Community Needs **ASSESSMENT** Summary Report

2019

DETAILED REPORT OF FINDINGS:
Introduction and Methods

Health and Social Services
Haldimand and Norfolk

Report prepared by Quality, Planning, Accountability and Performance (QPAP)

Acknowledgements

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Table of Contents

Introduction

Introduction

A Community Needs Assessment (CNA) aims to identify and understand the needs of the population within a region and identify factors that must be addressed to meet the population's needs[1], [2]. When used to understand health and social service needs, a CNA should be designed to understand the needs of the population as well as factors that individuals need to feel healthy, safe, and protected in their community. A CNA typically involves three key steps: (i) assessment; (ii) dissemination; and (iii) implementation[1].

The assessment phase of the Haldimand Norfolk Health and Social Services (HNHSS) Division CNA involved four elements: (i) a community profile; (ii) a community survey; (iii) focus group discussions with priority population groups; and (iv) key informant interviews. This report provides a summary of findings of the assessment phase.

The HNHSS CNA will contribute to the future planning and actions of the Division and will be used by Senior Leadership, Program Management, and Program Staff to inform program offerings and implementation strategies. The multi-faceted approach helped to ensure this diversity and representativeness.

Rationale for HNHSS CNA 2019

The HNHSS CNA 2019 is intended to inform actions and next steps for the Division. The findings will inform key community priorities for action and advocacy and guide agency planning, inform resource allocation, and improve service offerings for the public[1]. Further, community engagement throughout the CNA can improve relationships with community members, local agencies, and other groups. Finally, targeting interventions according to the mandate of the Ministry of Health will also increase the efficiency of health programming[1].

Objectives

The specific objectives of this CNA were to:

i. Describe current health and social status as well as needs of all residents in Haldimand and Norfolk Counties;

ii. Identify needs and gaps for future improved health and social programming in Haldimand and Norfolk Counties;

iii. Support evidence-informed decision-making and planning to address noted gaps in programming for health and social services in the region; and

iv. Share findings from the CNA in the form of a report internally within the HNHSS Division and the Board of Health, and in the form of a summary report externally with the residents of Haldimand and Norfolk Counties and Municipal Councils.

How to Use this Report

This report has been designed to be as usable and user-friendly as possible. The report exists in several forms: a 2-page infographic, an executive summary, and a full detailed report. The 2-page version is a brief overview of the entire CNA process meant to be accessible to all who are interested in the findings of the CNA. The executive summary is approximately 30 pages in length and includes key quantitative and qualitative results and high-level conclusions across all facets of HNHSS. The detailed report is presented in chapters. The detailed report includes 14 chapters that comprehensively cover the quantitative and qualitative results relevant to each topic and the related recommendations and next steps. The detailed report includes all findings from the community profile, the community survey, and the key informant interviews and focus group discussions in context of these particular topics.

We suggest that staff and agencies read the executive summary in full and identify any chapters of the detailed report

Methods

that influence their programming or interactions with the community. The HNHSS Quality, Planning, Accountability, and Performance Department (QPAP) staff are available to provide support internally and externally to agencies looking to understand the findings and implement any recommendations from the report.

Methods

Approach

Overall, the HNHSS CNA employed a community-based participatory mixed-methods approach. A community-based approach signifies that the methods chosen for this CNA are reflective of practices that put the community at the centre of the data collection and interpretation processes. A participatory approach is rooted in the participatory action research literature and emphasizes meaningful dialogues and collaboration with the community[3]. And finally, a mixed-methods approach purposefully incorporates both quantitative and qualitative data collection and analyses simultaneously, to more holistically understand the issues and data[4]. A focus on community-centered data and lived-experience were essential to this CNA process.

Ethical protocols for this study were evaluated by the Research Advisory Council (RAC) at HNHSS.

Community Profile

The purpose of the community profile element of the CNA was to describe the general residents and priority populations of Haldimand and Norfolk Counties. To generate the community profiles, a list of indicators for demographics, health, and social services was developed. The indicators were identified from a variety of sources, including the HNHSS Program Operational Plans, the CNA for Windsor-Essex County Health Unit [1], and in discussion amongst QPAP staff and other HNHSS staff.

Data to provide evidence for each of the identified indicators was collected by QPAP staff from available sources. Sources varied depending on the indicator, including Public Health Ontario, Statistics Canada, Intellihealth, and HNHSS previously collected and verified data (please see citations in results for more information). When available, data were collected for Haldimand County, Norfolk County, Haldimand and Norfolk Counties combined, and for Ontario.

Data were aggregated and analyzed to provide relevant measures for the region and to generate summary measures of the data (e.g. rates, means, medians, modes, ranges). Data were investigated for emerging trends over space and time that may differentiate the Haldimand and Norfolk region from other parts of Ontario (i.e. higher, lower, or different distributions). Data included in the community profile reflect the most recent data available at the time of publication of this report.

Community Survey

The purpose of the community survey was to collect data from members of the general population and to investigate demographics, perspectives, and health and social behaviours of the community. The survey was anonymous and open to all residents of Haldimand and Norfolk Counties.

The community survey primarily collected information via closed-ended questions, and included a limited number of open-ended questions for additional feedback. The survey tool was adapted from an existing validated tool for a CNA in a neighbouring health unit [1]. The adaptations to the tool included updating of terms to reflect the most culturally

appropriate language of the time, addition of questions specific to rural communities, addition of a section related to the environment and climate change, and addition of questions throughout for social services needs and program utilization (Appendix A).

The survey was available in English, French, and Spanish. Given the local demographics, a Low German version of the survey was also available; however, incorporating expert feedback, this version was shorter and used as a conversation guide for interview-style data collection. The Low German survey responses were analyzed separately given the modifications made to the methods.

