 2011/12.
- Compared to all other RHAs, Interlake-Eastern residents are most likely to visit a provider in Winnipeg.

Figure 4.3. Location of Visits to Family Practitioners and Nurse Practitioners by RHA, 2011/12 (T1) and 2016/17 (T2)



Source: MCHP RHA Indicators Atlas 2019

Ambulatory Consultation

Definition

The percentage of ambulatory consultations in a given year. These consults occur when a physician, nurse, or other allied health professional refer a patient to another physician (usually a specialist or surgeon) or nurse practitioner

Why is this indicator important?

Health professionals will often refer patients to another provider due to the complexity, obscurity, or seriousness of a condition. Patients may also request a second opinion. This indicator yields important information about initial access to specialist care, which is particularly important in rural areas where patients use specialist services less frequently due to access issues.

Provincial Key Findings

- Ambulatory consultation rate remained stable over time. This trend was also observed across all regions.
- The rates in Winnipeg RHA were significantly higher than the provincial average in both time periods, while rates in Northern RHA and PMH were significantly lower.

Figure 4.4. Percentage of Ambulatory Consultation by RHA, 2011/12 (T1) and 2016/17 (T2)

Age and sex adjusted percent of consults (first referral)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA	PMH	SH-SS	MB	IERHA	WRHA
T2 COUNT	15,537	44,304	52,645	402,497	40,948	248,592
T2 PERCENT	24.2% L	24.8% L	27.5%	29.0%	29.6%	31.8% H
T1 PERCENT	24.9% L	23.6% L	26.2% L	28.7%	28.4%	31.6% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- In 2016/2017, nearly 30% of all residents within Interlake-Eastern received a referral to another provider, which totaled 40,948 individuals.
- Both the South Zone and East Zone experienced statistically significant increases in consults over time while the North Zone saw a decrease from 30% to 26.3%.
- Residents in Springfield are 1.5 times more likely to receive an ambulatory consult than residents in Eriksdale/Ashern. Over time, disparity has remained relatively stable for ambulatory consultations.

Table 4.4. Ambulatory Consultation Rate by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1		
	Count	Percent	Percent		
Manitoba	402,497	29.1%	28.7%		
IERHA	40,948	29.6%	28.5%		
South Zone	19,895	32.4%	H+	30.4%	
Springfield	4,991	33.1%		31.7%	
Wpg Beach/St. Andrews	5,997	32.8%		30.5%	
St. Clements	3,080	32.4%		27.5%	
Stonewall/Teulon	5,827	29.0%		28.3%	
North Zone	4,825	26.3%	L-	30.0%	
Powerview/ Pine Falls	1,716	29.3%		31.9%	
Fisher/Peguis	1,689	25.8%	-	31.6%	
Eriksdale/Ashern	1,420	22.5%	L	24.4%	
East Zone	7,358	31.4%	+	27.1%	
Beausejour	3,108	31.2%		26.3%	
Pinawa/Lac du Bonnet	3,161	30.7%		27.2%	
Whiteshell	1,089	27.0%		22.8%	
West Zone	4,693	27.7%		25.9%	L
Gimli	2,257	29.4%		26.6%	
St. Laurent	1,200	25.5%		25.2%	
Arborg/Riverton	1,236	24.5%		23.5%	
Selkirk Zone	3,436	30.7%		31.2%	
Selkirk	3,436	30.7%		31.2%	

IERHA DISTRICT DISPARITY RATIO				
	T1 Disparity	1.4		
	T2 Disparity	1.5		
	Change	0.1↑		
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>				

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Majority of Care—Continuity

Definition

The percent of residents who received at least 50% of their ambulatory visits from the same physician (general practitioner, family practitioner, pediatrician or internal medicine specialist) or nurse practitioner over a two-year time period.

Why is this indicator important?

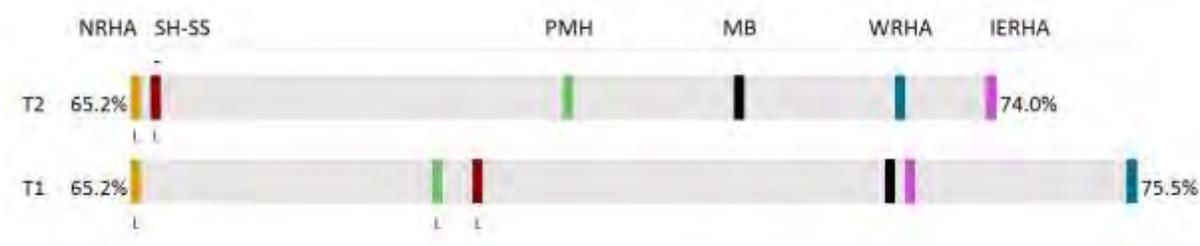
Continuity of care allows for a stronger patient-health-care provider relationship and correlates with better health outcomes, improved patient satisfaction, and fewer hospitalizations.

Provincial Key Findings

- The proportion of Manitoba residents receiving more than 50% of their visits from the same primary physician decreased slightly from 73.0% to 71.5% but not significantly. The only statistically significant decrease was in Southern RHA.
- Northern and Southern Health-Santé Sud RHAs had significantly lower rates than the provincial average in both time periods.

Figure 4.5. Majority of Care by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

Age and sex adjusted percent of residents with more than 50% of their visits from the same physician (among those with 3+ visits)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA		SH-SS		PMH		MB		WRHA		IERHA	
T2 COUNT	23,297		81,909		86,156		668,305		409,578		66,321	
T2 PERCENT	65.2%	L	65.5%	L-	69.7%		71.5%		73.1%		74.0%	
T1 PERCENT	65.2%	L	68.8%	L	68.4%	L	73.0%		75.5%		73.2%	

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- About three out of four Interlake-Eastern residents have received the majority of care from the same provider over a two-year time period.
- Residents residing in South, West and Selkirk zones have significantly higher rates of majority of care compared to the Manitoba average of 71.5%.
- At the district level there is wide variability in majority of care, for instance, 84.9% of residents in Arborg/Riverton received at least 50% of their visits from the same provider compared to 40% of residents in Fisher/Peguis.
- There is disparity between districts for majority of care and over time the disparity has remained stable.

Table 4.5. Majority of Care—Continuity by IERHA Zone Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

	T2		T1	
	Count	Percent	Percent	
Manitoba	668,305	71.5%	73.0%	

	T2		T1	
	Count	Percent	Percent	
IERHA	66,321	74.0%	73.2%	

South Zone	32,795	76.9%	H	78.9%	H
Springfield	8,266	79.5%	H-	83.7%	H
Wpg Beach/St. Andrews	9,538	78.8%	H	81.2%	H
St. Clements	4,900	78.1%	H	79.8%	H
Stonewall/Teulon	10,091	72.4%		73.4%	

North Zone	7,320	59.7%	L+	54.6%	L
Eriksdale/Ashern	3,024	70.4%		68.1%	L
Powerview/Pine Falls	2,813	63.9%	L+	51.3%	L
Fisher/Peguis	1,483	40.0%	L	40.0%	L

East Zone	11,602	74.9%		73.0%	
Beausejour	5,188	78.0%	H-	85.5%	H
Whiteshell	1,736	70.9%		59.1%	L
Pinawa/Lac du Bonnet	4,678	70.8%	+	64.1%	L

West Zone	7,752	80.8%	H	79.8%	H
Arborg/Riverton	1,676	84.9%	H+	76.5%	
Gimli	3,866	79.3%	H	82.7%	H
St. Laurent	2,210	75.6%		76.7%	

Selkirk Zone	6,115	78.1%	H	78.8%	H
Selkirk	6,115	78.1%	H	78.8%	H

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	2.1	
	T2 Disparity	2.1	
	Change	0	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Ambulatory Care Sensitive Conditions (ACSC) Hospitalization Rates

Definition

The annual hospitalization rate per 1,000 population, aged 0 to 74 years, for ambulatory care sensitive conditions (ACSC) which include a group of 25 diseases and diagnoses (e.g., asthma, angina, gastroenteritis, congestive heart failure) for which primary health care may be more appropriate than hospital care.

Why is this indicator important?

Lower rates reflect better access to good quality primary health care. Appropriate management and control of ACS conditions in the community could potentially reduce the need for hospitalization and improve quality of life, improve efficiency in resource utilization, and reduce health spending for chronic conditions.

Provincial Key Findings

- The rate of hospitalization for ACSC in Manitoba decreased over time from 7.0 to 6.1 hospitalizations per 1,000 residents (0-74 years of age).
- Three regions (Southern Health-Santé Sud, Interlake-Eastern, and Prairie Mountain Health) showed significant decreases over time.
- Income: The lowest income residents' hospitalization rate for ambulatory care sensitive conditions was 3.7 times higher than that of highest income residents.



Figure 4.6. Hospitalization Rate Ambulatory Care Sensitive Conditions by RHA, 2011/12 (T1) and 2016/17 (T2)
Age- and sex-adjusted per 1,000 residents aged 0-74



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA		SH-SS		IERHA		MB		PMH		NRHA	
T2 COUNT	3,467		1,010		861		8,023		1,522		995	
T2 RATE	4.5	L	5.2	-	5.7	-	6.1		8.5	H-	14.9	H
T1 RATE	4.5	L	6.6		7.7		7.0		11.4	H	15.7	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- In 2016/17, a total of 861 residents were hospitalized for ACSC, at a rate of 5.7 per 1,000 residents (0-74 years of age), which is significantly lower than 2011/12.
- The North Zone although significantly higher than the Manitoba average, has decreased over time from 18.7 to 12.4 hospitalizations per 1,000 for ACSC.
- District level findings show that the wide variability of hospitalizations from ACSC, with the lowest rates in Springfield (2.4) and the highest rates in Northern Remote (17.5), which means that residents in Northern Remote are seven times more likely to be hospitalized for ACSC.
- Therefore, some residents are much more likely to experience a hospitalization for ACSC compared to others and over time there has been relatively minimal narrowing in disparity.

Table 4.6. ACSC Hospitalization Rates by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1		
	Count	Rate		Rate	
Manitoba	8,023	6.1		7.0	

	T2		T1		
	Count	Rate		Rate	
IERHA	861	5.7	-	7.7	

South Zone	259	3.5	L	4.1	L
Springfield	40	2.5	L	2.6	L
Wpg Beach/St. Andrews	62	2.7	L	3.3	L
Stonewall/Teulon	106	4.3		5.8	
St. Clements	51	4.7		4.7	

North Zone	254	12.4	H-	18.7	H
Powerview/Pine Falls	61	9.5	-	19.9	H
Eriksdale/Ashern	88	14.6	H	20.6	H
Fisher/Peguis	105	15.7	H	17.6	H

East Zone	117	4.4	-	7.0	
Pinawa/Lac du Bonnet	45	4.0	-	8.0	
Whiteshell	21	4.5		4.6	
Beausejour	51	4.9		6.8	

Northern Remote	51	17.5	H	16.4	H
Northern Remote	51	17.5	H	16.4	H

West Zone	113	5.9		7.2	
Gimli	41	4.5		5.6	
St. Laurent	31	5.6		9.2	
Arborg/Riverton	41	7.6		6.6	

Selkirk Zone	67	5.4		6.9	
Selkirk	67	5.4		6.9	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	8.1
	T2 Disparity	7.4
	Change	0.7 ↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Benzodiazepine Overprescribing Community-Dwelling Older Adults (75+)

Definition

The percent of residents, aged 75 years and older, living in the community (excluding those who live in a personal care home) who had at least two prescriptions for benzodiazepines, or at least one prescription for benzodiazepine dispensed with more than a 30-day supply.

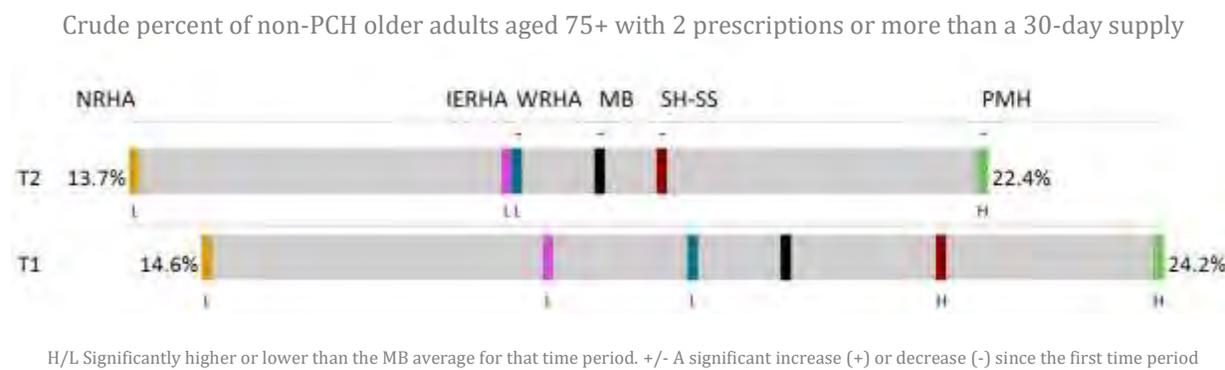
Why is this indicator important?

Benzodiazepines are medications widely used to treat seizures, anxiety and insomnia. Use by older adults is not recommended as it poses serious safety concerns including increased risk for confusion, memory loss, poor coordination, and muscle control potentially leading to falls and fractures.

Provincial Key Findings

- In 2012/13-2016/17, there were 30,430 community dwelling older adults aged 75+ who had used benzodiazepines.
- The proportion of community-dwelling older adults aged 75+ using benzodiazepines significantly decreased over time, from 20.4% to 18.5%.
- In both time periods, the proportion of community-dwelling older adults aged 75+ using benzodiazepines in Prairie Mountain Health was higher than the provincial average; while other regions were lower (with the exception of Southern Health-Santé Sud).

Figure 4.7. Benzodiazepine Prescribing for Community-Dwelling Older Adults by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)



	NRHA		IERHA		WRHA		MB		SH-SS		PMH	
T2 COUNT	467		2,933		17,052		30,430		4,034		5,895	
T2 PERCENT	13.7%	L	17.6%	L	17.6%	L-	18.5%	-	19.2%	-	22.4%	H-
T1 PERCENT	14.6%	L	18.0%	L	19.5%	L	20.4%		22.0%	H	24.2%	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- The rates of community dwelling older adults aged 75+ who had used benzodiazepines in Interlake-Eastern is significantly lower than the provincial average.
- At the zone level, the South (15.9%) had the lowest percentage of older adults using benzodiazepines and Selkirk (22.3%) had the highest.
- Selkirk residents are nearly twice as likely to be prescribed a benzodiazepine than residents in Powerview/Pine Falls. Over time, the district disparity has remained stable as shown below in Table 4.7.

Table 4.7. Benzodiazepine Overprescribing – Community (75+) by IERHA Zone Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2		T1	
	Count	Percent		Percent
Manitoba	30,430	18.5%	-	20.4%

	T2		T1	
	Count	Percent		Percent
IERHA	2,933	17.6%	L	18.0%

South Zone	1,006	15.9%	L	16.6%	L
St. Clements	122	14.4%		15.8%	
Wpg Beach/St. Andrews	267	14.6%	L	15.1%	L
Springfield	195	15.2%		13.8%	L
Stonewall/Teulon	422	17.7%		19.3%	

North Zone	326	16.3%		17.8%	
Powerview/Pine Falls	75	11.9%	L-	16.0%	
Eriksdale/Ashern	158	18.3%		17.8%	
Fisher/Peguis	93	18.5%		20.2%	

East Zone	614	17.4%		17.1%	L
Whiteshell	70	15.7%		18.2%	
Beausejour	219	16.7%	+	12.4%	L
Pinawa/Lac du Bonnet	325	18.3%		20.8%	

Northern Remote	s			s	
Northern Remote	s			s	

West Zone	561	19.7%		19.5%	
Arborg/Riverton	120	17.7%		21.6%	
St. Laurent	136	20.1%		20.1%	
Gimli	305	20.5%		18.3%	

Selkirk Zone	423	22.3%	H	22.9%	
Selkirk	423	22.3%	H	22.9%	

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	1.8
	T2 Disparity	1.9
	Change	0.1 ↑
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

CLOSER LOOK... PRIMARY HEALTH CARE EXPERIENCE SURVEY

During Fall 2018, all 16 regional primary care home clinics in Interlake-Eastern were provided with a survey to distribute to patients. The survey was designed to help gather feedback from all regional sites, focusing on the areas of: access/wait times, team collaboration, visit quality and experience, and dignity and respect. 682 patients completed surveys, with the average response rate of 86% per clinic.

Key Findings:

ACCESS AND WAIT TIME: “Was today your first choice to see your health care provider?”

93% of respondents stated either “yes, today was my first choice” or “the day did not matter”

VISIT QUALITY AND EXPERIENCE: “Does your healthcare provider spend enough time with you?”

80% of respondents selected “yes, definitely”

DIGNITY AND RESPECT: “Does your healthcare provider involve you in decisions about your care as much as you wanted?”

81% of respondents selected “yes, definitely”

TEAM COLLABORATION: Were you able to see the health-care provider you wanted?

92% answered “yes”

Access to a Regular Health Care Provider

Definition

The percent of Manitobans, aged 12 and older, participating in the Canadian Community Health Survey over a two-year time period, who reported that they have access to a regular health care provider.

Why is this indicator important?

A regular health care provider can offer preventive care, healthy lifestyle choices, treatment for common medical conditions, and referrals to specialists when needed. Having a regular primary care provider can help improve lives and save money on hospital admissions, emergency room visits, and surgeries.

Provincial Key Findings

- Approximately four out of five Manitobans reported having access to a regular health care provider.
- Access to a regular health care provider is found to be consistent between RHAs, with the exception of Northern RHA which is significantly lower than the provincial average.

Regional Key Findings

- In 2015-2016, nearly 85% of residents in Interlake-Eastern reported they have access to a regular health care provider.

Figure 4.8. Access to a Regular Health Care Provider by RHA, CCHS 2015-2016

Age and sex adjusted rate



H/L Significantly higher or lower than the MB average.

	NRHA		MB		WRHA		SH-SS		IERHA		PMH	
T1 RATE	66.6%	L	83.2%		83.4%		83.6%		84.8%		85.8%	

Source: CCHS 2015-2016

Type of Place for Minor Health Problem (Primary Care)

Definition

The percentage of Manitobans, aged 12 and older, participating in the Canadian Community Health Survey over a two-year time period, who reported the type of place they usually went for a minor health problem, such as doctor's office, walk-in clinic or emergency department.

Why is this indicator important?

Many minor health problems can be treated through self-care or over the counter medicines from a pharmacist. Accurate understanding of where residents seek medical care for minor health problems better informs the region of the accessibility of primary care services and education required to ensure optimal use of health-care resources.

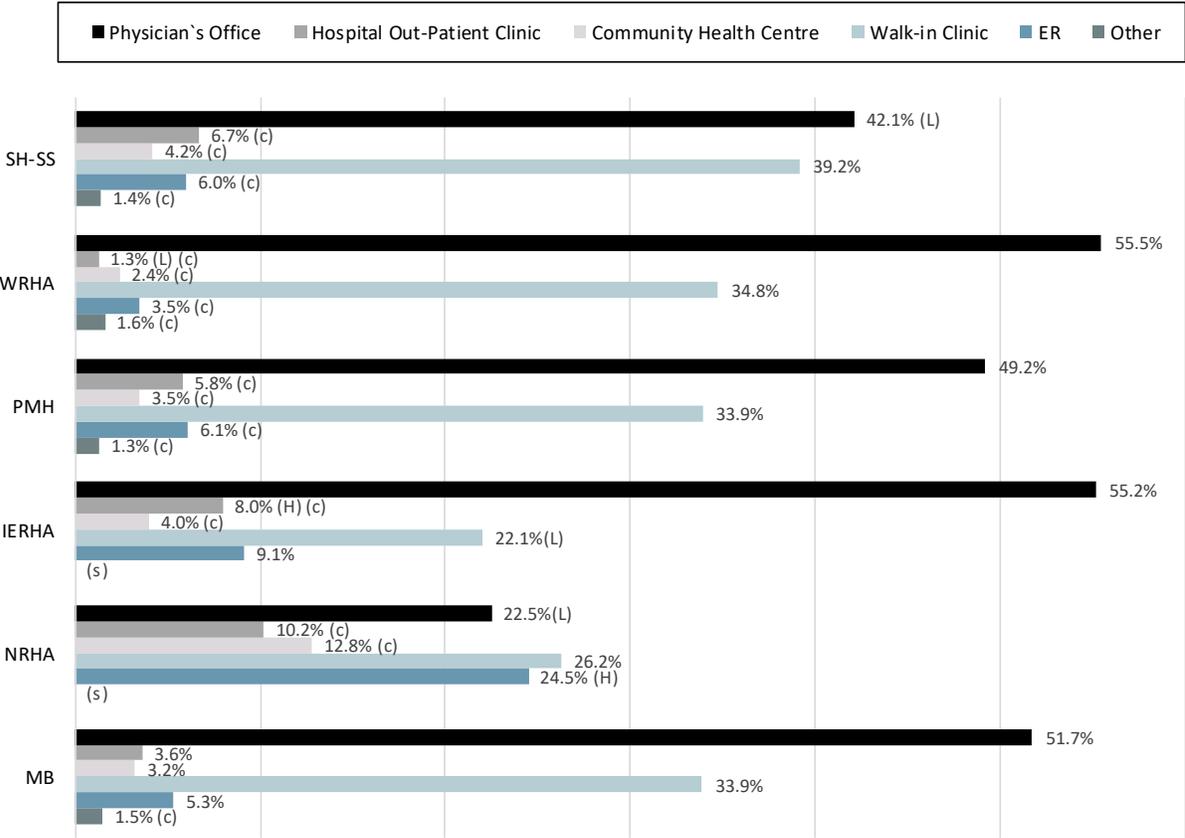
Provincial Key Findings

- In 2015-16, the most commonly reported places Manitoba residents went for a minor health problem were the physician's office followed by walk-in clinic.
- Northern RHA has a significantly higher percentage of residents visiting the ER for minor health problems compared to other RHAs.

Regional Key Findings

- The most common place Interlake-Eastern residents visit for a minor health care problem is the physician's office (55.2%).
- Compared to Manitoba data, residents in Interlake-Eastern are less likely to get care from a walk-in clinic and are more likely to visit an ER or out-patient clinic.

Figure 4.9. Type of Place for Minor Health Problem by RHA, CCHS 2015-2016
Age-and sex-adjusted rate



Reasons for No Regular Health Care Provider

Definition

The most frequent reasons given for not having a regular health care provider, by Manitobans aged 12 and older participating in the Canadian Community Health Survey, over a two-year time period.

Why is this indicator important?

Understanding potential gaps in delivery of primary care services is important in policy planning and resource allocation to create conditions that reduce health inequities and improve patient outcomes.

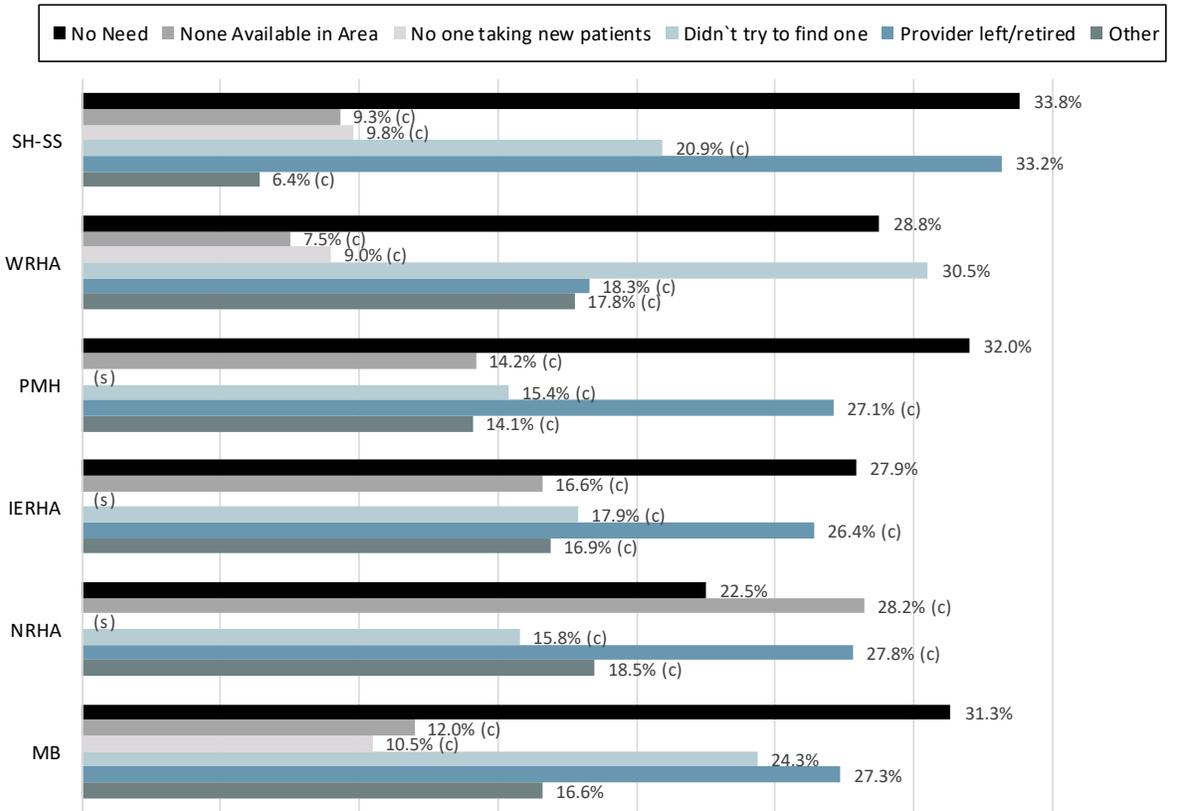
Provincial Key Findings

- The most commonly reported reasons why Manitoba residents do not have a regular health care provider are “no need” followed by “provider left/retired”.
- No RHA responses were statistically significant from the Manitoba average.

Regional Key Findings

- Similar to the provincial key findings, the leading reasons why Interlake-Eastern residents do not have a regular health care provider include: no need (27.9%), provider left/retired (26.4%), and did not try to find one (17.9%).

Figure 4.10. Reasons for No Regular Health Care Provider by RHA, CCHS 2015-2016



Wait Time for Minor Health Problem

Definition

The wait time for a medical appointment with their regular health care provider for a minor health problem, by Manitobans aged 12 and older, participating in the Canadian Community Health Survey, over a two-year time period.