The survey was available online (Select Survey, Norfolk County) and in paper formats. The online survey was distributed via HNHSS social media and across social media accounts for Haldimand and Norfolk Counties. The paper survey was distributed at several locations across the two counties, including libraries, churches, hospitals, county fairs, and community agencies. Completed paper surveys were returned to any of the HNHSS physical location sites (i.e. Simcoe, Dunnville, and Caledonia) and to the locations where surveys were obtained in the community.
The survey was reviewed by members of the QPAP team for accuracy and completeness. Further, Social Determinants of Health Public Health Nurses (SDOH PHNs) reviewed the survey for literacy level and accessibility considerations.

Participants must be ≥18 years of age to consent to participate in the community survey. Participants who completed the survey were eligible for inclusion in a draw for one of three grocery store gift cards.

Paper survey responses were entered into Select Survey (Norfolk County) by QPAP staff to create a single database for all survey data. Data were analyzed via descriptive statistics, which included frequencies and proportions. Descriptive statistics were further interrogated by stratification by gender (male, female, gender non-conforming, prefer not to answer), age (18-25 years, 26-40 years, 41-60 years, 61-75 years and >75 years), income bracket (<$30,000, $30,000-<$50,000, $50,000-<$70,000, $70,000-<$100,000, ≥$100,000), and county (Haldimand, Norfolk). Data were analyzed using Select Survey (Norfolk County) and Microsoft Excel ©.

Focus Groups Discussions and Interviews

The purpose of the focus groups with priority population groups and the key informant interviews was to intentionally elicit and incorporate lived-experiences that might not otherwise be included in the CNA.

Focus groups were conducted with community members with lived-experiences from a variety of different backgrounds and who possessed various knowledges in groups of 3-8 participants. Priority populations were identified in expert consultations with SDOH PHNs, Program Managers, and the Overseeing Committee. Priority populations were contacted purposively through HNHSS known contacts, community agencies, and snow-ball (i.e. step-wise) sampling strategies. In some cases, staff from agencies that worked with or represented priority populations were included in the focus groups, at the discretion of the participants and agency. To protect the confidentiality of participants, no list of community agencies was included in this report.

Key informant interviews were primarily conducted with representatives from HNHSS and other health and social services-related community agencies. Where appropriate or desired by participants for a variety of reasons (e.g. anonymity), lived-experiences were documented via key informant interviews rather than via focus groups. Key informants were identified via a purposive snow-ball sampling strategy.

Both focus groups and interviews were conducted using open-ended questions in a semi-structured, participatory interview[3]. All focus groups and interviews were facilitated by the CNA Project Lead. Focus group and interview guides were developed a priori and modified conversationally as needed to collect the most relevant and useful information. Topics investigated in focus groups and interviews reflected the topics of the survey (e.g. perspectives, health and social behaviours of the community), allowing

for a more comprehensive understandings of the needs of the community. Participants were guaranteed a safe-space to share their feedback, both negative and positive, with the facilitator/ interviewer.

Participation in either focus groups or interviews was entirely voluntary. Focus group participants and interview participants that were part of a priority population sample were offered a small incentive gift card as a token of thanks. Key informants representing community agencies were thanked for their time but not offered incentives. Inclusion criteria for focus groups and interviews included being a resident of Haldimand or Norfolk County and fitting the profile of the specific demographic group or agency type that was sought for participation.

Conversations were recorded with consent from participants. The facilitator recorded detailed notes to supplement the recordings. Recordings of focus groups and interviews were later transcribed by members of the QPAP team. Transcripts from focus groups and interviews were analyzed via thematic analyses according to a codebook generated by members of the research team[5]. The codebook included data-driven (i.e. emergent) and theory-driven (i.e. determined a priori from the literature) codes. Thematic analyses were conducted in Dedoose vs. 8.2.14 ©.

Staff Workshop

HNHSS staff participated in a full-day, offsite training workshop focused on anti-oppression tactics on Thursday, November 7th, 2019. The final workshop activity involved working in groups of approximately 10 staff to generate a list of weaknesses of the organization (i.e. related to health inequities and oppressive practices) and then generate a variety of solutions to the problem. Over 100 staff participated in the training from across all departments of HNHSS and across all levels of management. The lists and ideas generated by staff were recorded by group note-takers and submitted to the CNA Research Team. The data were analyzed qualitatively, according to the same processes as the focus group discussions and interviews.

Triangulation and Results Validation

The data collected from the four elements described above were not analyzed in isolation. A series of results validation tools for qualitative and mixed-methods analyses were employed to ensure the accuracy and reliability of findings[6]. The synthesis process results in stronger support for the conclusions drawn from the data.

Triangulation was used to synthesize the findings from the various data collection strategies to identify areas of agreement and disagreement in the data and to increase the validity of the research findings[6]. Triangulation refers to the ways that the different sources and types of information (i.e. community profile, community survey, and focus group and interview transcripts) are integrated into comprehensive understandings of an issue. Specifically, we employed triangulation across data sources (i.e. participants), methods, and investigators[6].

Additional strategies used for data validation in the CNA were member checking, collaboration, and peer debriefing. Member checking was to increase the validity of the results by speaking with participants about emerging themes and ideas, asking for clarification, and seeking elaboration or correction as needed[6]. Collaboration refers to the intentional involvement of participants as co-researchers in a variety of roles[6]. Collaborators for the CNA included HNHSS clients and community agencies. Finally, peer debriefing was repeated regularly throughout the research process as the CNA Research Team investigated trends and themes and discussed the emerging results with other members of the QPAP Team.

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