Why is this indicator important?

While not all waits are avoidable, repetitive long waits could be a sign of inadequate resources or scheduling issues.

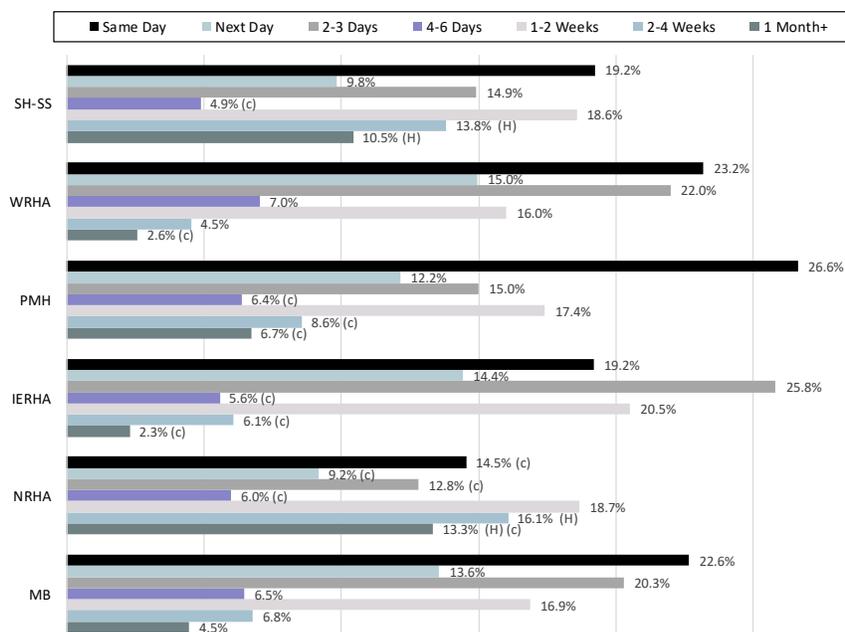
Provincial Key Findings

- Nearly 60% of Manitoba respondents indicated that the wait time for getting an appointment for a minor health problem is three days or less.
- Both Southern Health-Santé Sud and Northern RHA have the largest percentage of residents waiting over two weeks for a minor health care problem appointment.

Regional Key Findings

- The most common wait time reported by Interlake-Eastern residents was two to three days for a minor health care problem.

Figure 4.11. Wait Time for Minor Health Problem by RHA, CCHS 2015-2016



(H) = significantly higher than MB average for the time period. (c) = significantly lower than MB average for the time period.
 (c) = estimate displayed with caution. (s) = estimate suppressed.

Source: CCHS 2015-2016

Coordination Between Health Professionals and Other Providers

Definition

The level of coordination between their regular health care provider and other health professionals using a five scale rating, by Manitobans aged 12 and older, participating in the Canadian Community Health Survey, over a two-year time period.

Why is this indicator important?

Monitoring coordination of care between providers is one way to assess fragmentation of health services. Patients perceive interruptions in care as unreasonable as they navigate the health-care system.^{xxxi} Patient input is necessary to achieve safer, more effective, and efficient care, and bridge the gaps that remain along health-care pathways.

Provincial Key Findings

- Nearly 50% of Manitoba respondents reported positively about the coordination between health care providers.
- Responses were consistent between RHAs, with Interlake-Eastern RHA having the highest level of positive scores.

Regional Key Findings

- 50.5% of Interlake-Eastern respondents indicated that coordination between providers is “excellent or very good”.
- Although not statistically significant, Interlake-Eastern has the highest rate of positive coordination between providers across the entire province.

Figure 4.12. Coordination between health care providers reported as 'Excellent/Very Good'

Age and sex adjusted proportion (%) of weighted sample CCHS 2015-2016



H/L Significantly higher or lower than the MB average.

	PMH	SH-SS	NRHA	WRHA	MB	IERHA
T1 PERCENT	44.6%	45.0%	45.6%	45.9%	46.3%	50.5%

Source: CCHS 2015-2016

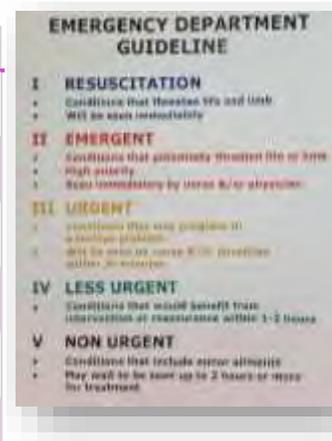
CLOSER LOOK... ANNUAL EMERGENCY ROOM VISITS BY CANADIAN TRIAGE ASSESSMENT LEVELS (CTAS)

Emergency Room Visits Are Unique: Emergency patients have many characteristics that differ from patients in other hospital settings. Their arrival is often unscheduled and critically ill or injured patients can arrive simultaneously. Triage helps decide who should be assessed first. The triage nurse collects information and history on all patients presenting to the emergency room. Each patient is assigned an acuity score based on a scale from one to five consistent with guidelines provided in the Canadian Triage and Acuity Scale (CTAS). One is considered most urgent and five is considered non-urgent.

Annual Emergency Room Visits for Interlake-Eastern: Table 4.8 presents three years of regional CTAS data for Interlake-Eastern. Annual emergency room visits range from 81,000 to 82,000 over the three years in Interlake-Eastern. Over time there has been an increasing number of resuscitation and emergent visits (CTAS 1 and 2s), while less urgent and non urgent make up the largest percentage of all emergency room visits.

Table 4.8 IERHA Annual CTAS, 2016-2019

	2016/2017	2017/2018	2018/2019
1 Resuscitation	412	704	618
2 Emergent	7,503	9,010	9,908
3 Urgent	20,725	20,150	20,900
4 Less Urgent	23,380	21,208	19,990
5 Non Urgent	14,066	9,345	11,878
Registered and not triaged	3,382	3,255	2,582
Scheduled	12,200	17,346	17,334
TOTAL VISITS:	81,668	81,018	83,210



- data includes levels 1 through 5, registered and not triaged and scheduled visits to the emergency departments.

Acute Care

Use of Hospitals

Definition

The percent of residents who were admitted to an acute care hospital at least once in a fiscal year.

Why is this indicator important?

Hospitalizations can indicate the level of illness in the population, capacity of community-based supports and accessibility of hospital care for local residents.

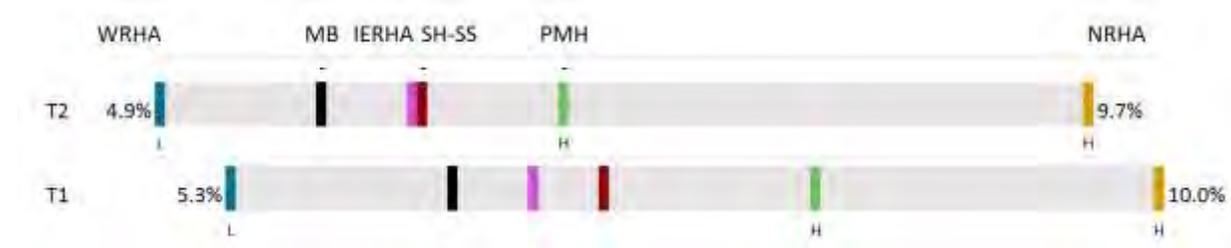
Provincial Key Findings

- Hospital use in Manitoba decreased significantly over time from 6.5% to 5.8%;
- Large variation in hospital use was observed across the regions in 2016/17, from 4.9% of Winnipeg RHA residents to almost 10% of Northern RHA residents.
- Three regions had decreasing values, but the magnitude of the change varied by region.



Figure 4.13. Use of Hospitals by RHA, 2011/12 (T1) and 2016/17 (T2)

Age- and sex-adjusted percent of residents (all ages) with at least one inpatient hospital stay per year



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	IERHA	SH-SS	PMH	NRHA
T2 COUNT	39,999	80,193	8,232	11,736	13,107	6,317
T2 PERCENT	4.9% L	5.8% -	6.2% H	6.2% -	7.0% H-	9.7% H
T1 PERCENT	5.3% L	6.5%	6.9%	7.2%	8.3% H	10.0% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- In 2016/17, a total of 8,232 Interlake-Eastern residents were hospitalized which represents 6.2% of the population.
- The majority of zones experienced decreases in hospital use over time, with the exception of Northern Remote which increased to 11.7% from 11%.
- Both North and Northern Remote districts have rates of hospital use significantly higher than the provincial average of 5.8%.
- Over time there has been a slight widening in disparity, therefore, residents in some districts are more likely to be hospitalized compared to others.

Table 4.9. Use of Hospitals by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1	
	Count	Percent	Percent	
Manitoba	80,193	5.8%	-	6.5%

	T2		T1	
	Count	Percent	Percent	
IERHA	8,232	6.2%		6.9%

South Zone	3,043	4.9%	L	5.5%	L
Wpg Beach/St. Andrews	821	4.4%	L	4.6%	L
St. Clements	433	4.5%	L-	5.9%	
Springfield	716	4.7%	L	5.2%	L
Stonewall/Teulon	1,073	5.15		5.7%	

North Zone	1,691	8.9%	H	9.6%	H
Powerview/Pine Falls	446	7.5%	H	8.6%	H
Eriksdale/Ashern	605	9.1%	H	9.7%	H
Fisher/Peguis	640	9.5%	H	9.8%	H

East Zone	1,260	5.3%	-	6.4%	
Pinawa/Lac du Bonnet	512	4.9%	-	6.4%	
Beausejour	534	5.1%	-	6.4%	
Whiteshell	214	5.4%		6.1%	

West Zone	1,146	6.3%		6.5%	
Gimli	490	5.8%		5.7%	
St. Laurent	308	6.1%		6.7%	
Arborg/Riverton	348	6.5%		6.8%	

Selkirk Zone	752	6.0%		6.5%	
Selkirk	752	6.0%		6.5%	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	2.4	
	T2 Disparity	2.7	
	Change	0.3 ↑	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Inpatient Hospitalization Rate

Definition

The total annual number of inpatient hospitalizations per 1,000 population. Multiple admissions of the same person are counted as separate events.

Why is this indicator important?

The number of hospital admissions per resident can provide insight into the chronic nature of many health conditions, patient capacity to self-manage, capacity of community based supports, and utilization of inpatient hospital services over time.

Provincial Key Findings

- There were 109,146 inpatient hospitalizations among Manitoba residents.
- The overall inpatient hospitalization rate decreased significantly over time, from 90.6 to 78.4 per 1,000 residents per year.
- Rates for Northern RHA and Prairie Mountain Health were significantly higher than the Manitoba average, while the rate for the WRHA was significantly lower.
- The most frequent causes for hospitalization in Manitoba were pregnancy and childbirth followed by digestive and circulatory diseases.
- Income: The lowest income residents' percentage of inpatient hospitalization was 1.9 times higher than that of highest income residents.



Figure 4.14. Inpatient Hospitalization by RHA, 2011/12 (T1) and 2016/17 (T2)

Age- and sex- adjusted rate of hospitalizations per 1,000 residents



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	IERHA	SH-SS	PMH	NRHA
T2 COUNT	51,182	109,146	11,493	16,573	19,717	9,016
T2 RATE	63.1 L	78.4 -	87.5 -	89.7 -	103.7 H-	144.0 H
T1 RATE	69.3 L	90.6	98.9	109.2 H	125.3 H	157.6 H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- There was a statistically significant decrease in Interlake-Eastern inpatient hospitalization from 98.9 to 87.5 per 1,000 population.
- Five of the six zones experienced a decrease in inpatient hospitalizations.
- North and Northern Remote zones have inpatient hospitalization rates significantly higher than the provincial rate of 78.4 per 1,000 population.
- The district disparity ratio presented below in **Table 4.10**, indicates that disparity does exist between districts, as some areas are nearly three times more likely to be hospitalized compared to others.
- The leading reasons for hospitalization among Interlake-Eastern residents were pregnancy and childbirth followed by circulatory diseases (**Table 4.11**).
- It is important to note that the disparity ratio may be driven by pregnancy related hospitalizations and not necessarily by illness or disease.

Table 4.10. Inpatient Hospitalization Rate by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)

	T2			T1	
	Count	Rate		Rate	Rate
Manitoba	109,146	78.4	-	90.6	
IERHA	11,493	87.5	-	98.9	
South Zone	4,037	68.0		77.6	
Springfield	885	61.3		74.3	
St. Clements	575	61.4		86.0	
Wpg Beach/St. Andrews	1,128	64.5		66.4	
Stonewall/Teulon	1,449	73.3		85.6	
North Zone	2,512	136.9	H	148.6	H
Powerview/Pine Falls	621	111.6		141.8	
Eriksdale/Ashern	938	144.8	H	155.7	H
Fisher/Peguis	953	150.9	H	155.0	H
East Zone	1,730	73.7		93.6	
Pinawa/Lac du Bonnet	726	71.4		95.2	
Beausejour	719	73.3		97.1	
Whiteshell	285	80.0		88.2	
Northern Remote	438	163.7	H	145.2	H
Northern Remote	438	163.7	H	145.2	H
West Zone	1,700	93.1		95.2	
Gimli	712	81.9		80.9	
St. Laurent	483	99.2		111.4	
Arborg/Riverton	505	99.5		99.7	
Selkirk Zone	1,076	86.4		95.6	
Selkirk	1,076	86.4		95.6	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	2.3	
	T2 Disparity	2.7	
	Change	0.3 ↑	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Table 4.11. Most Frequent Causes of Hospitalizations, 2007-2011 (T1) & 2012-2016 (T2)

	T2		T1
	Count	Percentage	Percentage
Pregnancy and Birth	1,621	13.2%	14.1%
Circulatory	1,373	13.0%	12.0%
Digestive	1,283	10.8%	11.1%
Injury and Poisoning	1,079	9.3%	9.4%
Respiratory	973	8.0%	8.5%

Source: MCHP RHA Indicators Atlas 2019



Hospital Days for Acute Care

Definition

The number of days of hospital care provided to patients who are acutely ill and require medical care or surgery for treatment of disease or severe illness (excluding newborns), per 1,000 population, for a one-year time period.

Why is this indicator important?

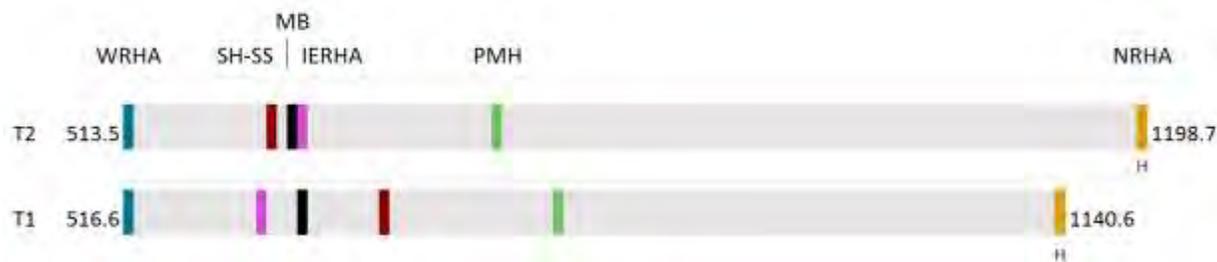
Providing targeted care and timely discharge from hospital results in better patient outcomes and reduced financial cost to the health-care system.

Provincial Key Findings

- The rate of hospital days for acute care (excluding newborns) was 628.4 days per 1,000 patients in 2016/17.
- The rate decreased slightly but was not statistically significant.
- There were considerable variations in rates of hospital days for acute care across all RHAs. Northern RHA had significantly higher rates in both time periods.
- In 2016/17, the most frequent causes of hospital days were circulatory diseases (11.7%), health status and contact (11.7%), mental illness (11.1%), injury & poisoning (9.3%), and respiratory diseases (9.5%). The top rankings of hospital days did not change much over time. The most frequent causes of hospital days varied considerably by region.



Figure 4.15. Hospital Days for Acute Stays (Excluding Newborns) by RHA, 2011/12 (T1) and 2016/17 (T2)
Age- and sex-adjusted per 1,000 residents (all ages)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	SH-SS	MB	IERHA	PMH	NRHA	
T2 COUNT	412,097	109,142	844,018	87,076	159,209	52,871	
T2 RATE	513.5	618.4	628.4	634.4	766.0	1198.7	H
T1 RATE	516.6	690.3	636.2	611.1	806.2	1140.6	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- The number of hospital days for acute care (excluding newborns) was 634.4 days per 1,000 residents in 2016/17, which is slightly higher than the rate in 2011/12.
- Both the North and Northern Remote zones have significantly higher hospital days for acute care compared to the Manitoba at 628.4 days per 1,000 residents.
- The district disparity ratio presented in **Table 4.12.** indicates that those living in Northern Remote (1,257.9 days per 1,000) have hospital days for acute care nearly three times greater than residents in Stonewall/Teulon (432.8 days per 1,000).
- Circulatory diseases make up the largest percentage of hospital days for acute care (**Table 4.13**).

Table 4.12. Hospital Days for Acute Care (Excluding Newborns) by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1	
	Count	Rate	Rate	
Manitoba	844,018	628.4	636.2	

	T2		T1	
	Count	Rate	Rate	
IERHA	87,076	634.4	611.1	

South Zone	29,764	480.0	476.5	
Stonewall/Teulon	9,478	432.8	505.8	
Springfield	6,727	442.4	454.2	
St. Clements	4,217	473.0	589.9	
Wpg Beach/St. Andrews	9,342	488.9	488.7	

North Zone	17,518	1,008.5	H	917.3	
Fisher/Peguis	5,066	922.4		853.3	
Powerview/Pine Falls	4,793	933.1		995.1	
Eriksdale/Ashern	7,659	1,175.5	H	1019.5	

East Zone	13,819	534.3	602.5	
Pinawa/Lac du Bonnet	6,181	543.3	587.6	
Beausejour	5,573	544.4	640.8	
Whiteshell	2,065	617.0	494.4	

Northern Remote	2,282	1,257.9	H	1107.3	H
Northern Remote	2,282	1,257.9	H	1107.3	H

West Zone	13,505	615.3	563.7	
Gimli	5,950	578.9	429.3	
St. Laurent	3,672	604.2	689.7	
Arborg/Riverton	3,883	645.6	630.6	

Selkirk Zone	10,188	714.7	730.0	
Selkirk	10,188	714.7	730.0	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	2.6	
	T2 Disparity	2.9	
	Change	0.3 ↑	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Table 4.13. Most Frequent Causes of Hospital Days, 2007-2011 (T1) & 2012-2016 (T2)

	T2		T1
	Count	Percentage	Percentage
Circulatory	11,034	14.1%	14.3%
Health Status and Contact	8,365	10.7%	12.8%
Injury and Poisoning	8,117	10.4%	9.5%
Respiratory	7,849	10.0%	8.5%
Digestive	7,106	9.1%	10.0%

Source: MCHP RHA Indicators Atlas 2019

Where Residents Were Hospitalized: Hospital Location

Definition

The percent of all hospitalizations of residents by location: within their home RHA, in another RHA, in Winnipeg, or out-of-province, for a one-year time period. If a patient transfers to another hospital, each stay is counted as a separate event and attributed to the appropriate location.

Why is this indicator important?

Understanding where residents were hospitalized and the proportion of residents who travel to receive appropriate health-care services is important for health-care resource planning to meet resident needs and address barriers to care.

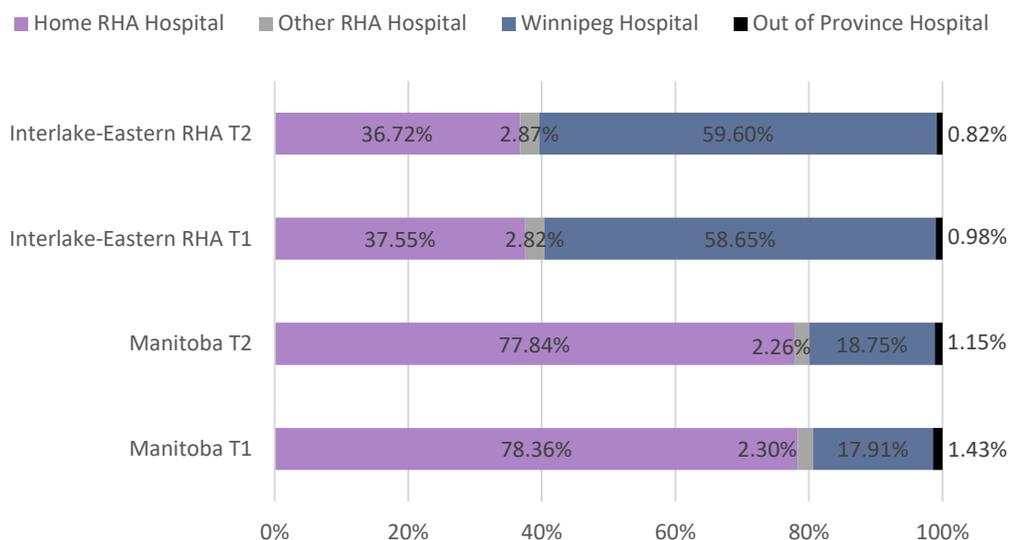
Provincial Key Findings

- In every RHA, the majority of hospitalizations of their residents occurred either in their home region or in a Winnipeg hospital, and this has remained stable over time.

Regional Key Findings

- Hospitalization locations for Interlake-Eastern residents have remained stable over time.
- Compared to Manitoba data, Interlake-Eastern residents are less likely to be hospitalized in a home RHA hospital and are more likely to be hospitalized in Winnipeg.
- Some hospitalizations out of region for Interlake-Eastern residents are expected as some specialized services and care providers are only in other Regional Health Authorities.

Figure 4.16. Hospital Location: Where Residents Went for Hospitalization, by RHA, 2011/12 (T1) and 2016/17 (T2)



Source: MCHP RHA Indicators Atlas 2019

Hospital Days for Alternate Level of Care Stays

Definition

The number of days of hospital care provided to patients (excluding newborns) who were designated as alternate level of care (ALC), per 1,000 population, for a one-year time period. A patient may be designated as ALC if they occupy an acute care hospital bed but no longer require the intensity of resources and services provided in an acute care setting.

Why is this indicator important?

Reducing the number of ALC hospital days helps to ensure patients are cared for in the most appropriate setting and that hospital resources are used more efficiently, resulting in substantial cost savings for the health-care system.

Provincial Key Findings

- The rate of hospital days for Alternate Levels of Care (excluding newborns) was 191.7 days per 1,000 residents in 2016/17.
- The rate increased over time from 153.4 to 191.7 days per 1,000 residents but the increase was not statistically significant. This trend has been observed across all regions.

Figure 4.17. Hospital Days for ALC Stays (Excluding Newborns) by RHA, 2011/12 (T1) and 2016/17 (T2)

Age- and sex-adjusted per 1,000 residents (all ages)



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	IERHA	SH-SS	MB	PMH	NRHA
T2 COUNT	73,640	31,748	45,593	243,007	56,826	6,878
T2 RATE	136.4	164.6	176.3	191.7	227.5	256.5
T1 RATE	113.4	111.7	157.3	153.4	164.6	172.7

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- The number of days of hospital care provided to patients who were designated as ALC total 31,748 over a one-year time period, which is higher than 2011/12 data.
- The one zone that experienced a statistically significant increase in ALC days was the West Zone; increasing by over 500% between 2011 to 2017, while other zones remained relatively stable.
- District disparity has increased significantly over time and this is in large part being driven by the significant increase in ALC days within both the Gimli and St. Laurent districts.
- Over time, Interlake-Eastern has experienced a widening in ALC disparity between our highest (Gimli) and lowest (Fisher/Peguis) districts.

Table 4.14. Hospital Days—Hospital Days for Alternate Level of Care Stays (Excluding Newborns) by IERHA Zone Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1
	Count	Rate	Rate
Manitoba	243,007	191.7	153.4

IERHA	T2		T1
	Count	Rate	Rate
	31,748	164.6	111.7

South Zone	9,902	102.9	81.0
Wpg Beach/St. Andrews	1,194	35.2	40.8
Springfield	2,634	68.8	36.3
Stonewall/Teulon	5,466	116.7	62.6
St. Clements	608	163.7	100.4

North Zone	4,084	204.5	197.6
Fisher/Peguis	131	10.6	L 8.3 L
Eriksdale/Ashern	2,641	111.7	103.9
Powerview/Pine Falls	1,312	456.8	579.6

East Zone	4,317	74.2	90.8
Beausejour	1,742	35.6	92.4
Pinawa/Lac du Bonnet	1,514	51.0	44.4
Whiteshell	1,061	123.5	39.5

Northern Remote	116	219.2	80.3
Northern Remote	116	219.2	80.3

West Zone	7,685	377.5	+	61.1
Arborg/Riverton	752	52.6		69.7
St. Laurent	1,971	530.4	+	25.2
Gimli	4,962	888.8	+	51.1

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	69.9
	T2 Disparity	84.1
	Change	14.3 ↑
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

Selkirk Zone	5,644	229.3	159.3
Selkirk	5,644	229.3	159.3

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Hospital Catchment: Where Patients Using RHA Hospitals Came From

Definition

The percent of all hospitalizations by residents of each RHA within the resident’s home RHA, another RHA, Winnipeg, or out-of-province, for a one-year time period.

Why is this indicator important?

Where residents are hospitalized provides valuable insight into the availability and accessibility of acute care services, which helps to plan and allocate resources appropriately.

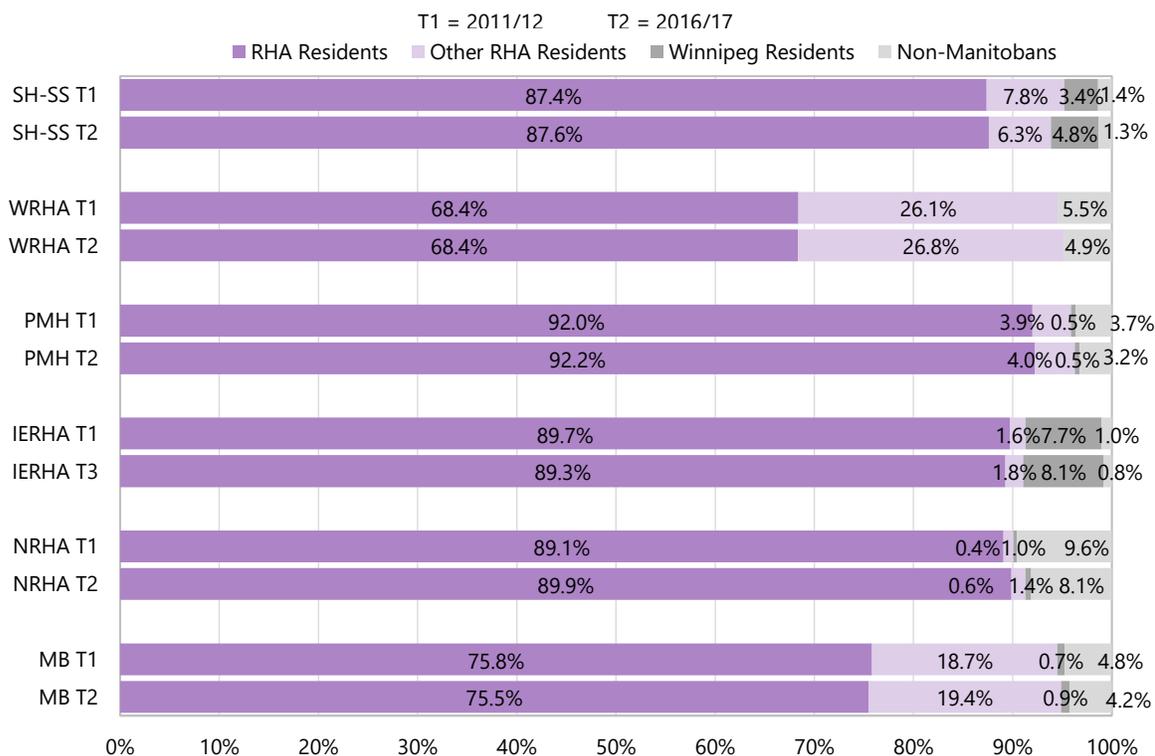
Provincial Key Findings

- In every RHA, the majority of hospital patients were residents of that region. These findings have remained stable over time.

Regional Key Findings

- Similar to the provincial key findings, hospital catchment data has remained stable over time.
- Interlake-Eastern primarily hospitalizes local residents, followed by Winnipeg Residents, which make up about 10% of all patients.

Figure 4.18. Hospital Catchment: Where Patients Using RHA Hospitals Came From, 2011/12 and 2016/17



Source: MCHP RHA Indicators Atlas 2019

Hospital Readmission Rates

Definition

Unplanned inpatient readmissions to an acute care facility (the same or different hospital) within 30 days, following discharge, for a one-year time period.

Why is this indicator important?

Hospital readmission is a nationally used indicator of overall health system performance. Although readmission may involve factors outside the direct control of the hospital, high rates of readmission act as a signal to review practices including discharge planning and continuity of services after discharge. Reducing hospital readmissions is a recognized strategy to improve patient outcomes and reduce health-care costs.

Provincial Key Findings

- There were 8,642 hospital readmissions among Manitoba residents in 2016/17. Overall, hospitalization readmissions (within 30 days) slightly decreased in Manitoba over time from 7.9% to 7.7% of all hospital episodes.
- The readmission hospitalization rate significantly decreased in Southern Health-Santé Sud RHA.
- WRHA residents had significantly lower rates while Prairie Mountain and Northern residents had significantly higher rates than the provincial average in both time periods.
- Income: The lowest income residents had 1.4 times more inpatient readmissions to an acute care facility compared to that of highest income residents.

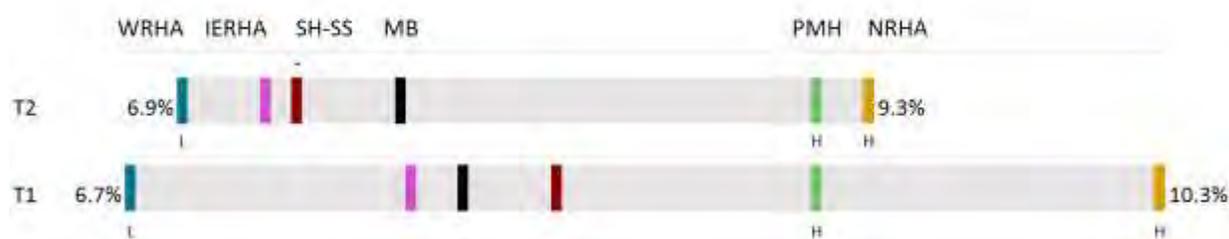


Rural Quintiles

T2 1.4

Figure 4.19. Hospital Readmission by RHA, 2011/12 (T1) and 2016/17 (T2)

Age- and sex-adjusted percent of hospital episodes with a readmission within 30 days of discharge



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	IERHA	SH-SS	MB	PMH	NRHA
T2 COUNT	3,865	861	1,225	8,642	1,877	806
T2 PERCENT	6.9% L	7.2%	7.3% -	7.7%	9.1% H	9.3% H
T1 PERCENT	6.7% L	7.7%	8.2%	7.9%	9.1% H	10.3% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- 7.2% of discharges result in hospital re-admission for Interlake-Eastern residents, which totaled 861 residents in 2016/17.
- Both the South and East Zone have hospital readmission rates significantly lower than the provincial average.
- Four of the six zones experienced decreasing rates of hospital readmissions over time.
- Some districts are more likely to experience hospital readmissions compared to others, although rates have narrowed over time. For instance, Northern Remote residents are 2.4 times more likely to be readmitted than residents in Beausejour.

Table 4.15. Hospital Readmission Rates (Unplanned) by IERHA Zone & District Findings, 2011/12 (T1) and 2016/17 (T2)

	T2		T1	
	Count	Percent	Percent	
Manitoba	8,642	7.7%	7.9%	

	T2		T1	
	Count	Percent	Percent	
Interlake-Eastern	861	7.2%	7.7%	

South Zone	273	6.2%	L	6.5%	L
Springfield	47	4.9%		5.1%	
Wpg Beach/St. Andrews	78	6.3%		5.1%	L
Stonewall/Teulon	107	6.4%		7.8%	
St. Clements	41	7.1%		6.1%	

North Zone	207	8.4%		9.5%	H
Powerview/ Pine Falls	49	7.7%		9.4%	
Fisher/Peguis	77	8.2%		9.0%	
Eriksdale/Ashern	81	8.9%		9.6%	

East Zone	107	5.6%	L	6.5%	
Beausejour	39	4.7%	L	5.8%	
Pinawa/Lac du Bonnet	53	6.3%		7.7%	
Whiteshell	15	6.5%		3.4%	

Northern Remote	53	11.1%		7.7%	
Northern Remote	53	11.1%		7.7%	

West Zone	125	6.9%		8.3%	
Gimli	53	6.7%		7.3%	
Arborg/Riverton	40	6.7%		7.9%	
St. Laurent	32	6.8%		9.6%	

Selkirk Zone	96	8.0%		7.2%	
Selkirk	96	8.0%		7.2%	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	2.8	
	T2 Disparity	2.4	
	Change	-0.4 ↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Caesarean Section

Definition

The percent of caesarean section (C-section) procedures for in-hospital births among female residents for a two-year time period.

Why is this indicator important?

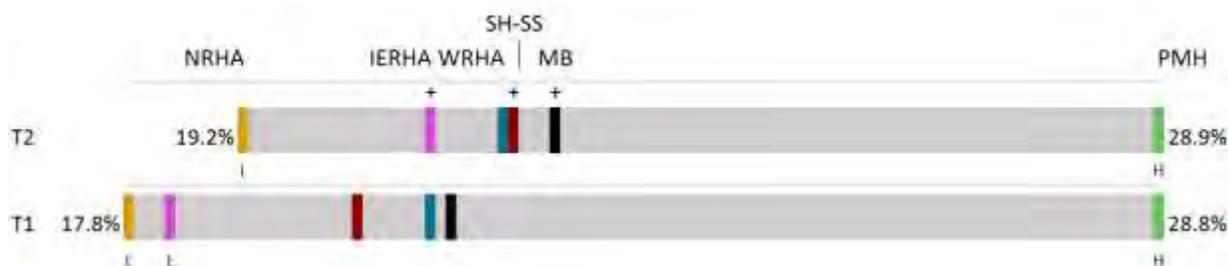
C-sections are associated with a greater risk of maternal morbidity, negative maternal and infant health outcomes, and higher costs to the health care system. C-section prevalence is often used to monitor clinical practices with an implicit assumption that lower rates indicate more appropriate and efficient care.

Provincial Key Findings

- There were a total of 7,446 caesarean sections among Manitoba females in 2015/16-2016/17.
- Overall, the rate of C-sections significantly increased over time, from 21.4% to 22.5%. Rates also significantly increased in Southern Health-Santé Sud and Interlake-Eastern RHAs.
- Age: The proportion of C-sections for women 40 years of age and older was generally higher than all other age groups.

Figure 4.20. Caesarean Section Rate by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

Maternal age adjusted average annual percent of singleton in-hospital births



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	NRHA		IERHA		WRHA		SH-SS		MB		PMH	
T2 COUNT	584		586		3,813		1,276		7,446		1,183	
T2 PERCENT	19.2%	L	21.2%	+	21.9%		22.1%	+	22.5%	+	28.9%	H
T1 PERCENT	17.8%	L	18.4%	L	21.1%		20.4%		21.4%		28.8%	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Between 2015 to 2017, one out of five births for Interlake-Eastern residents resulted in a caesarean section, which is significantly higher than the rates in 2010 to 2012.
- All six zones experienced increasing rates over time, with Selkirk Zone having the highest rate at 29%.
- During both time periods, residents in Northern Remote were least likely to have a caesarean section, and at rates well below the provincial average.
- Interlake-Eastern has experienced a narrowing in disparity over time.

Table 4.16. Caesarean Section by IERHA Zone & District Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

	T2		+	T1	
	Count	Percent		Percent	
Manitoba	7,446	22%	+	21%	

IERHA	T2		+	T1	
	Count	Percent		Percent	
IERHA	586	22%	+	18%	L

South Zone	244	22%		19%	
Springfield	58	18%		20%	
Wpg Beach/St. Andrews	61	23%		18%	
Stonewall/Teulon	92	24%	+	17%	
St. Clements	33	25%		30%	

North Zone	119	20%		17%	
Fisher/Peguis	44	18%		15%	
Eriksdale/Ashern	35	19%		18%	
Powerview/Pine Falls	40	22%		19%	

East Zone	82	22%		19%	
Whiteshell	12	15%		15%	
Pinawa/ Lac du Bonnet	21	21%		24%	
Beausejour	49	26%		18%	

Northern Remote	26	13%	L	10%	L
Northern Remote	26	13%	L	10%	L

West Zone	58	20%		19%	
Arborg/Riverton	28	20%		17%	
Gimli	14	20%		22%	
St. Laurent	16	22%		19%	

Selkirk Zone	57	29%		23%	
Selkirk	57	29%		23%	

IERHA DISTRICT DISPARITY RATIO			
	T1 Disparity	3.1	
	T2 Disparity	2.2	
	Change	-0.8↓	
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>			

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Vaginal Birth after Caesarean Section (VBAC)

Definition

The percent of female residents aged 15 to 54 giving birth vaginally, in a five-year period, who had previously had at least one delivery by caesarean section.

Why is this indicator important?

Vaginal birth is a safe option for many women who previously had a C-section and is preferred because there is less risk to the mother and a shorter recovery time. Clinical practice guidelines recommend women who had a previous C-section be offered the opportunity to deliver vaginally following discussion about maternal and perinatal risks and benefits with their health-care provider.

Provincial Key Findings

- There was an average of 2,847 VBACs per year among Manitoba females age 15-54 years in 2012/13-2016/17.
- Overall, the rate of VBAC decreased slightly over time, but not significantly, from 31.2% to 30.2%. Most regions had decreasing rates though Northern RHA experienced an increase over time. None of the changes were statistically significant.
- Age: The majority of women who had a VBAC were between the ages 25 to 34 years.

Figure 4.21. Vaginal Birth After Prior Caesarean Section by RHA, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

Maternal age adjusted percent of births among females with previous Caesarean section



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	PMH	MB	SH-SS	WRHA	IERHA	NRHA
T2 COUNT	230	2,847	549	1,450	232	384
T2 PERCENT	15.5% L	30.2%	31.5%	31.7%	32.4%	41.7% H
T1 PERCENT	18.0% L	31.2%	33.2%	32.7%	36.3%	37.3% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Over a five-year time period, nearly one-third of Interlake-Eastern residents had a VBAC, which is slightly lower than the previous five years.
- Female residents living in the North Zone have the highest VABC rates within Interlake-Eastern at 42%, which is significantly higher than the provincial average of 30%.
- Female residents living in Fisher/Peguis are three times more likely to have a VBAC than females living in Winnipeg Beach/St. Andrews.
- District rates have remained relatively stable over time, therefore there has been little narrowing of disparity within Interlake-Eastern.

Table 4.17. Vaginal Birth After Caesarian Section by IERHA Zone & District Findings, 2007/08-2011/12 (T1) and 2012/13-2016/17 (T2)

	T2		T1
	Count	Percent	Percent
Manitoba	2,847	30%	31%

	T2		T1
	Count	Percent	Percent
Interlake-Eastern	232	32%	36%

South Zone	72	25%	29%
Stonewall/Teulon	35	33%	39%
Springfield	19	24%	26%
St. Clements	9	20%	27%
Wpg Beach/St. Andrews	9	16%	18%

North Zone	64	42%	H	45%	H
Fisher/Peguis	30	49%		50%	
Powerview/Pine Falls	23	45%		45%	
Eriksdale/Ashern	11	29%		37%	

East Zone	36	35%	37%
Whiteshell	8	44%	51%
Pinawa/Lac du Bonnet	9	34%	31%
Beausejour	19	32%	35%

Northern Remote	17	49%		59%	H
Northern Remote	17	49%		59%	H

West Zone	32	34%	36%
St. Laurent	8	39%	46%
Arborg/Riverton	17	35%	39%
Gimli	7	26%	s

IERHA DISTRICT DISPARITY RATIO		
	T1 Disparity	3.2
	T2 Disparity	3.0
	Change	-0.2↓
<small>Disparity with a value of "0" suggest no inequities exist. Change over time informs whether or not disparity is widening or narrowing between districts.</small>		

Selkirk Zone	11	23%	25%
Selkirk	11	23%	25%

L/H Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

Source: MCHP RHA Indicators Atlas 2019

Canadian Patient Experience Survey—Inpatient Care

Definition

The percentage of adult patients participating in the Canadian Patient Experience Survey – Inpatient Care (CPES-IC), over a one-year time period, who reported positively about the quality of care they received during a recent hospital stay. It excludes patients admitted for primary mental health diagnosis or from a mental health facility, admitted from correctional facilities, discharged to personal care homes, or selected for the survey in the last 12 months within the same hospital.

Why is this indicator important?

This survey is a partnership among all regional health authorities and the Manitoba government as part of a larger initiative across Canada that supports comparison of patients’ experiences across the country. It supports quality improvement initiatives at all service delivery sites, informs hospital care, and supports accreditation processes.

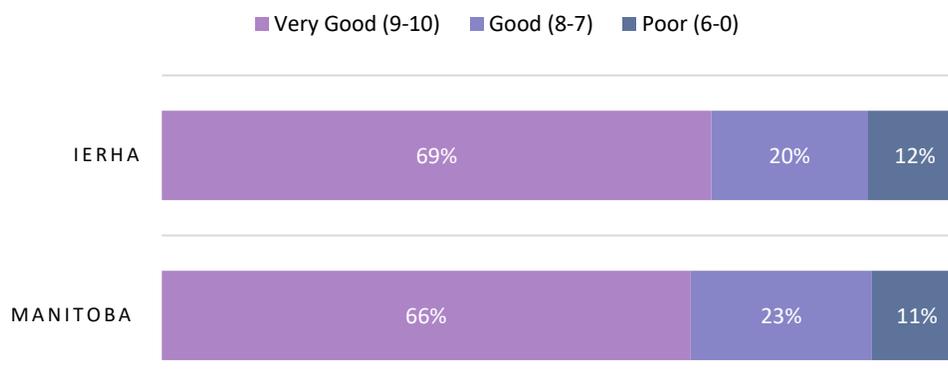
To learn more about the CPES-IC and explore survey results, please visit: <https://www.cihi.ca/en/patient-experience>



Provincial Key Findings

- In 2017-18, a total of 12,430 individuals across Manitoba responded to the CPES-IC which represents a 35.4% response rate. Interlake-Eastern received a total of 1,020 completed surveys reflecting a 40.0% response rate.
- In Manitoba, the overall percentage of respondents who had a “very good” hospital stay was 66%. Interlake-Eastern scored slightly higher at 69% (Figure 4.22.).

Figure 4.22. Overall hospital experience, Manitoba and IERHA, 2017-18

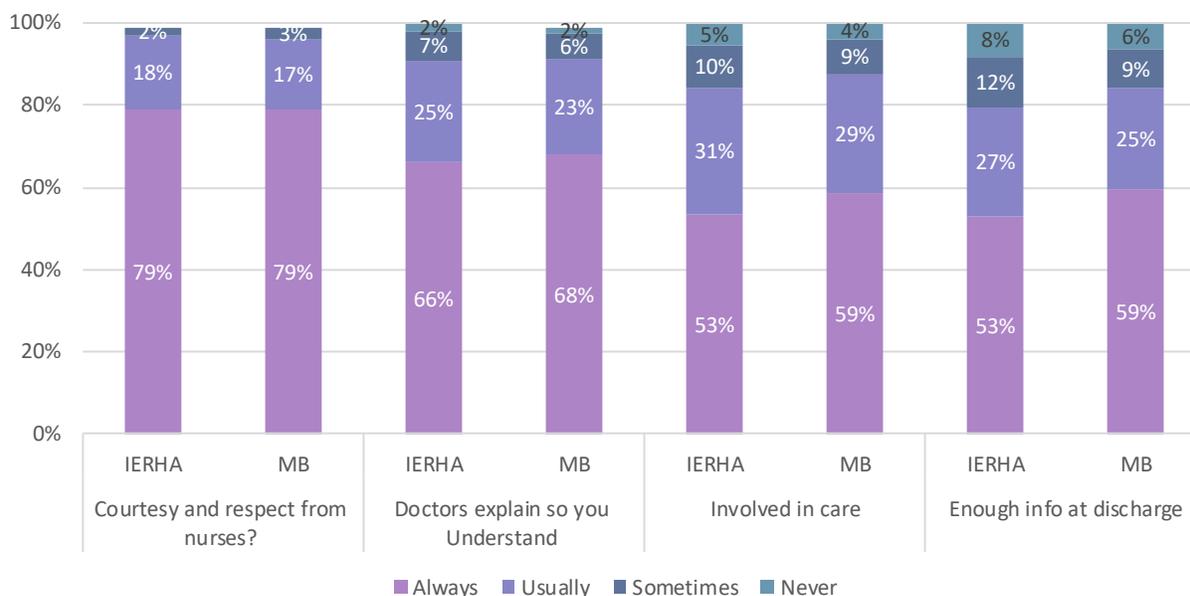


Source: Manitoba Health, CPES-IC Annual Report, 2017-2018

Regional Key Findings

- **Figure 4.23.** highlights four questions from different survey domains: courtesy and respect by nurses, doctors explaining clearly, patient involvement in care decision, and patients receiving enough information about condition at time of discharge.
- Interlake-Eastern scored similarly to provincial results, although both involvement in care and enough information at discharge indicate there is a smaller percentage of respondents from Interlake-Eastern reporting “always”.

Figure 4.23. Canadian Patient Experience Survey—Inpatient Care by IERHA Findings, 2017-18



Source: Manitoba Health, CPES-IC Annual Report, 2017-2018

Additional Key Findings

- In Interlake-Eastern, 4% of respondents indicated they spoke French well enough to conduct a conversation. When participants were asked, “How were French language services offered to you?” the majority selected that French language services were not offered.
- In 2017-18, 7% of survey respondents from Interlake-Eastern were related to a recent hospital stay for a childbirth experience. Findings suggest that those hospitalized for a childbirth experience were generally more satisfied with the overall care provided.
- Canadian Institute of Health Information (CIHI) interviewed jurisdictions from across Canada to learn how CPES-IC results were being utilized. Interlake-Eastern was one of two organizations from across Canada recognized for their efforts to use data to inform daily quality and patient safety huddles. To read the full interview, visit the link below.



To read more about Interlake-Eastern’s Success Story, click here:

<https://www.cihi.ca/en/patient-experience/patient-experience-in-canadian-hospitals/coordination-of-care>

CLOSER LOOK... PATIENT FLOW

On a daily basis, Interlake-Eastern RHA works to ensure safe and efficient patient flow among acute care sites, home care service delivery, and personal care homes. Collaboration occurs daily among programs to make sure patients receive the care they require, at the right time, and in the right place. **Table 4.18.** highlights the occupancy rates for Acute Care sites for both 2017-18 and 2018-19.

Table 4.18. Bed Occupancy Data by Facility, 2018-19 and 2017-18

	2018-19	2017-18
Interlake-Eastern	97.9%	98.9%
Arborg & District Health Centre	100.4%	91.9%
Ashern Lakeshore General Hospital	104.2%	97.9%
Beausejour Health Centre	97.2%	99.6%
Eriksdale E.M. Crowe Memorial Hospital	98.7%	96.1%
Gimli Johnson Memorial Hospital	95.0%	98.7%
Pinawa Hospital	95.9%	101.0%
Pine Falls Health Centre	94.7%	97.9%
Selkirk Regional Health Centre*	95.8%	97.1%
Stonewall & District Health Centre	108.4%	113.5%
Teulon Hunter Memorial Hospital	98.6%	98.7%
*excludes obstetrical and newborn beds		

Source: IERHA, Patient Flow Governance Committee, 2019

Why does Interlake-Eastern have high bed occupancy rates?

- **↑ Alternate level of care (ALC) days:** Over time, the region has experienced an increasing number of patients designated as ALC (see indicator on page 254). Although there has been an increase in ALC cases between 2017-18 and 2018-19, ALC days have decreased in the same time period. This results in a lower ALC average length of stay between 2017-18 and 2018-19. ALC patients typically have longer lengths of stays that greatly affects the overall bed supply. For example, over half of all acute care beds in the region are occupied by patients who are paneled, who are waiting to be paneled and those awaiting services such as home care, rehab, and housing.
- **↑ Acute care hospital days:** The region has experienced an increasing rate of hospital days for acute care (see indicator on page 250) meaning that patients admitted into the hospital are having longer lengths of stays for medical care or surgery.

Home Care

Home Care Regional Prevalence

Definition

The prevalence rates of person years for active clients receiving one or more home care services, by type of service (health care aides/home support worker and nursing services), for a two-year time period.

Why is this indicator important?

Home care use provides insight into services and supports provided (such as personal care, nursing care and home support) to help individuals remain at home and live independently in their community. An aging population and an increase in those living with chronic conditions will result in the need for additional home care support services.

Provincial Key Findings

- The overall prevalence of home care use for all ages was 3.3% per person-year; an estimated 43,155 Manitoban residents received one or more services during a two-year period.
- In 2013/14-2014/15, an estimated 29,149 Manitoban residents received health care aid (HCA) and home support worker services (HSW), representing a prevalence of 2.2% in the province.
- In 2013/14-2014/15, an estimated 23,442 Manitoban residents received home care for nursing services, representing a prevalence of 1.8% in the province.

Table 4.19. Overall Home Care Prevalence 2013/14-2014/15

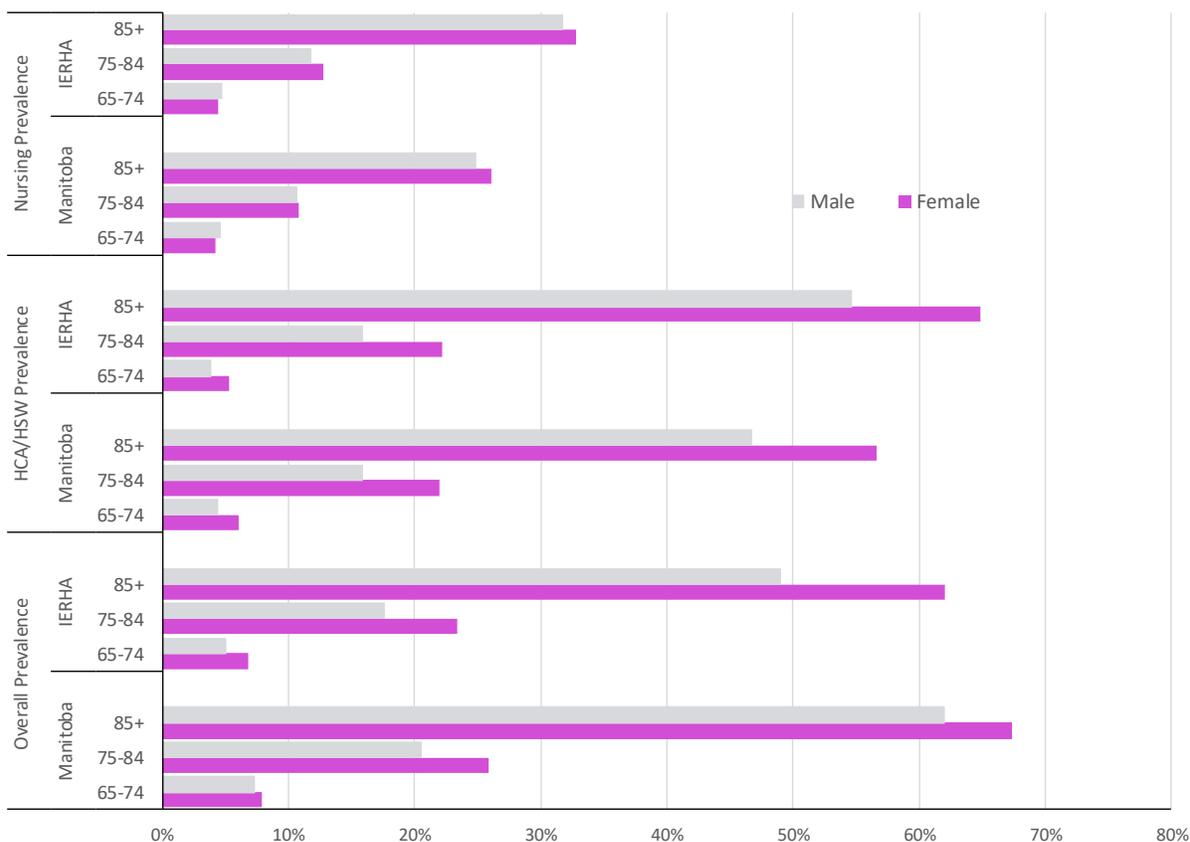
	Count	Crude (%)	
Manitoba	43,157	3.3%	
IERHA	4,326	3.5%	
SH-SS	5,276	2.8%	L
WRHA	26,769	3.6%	H
PMH	5,482	3.3%	
NRHA	1,304	1.7%	L

H/L Significantly higher or lower than the MB average for that time period.
Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- **Nursing Prevalence:** A total of 1,705 Interlake-Eastern residents over the age of 65 years received home care nursing services between 2013-2015. The East Zone had the highest prevalence for nursing home care services.
- **HCA/HSW Prevalence:** A total of 2,197 Interlake-Eastern residents over the age of 65 years received HCA/HSW services between 2013-2015. The West Zone had the highest prevalence for HCA/HSW.
- **Overall Prevalence:** Between 2013-2015, a total of 3,902 residents over the age of 65 received home care services in Interlake-Eastern.

Figure 4.24. Home Care Prevalence by IERHA, 2013-14-2014-15



Source: MCHP RHA Indicators Atlas 2019

Duration of Care: How Long On Average People Receive Health Care Aid/Home Support Worker Services

Definition

The average number of days residents received health care aide/home support worker services, for a two-year time period.

Why is this indicator important?

Understanding service delivery needs helps with resource planning, including the availability of the appropriate care provider.

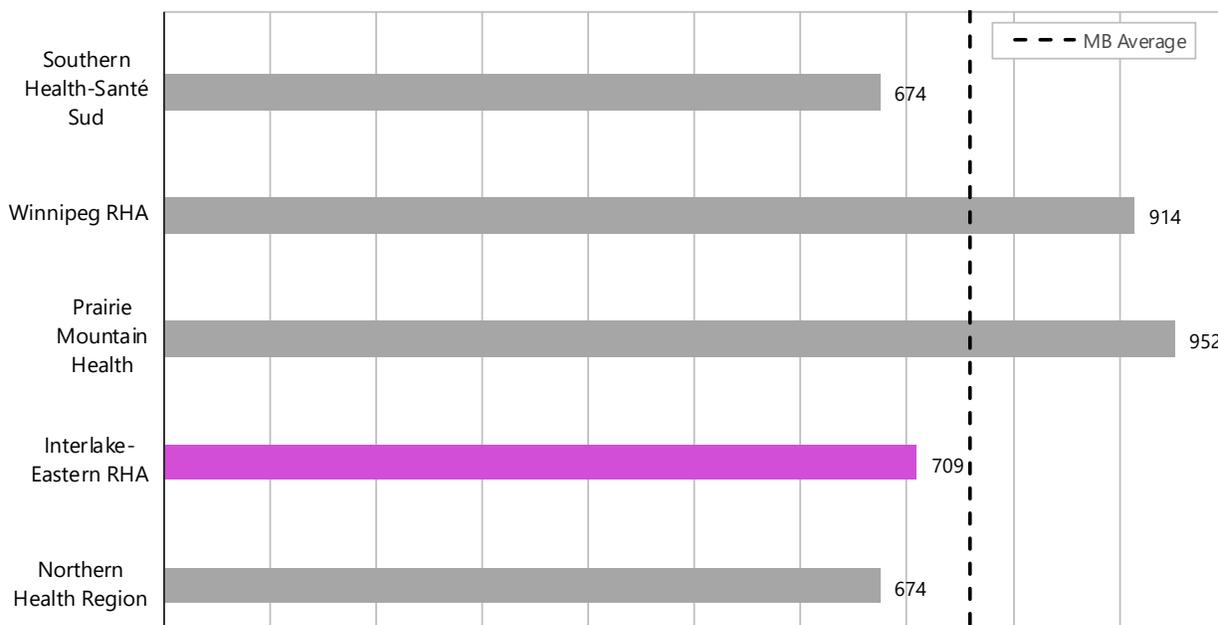
Provincial Key Findings

- In 2013/14-2014/15, an average duration of people receiving health care aid and home support work services was 758.5 days in the province.
- There were considerable variations of duration of care across all regions.

Regional Key Findings

- In 2013/14-2014/15, an average duration of people receiving health care aid and home support worker services was 709 days in Interlake-Eastern, slightly below the provincial average.

Figure 4.25. Episode length (Number of Days) for HCA/HSW by Health Region, 2013/14-2014/15



Wait Time from Intake to First Visit

Definition

The number of days from intake to first visit by health care aide/home support worker, for a two-year time period.

Why is this indicator important?

Appropriate and timely home care support services allow individuals to remain living independently in the community longer or return home from hospital sooner. This results in improved quality of life and better use of health-care resources.

Key Findings

- In 2013-2015, 50% of Interlake-Eastern home care clients waited eight days from intake until first visit.
- The majority of all clients were seen in their home within 30 days from intake date.



Personal Care Homes

Residents in Personal Care Homes

Definition

The percent of residents, 75 years and older, who live in a personal care home for a one-year time period.

Why is this indicator important?

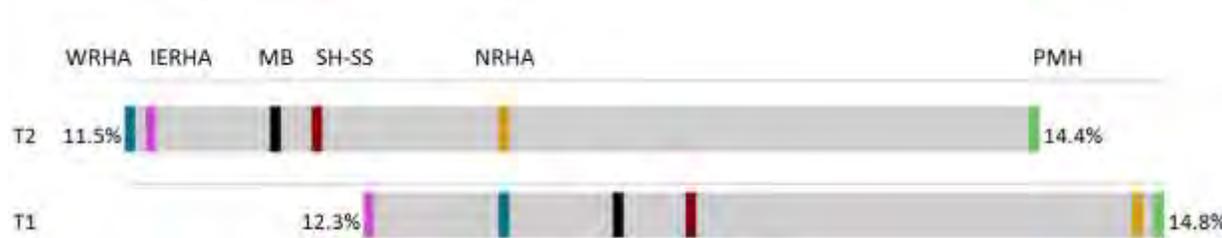
As the population continues to age, it is important to monitor the proportion of residents living in PCHs to anticipate increasing health-care resource requirements.

Provincial Key Findings

- In 2016/17, there were 21,719 Manitoba residents aged 75 years and older living in PCHs.
- Overall, the percent of residents aged 75 years and older and living in a PCH in Manitoba decreased from 13.1% to 11.9% over time, but this decrease did not reach statistical significance.

Figure 4.26. Residents in Personal Care Homes by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

Age- and sex-adjusted average annual percent of residents 75+ living in a PCH



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	IERHA	MB	SH-SS	NRHA	PMH
T2 COUNT	12,663	1,705	21,719	2,584	310	4,457
T2 PERCENT	11.5%	11.6%	12.0%	12.1%	12.7%	14.4%
T1 PERCENT	12.7%	12.3%	13.1%	13.3%	14.7%	14.8%

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern, had 11.6% of residents 75 years and older in a personal care home over a one-year time period.
- At the zone level, there appears to be a large variation in access to personal care home beds that requires additional explanation. Twenty-six percent of Selkirk Zone residents aged 75 and older resided in a personal care home compared to only 4.4% of residents in the South Zone between 2015-2017. This is a reflection of the fact that three of the region’s 16 personal care homes are in Selkirk and these facilities accept residents from all over the region.

Table 4.20 Residents in Personal Care Homes by IERHA Zone Findings, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)

	T2		T1	
	Count	Percent	Percent	
Manitoba	21,719	12.0%	13.1%	

	T2		T1	
	Count	Percent	Percent	
IERHA	1,705	11.6%	12.3%	

South Zone	223	4.4%	L	5.0%	L
East Zone	296	10.2%		11.7%	
West Zone	368	14.0%	H	13.0%	

Selkirk Zone	629	26.0%	H -	31.7%	H
North Zone	189	10.7%		10.1%	L
Northern Remote	s				

H/L Significantly higher or lower than the MB average for that time period. (s) indicates data suppressed due to small numbers.
 Source: MCHP RHA Indicators Atlas 2019



Level of Care on Admission to Personal Care Homes

Definition

The percent of residents aged 75 and older admitted to a PCH at each level of care, for a two-year time period.

Why is this indicator important?

Understanding levels of care upon admission provides an indication of accessibility and affordability of alternate housing options and community based support for older adults requiring minimal care, and the resources required to meet more intensive care needs, across the continuum of care.

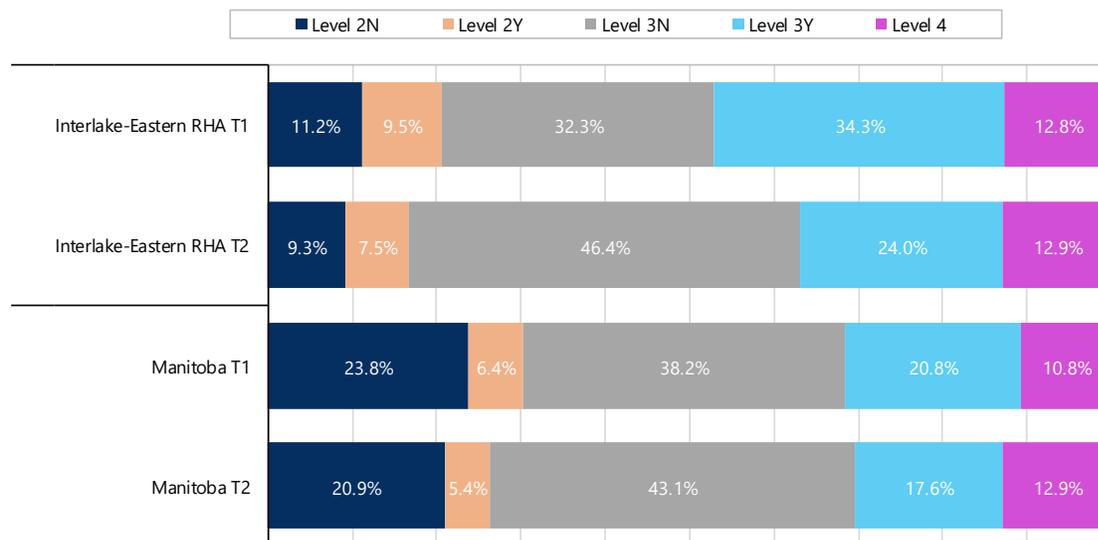
Provincial Key Findings

- Overall, the proportion of PCH residents requiring high levels of care increased. In 2015/16—2016/17, no residents were admitted for level 1 (the lowest level of care).
- The proportion of residents admitted for level 4 (the highest) care increased from 10.8% to 12.9%.

Regional Key Findings

- Level of admission to PCH has shifted slightly within Interlake-Eastern, with more level 3s and 4s being admitted between 2015-2017 compared to 2010-2012.
- Interlake-Eastern saw a smaller percentage of level 2 and level 2Y admissions over time and an increasing percentage of residents admitted at level 3N.

Figure 4.27. Level of Care on Admission to PCH for Residents Age 75+ by RHA, 2010/11-2011/12 (T1) and 2015/16-2016/17 (T2)



Y Indicates requirement for close supervision
 N Indicates no requirement for close supervision

Source: MCHP RHA Indicators Atlas 2019

Median Wait Times for Personal Care Home Admission

Definition

The median length of time (in weeks) from initial assessment to admission to PCH among residents, aged 75 and older, for a two-year time period.

Why is this indicator important?

Admission to PCH is largely driven by the demand for PCH beds, personal preference of facility and the ability of the health-care system to prepare rooms in a timely fashion. Panded individuals often wait in a hospital or require extensive home care services and other inpatient hospital supports in the community. Reducing the median wait for admission to PCH helps to ensure residents are cared for in the most appropriate setting and that resources are used more efficiently.

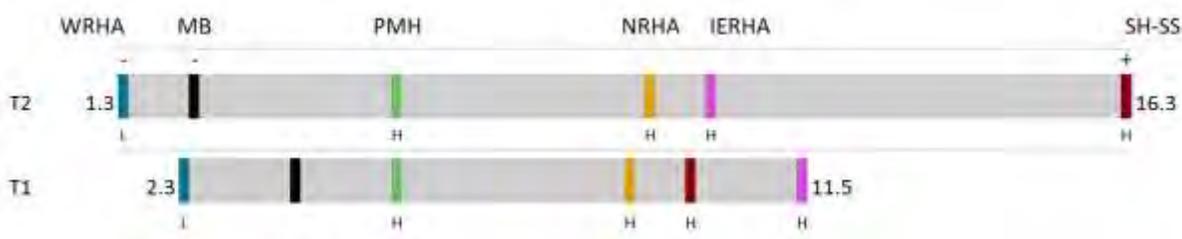
Provincial Key Findings

Median Wait Times for Personal Care Home Admission from hospital

- In 2015/16—2016/17, there were 2,717 Manitoba residents admitted to PCHs from hospital. The median wait time for PCH admission was 2.5 weeks.
- There was a significant decrease from 4.0 to 2.5 weeks in median wait times for PCH admission from hospital in Manitoba. Changes varied by RHA.

Figure 4.28. Median Waiting Times for Personal Care Home Admission from Hospital by RHA, 2010/11-2011/12 and 2015/16-2016/17

Age- and sex-adjusted median number of weeks from assessment to admission by residence prior to admission per 1,000 residents 75+



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA		MB		PMH		NRHA		IERHA		SH-SS	
T2 COUNT	1,510		2,717		609		45		216		327	
T2 RATE	1.3	L-	2.5	-	5.5	H	9.3	H	10.1	H	16.3	H+
T1 RATE	2.3	L	4.0		5.5	H	8.9	H	11.5	H	9.9	H

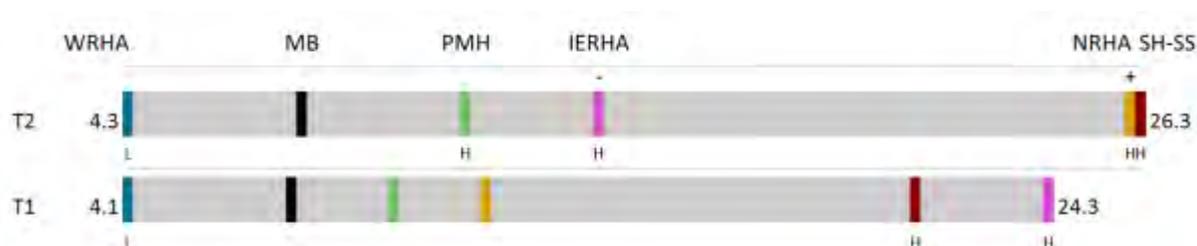
Source: MCHP RHA Indicators Atlas 2019

Median Wait Times for Personal Care Home Admission from Community

- In 2015/16—2016/17, there were 2,403 Manitoba residents admitted to PCHs from the community. The median wait time for PCH admission was 8.1 weeks.
- Overall, median wait times for PCH admission from the community did not significantly change over time. However, changes varied by RHA: wait times increased significantly in Northern RHA, Interlake-Eastern wait times decreased significantly, while the other RHAs did not experience significant change.

Figure 4.29. Median Waiting Times for Personal Care Home Admission from the Community by RHA, 2010/11-2011/12 and 2015/16-2016/17

Age- and sex-adjusted median number of weeks from assessment to admission by residence prior to admission per 1,000 residents 75+



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA		MB		PMH		IERHA		NRHA		SH-SS	
T2 COUNT	1,423		2,403		388		226		53		301	
T2 RATE	4.3	L	8.1		11.5	H	14.5	H-	26.0	H+	26.3	H
T1 RATE	4.1	L	7.8		10.0		24.3	H	12.1		21.4	H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Median wait times from community and hospital into PCH have improved over time for Interlake-Eastern.
- A total of 216 residents waited in hospital for admission into PCH between 2015-2017. All zones in Interlake-Eastern have significantly higher median wait times for admission to PCH from hospital compared to Manitoba.
- A total of 226 residents waited in community for admission into PCH between 2015-2017. East Zone had the longest median wait time, which was found to be significantly higher than the provincial median wait.

Table 4.21. Median Wait Times for Personal Care Home Admission by IERHA Zone Findings, 2010/11-2011/12 and 2015/16-2016/17

	Hospital Wait Times			Community Wait Times		
	Count	Median		Count	Median	
Manitoba	2,717	2.5		2,403	8.1	
IERHA	216	10.1	H	226	14.5	H
South Zone	77	6.8	H	74	13.2	
East Zone	52	14.6	H	39	32.5	H
West Zone	43	13.7	H	49	17.0	
Selkirk Zone	20	8.8	H	31	15.1	
North Zone	23	11.9	H	32	5.7	
Northern Remote Zone	s	0		s	0	

H/L Significantly higher or lower than the MB average for that time period. (s) indicates data suppressed due to small numbers.
Source: MCHP RHA Indicators Atlas 2019

Benzodiazepine overprescribing—Personal Care Homes (75+)

Definition

The percent of adults age 75 and older who had at least two prescriptions for benzodiazepines or at least one prescription for benzodiazepines with a greater than 30 day supply per year, in a two-year period.

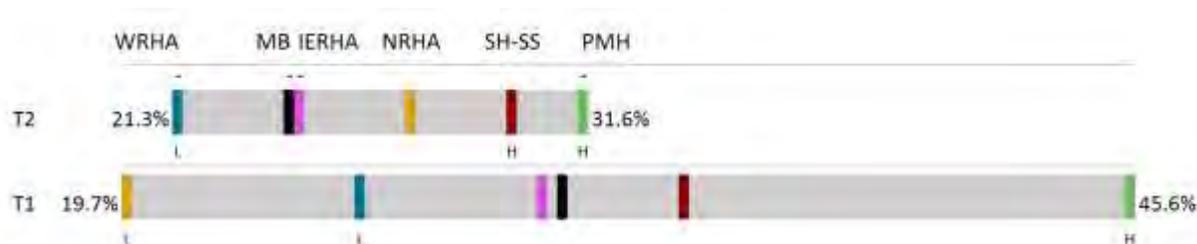
Why is this indicator important?

Benzodiazepines are medications widely used to treat seizures, anxiety and insomnia. Use by older adults is not recommended as they pose serious safety concerns including increased risk for confusion, memory loss, poor coordination and muscle control potentially leading to falls and fractures.

Provincial Key Findings

- 2015/16-2016/17, 4,298 PCH residents aged 75 years and older received benzodiazepines.
- Overall, the proportion of Manitoban PCH residents 75 years and older receiving benzodiazepines decreased significantly over time, from 30.0% to 24.4%. Decreases were seen in all RHAs except Northern RHA; however, the increase was not significant.

Figure 4.30. Crude Proportion of PCH older adults with Inappropriate Benzodiazepine Rx by RHA
2010/11-2011/12 and 2015/16-2016/17, age 75+



H/L Significantly higher or lower than the MB average for that time period. +/- A significant increase (+) or decrease (-) since the first time period

	WRHA	MB	IERHA	NRHA	SH-SS	PMH
T2 COUNT	2,322	4,298	417	65	269	1,225
T2 PERCENT	21.3% L-	24.4%	24.4%	27.2%	29.7% H	31.6% H-
T1 PERCENT	19.7% L	30.0%	30.6%	19.7% L	34.1%	45.6% H

Source: MCHP RHA Indicators Atlas 2019

Regional Key Findings

- Interlake-Eastern saw a significant decrease in for benzodiazepine prescribing in PCHs over time from 30.6% down to 24.4%.
- Three of the six zones had statistically significant decreases over time.

Table 4.22. Benzodiazepine overprescribing—Personal Care Homes (75+) by IERHA Zone Findings

	T2		T1		T2		T1	
	Count	Percent	Percent		Count	Percent	Percent	
Manitoba	4,298	24.4%	31.0%		417	24.4%	30.6%	
South Zone	48	21.1%	21.5%		Selkirk Zone	153	24.2%	28.9%
East Zone	71	24.1%	- 33.6%		North Zone	41	21.7%	- 40.6%
West Zone	104	28.6%	- 37.9%		Northern Remote	s		

+/- A significant increase (+) or decrease (-) since the first time period. (s) indicates data suppressed due to small numbers.
 Source: MCHP RHA Indicators Atlas 2019



Appendices

Appendix A: Acronyms

ACS	Ambulatory Care Sensitive
ACSC	Ambulatory Care Sensitive Conditions
ADL	Activities of Daily Living
ALC	Alternate Level of Care
AMI	Acute Myocardial Infarction
ATV	All-Terrain Vehicle
BMI	Body Mass Index
CN	Cancer Navigation
CCHS	Canadian Community Health Survey
CFHI	Canadian Foundation for Healthcare Improvements
CHA	Community Health Assessment
CHAN	Community Health Assessment Network
CHF	Congestive Heart Failure
CIHI	Canadian Institute for Health Information
CKD	Chronic Kidney Disease
CMA	Canadian Medical Association
COPD	Chronic Obstructive Pulmonary Disease
CPES-IC	Canadian Patient Experiences Survey-Inpatient Care
CTAS	Canadian Triage and Acuity Scale
CT	Computed Tomography Scans
ECC	Early childhood caries
ED	Emergency Department
EDI	Early Development Instrument
EMS	Emergency Medical Services
ER	Emergency Room
ESKD	End Stage Kidney Disease
FASD	Fetal Alcohol Spectrum Disorder
FiT	Fecal Immunochemical Test
FNHSSM	First Nations Health and Social Secretariat of Manitoba
FOBT	Fecal Occult Blood Test
HCA	Health Care Aid
HIV	Human Immunodeficiency Virus
HSW	Home Support Worker
ICT	Information & Communication Technology
IHD	Ischemic Heart Disease
IERHA	Interlake-Eastern Regional Health Authority
IMA	Information Management and Analytics Branch
LGA	Large for Gestational Age

LIM-AT	LOW-INCOME Measure-After Tax
LRHC	Local Renal Health Centres
MB	Manitoba
MCHP	Manitoba Centre for Health Policy
MHLN	Mental Health Liaison Nurse
MHSAL	Manitoba Health, Seniors and Active Living
MQLF	Manitoba Quality and Learning Framework
MRI	Magnetic Resonance Imaging
MVA	Motor Vehicle Accident
NC	Neighbourhood Cluster
NHR	Northern Health Region or Northern Regional Health Authority
NHS	National Household Survey
NP	Nurse Practitioner
NRHA	Northern Regional Health Authority or Northern Health Region
PCH	Personal Care Home
PMH	Prairie Mountain Health
PMR	Premature Mortality Rate
PPHS	Population and Public Health Surveillance
PYLL	Potential Years of Life Lost
RCMP	Royal Canadian Mountain Police
RHA	Regional Health Authority
RHS	First Nations Regional Health Survey
RRT	Renal Replacement Therapy
SGA	Small for Gestational Age
SH-SS	Southern Health-Santé Sud
SIDS	Sudden Infant Death Syndrome
STBBI	Sexually Transmitted Blood-Borne Infection
STI	Sexually Transmitted Infection
TRC	Truth and Reconciliation Commission
TRM	Total Respiratory Morbidity
URIS	Unified Referral Intake System
VBAC	Vaginal Birth After C-Section
WRHA	Winnipeg Regional Health Authority

Appendix B: Community Health Assessment Indicator Selection Process – for the 5th CHA cycle in Manitoba 2015-2019

The work of the CHA is very much an ongoing process. Although the statistics are compiled into one report, there was a lot of work that happened behind the scenes in preparation for the five-year comprehensive report.

The Community Health Assessment – Indicator Review Committee (CHA-IRC) went through an extensive review process to select indicators for the 2019 CHA cycle. The goal of this working group was to recommend a common and comparable set of health indicators for the CHA that describes the health and burden of illness experienced by their residents, and describes the way health services are used in Manitoba. CHA-IRC completed an environmental scan of indicators that were used in other sources measuring population health and health status. The framework used for CHA indicator selection was adapted from A Citizen’s Guide to Health Indicators (2011) which was developed by the Canadian Institute for Health Information. Additionally, experts were consulted to further the selection process.

Criteria for CHA Indicator Selection

The CHA indicators selected for reporting that met the following five criteria:

1. **Important and Relevant:** The indicator reasonably reflects efforts to reduce health risks and improve health status and health systems. The indicator is understandable, relevant, and useful for health planning.
2. **Valid:** This indicator actually measures what it is claiming to measure.
3. **Possible:** The indicator is currently collected at the regional health authority and provincial level. The indicator supports meaningful comparisons over time and place.
4. **Meaning:** The indicator is sensitive and reflects change in the phenomena it is intended to measure.
5. **Implications:** The indicator is amenable to action and support.

Framework for CHA Indicator Selection: Adapted from Canadian Institute for Health Information (CIHI) Framework

A CIHI framework has been adapted based on feedback from past CHAs, to structure this report. Measuring health equity is central to this report, as is indicated by its central location, surrounded by the four domains of health with categories measuring health status, social determinants of health, community and health system characteristics and health system performance.

Indicators are organized within the report based on the four categories illustrated below, with equity in the centre.



Measuring Health Inequalities

Manitoba participated in a pan-Canadian expert working group to inform collaborative work by Statistics Canada and the Canadian Institute for Health Information (CIHI) to harmonize and strengthen the measurement of health inequalities between subpopulations, using common equity characteristics for disaggregating health indicators.

This collaborative national work resulted in recommended definitions for six equity characteristics for measuring health inequalities: age, sex, gender, income, education and geographic location. (Source: In Pursuit of Health Equity: Defining Stratifiers for Measuring Health Inequality — A Focus on Age, Sex, Gender, Income, Education and Geographic Location.

<https://www.cihi.ca/sites/default/files/document/defining-stratifiers-measuring-health-inequalities-2018-en-web.pdf>)

This CHA report supports measuring health inequalities by:

- Stratifying data by geographic location and sometimes also by age groupings and sex
- Reporting disparity ratios (by geography and/or income)
- Presenting data graphs and tables in a new way to help identify disparities or health gaps

Measuring Changes in Population Health

Wherever possible, indicators are reported in several ways:

- For at least two time periods, to measure change over time
- By large geographies: the health regions as well as the provincial Manitoba rates
- By smaller geographies, at the zone and district levels (or Community Areas and Neighborhood Clusters for WRHA) to provide more details at local levels.
- By geographic and/or income disparity
- Select indicators are further disaggregated by other factors such as sex or age groupings.

To provide a comprehensive picture of the health of the people living in our communities, information regarding the social determinants of health, health status measures by region and health status changes over time is presented throughout this report.

ENDNOTES

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- ^{xv} Canadian Medical Association (2013). *Health care in Canada: What makes us sick?: Canadian Medical Association Town Hall Report*. Ottawa (ON): Canadian Medical Association.
- ^{xvi} Heaman M, Kingston D, Helewa ME, Brownell M, Derksen S, Bogdanovic B, McGowan KL, Bailly A. *Perinatal Services and Outcomes in Manitoba*. Winnipeg, MB. Manitoba Centre for Health Policy, November 2012.
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