Central New Brunswick Area

COMMUNITY HEALTH NEEDS ASSESSMENT

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

08/2015

Produced by

Horizon Health Network's

Community Health Assessment Team

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LIST OF ABREVIATIONS

CHA Team – Community Health Assessment Team

CHNA – Community Health Needs Assessment

EMP – Extra-Mural Program

NBHC – New Brunswick Health Council

CAC – Community Advisory Committee

ID – Interpretive Description

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1.0 EXECUTIVE SUMMARY

Introduction

The Central New Brunswick area is a diverse region both geographically and demographically. With the exception of the growing community of Douglas, the region is primarily comprised of rural villages. Although the population has seen an increase of 3% between 2006-2011, this increase is due mainly to the development of the Douglas area. Similarly, although data indicates Central N.B. has a younger population, this is also skewed by the inclusion of the Douglas area where many younger families reside. Historically, the rural areas of Central N.B. relied predominantly on the forestry industry which has seen a decline in recent decades. Given that large part of the area follows the Miramichi River, the salmon fishing industry is a major aspect of the community's history and culture, as well as a source of employment. In the more rural parts of the community, the population is mainly made up of seniors. Median household income in the community is $56,579 (2011) and 17% of people in the Central N.B. area live in low income. Data shows that the community has elevated rates of chronic diseases such as arthritis, asthma, diabetes, and emphysema/COPD.

Background

In 2012, the province of New Brunswick released the Primary Health-Care Framework for New Brunswick, highlighting Community Health Needs Assessments as an integral first-step to improving existing primary health-care services and infrastructure in the province. Following the Department of Health's recommendation for Community Health Needs Assessments, the two regional health authorities in the province, Horizon Health Network (Horizon) and Vitalité Health Network (Vitalité), assumed responsibility to conduct assessments in communities within their catchment areas.

Community Health Needs Assessment

Community Health Needs Assessment (CHNA) is a dynamic, ongoing process that seeks to identify a defined community's strengths, assets, and needs to guide in the establishment of priorities that improve the health and wellness of the population.

While the CHNA process is designed to be flexible and accommodate unique differences in each community, Horizon's Community Health Assessment (CHA) Team uses a 12-step process to conduct CHNAs that takes into account these differences at each stage:

1. Develop a local management committee for the selected community
2. Select Community Advisory Committee (CAC) members with the assistance of the management committee
3. Establish CAC
4. Review currently available data on selected community
5. Present highlights from data review to CAC members
6. CAC members share insights about what is missing from currently available data and discuss how best to fill these information gaps
7. Development a qualitative data collection plan
8. Qualitative data collection in the community
9. Data analysis
10. Share emerging themes from data analysis with CAC members and identify priorities
11. Finalize themes, recommendations, and final report
12. Share final report with CAC members and the larger community and begin work planning

CHNAs conducted within Horizon communities are guided by the population health approach, which endeavors to improve the health of the entire population and to reduce health inequities by examining and acting upon the broad range of factors and conditions that have a strong influence on our health, often referred to as the **determinants of health**. Horizon's CHA Team uses determinant of health categorizations from the Public Health Agency of Canada and the New Brunswick Health Council (NBHC).

Methodology

Quantitative data review and qualitative data collection, review and analysis were used by Horizon's CHA Team. Data compilations produced by the NBHC such as *My Community at a Glance* and *The Primary Health Care Survey* were used to review currently available quantitative data as many of the indicators are broken down to the community level. Based on limitations of the quantitative data review, a qualitative data collection plan was established by the CHA Team in partnership with the Central NB Area Community Advisory Committee (CAC). Five key stakeholder groups were identified for consultation through the focus group interview method:

- Stanley Women's Breakfast Club
- Seniors Issues
- Mental Health & Addictions Professionals
- Young Adults
- Primary Health-Care

The qualitative component of CHNAs conducted by Horizon's CHA Team is guided by the Interpretive Description methodology, using a key issues analytical framework approach. A summarized list of key issues was then presented to the Central N.B. Area CAC for feedback, and CAC members were asked to participate in a prioritization exercise of the key issues based on their own experience of the community. The priorities that emerged from the exercise are used to finalize the list of priorities and recommendations for the Central N.B. Area.

Results & Recommendations

The methodology used by the CHA Team resulted in the identification of seven priority issues. Table 1 below outlines the seven priority issues and provides recommendations for each.

Table 1: Central N.B. Area CHNA Identified Priority Areas and Recommendations

Priority → → → → → → →	Recommendation
1. Transportation issues in the community that impact health	Examine the health challenges faced in the community due to limited transportation, review how other communities are addressing this challenge and work with key community stakeholders to develop a strategy to improve transportation
2. The need for more mental health services in the community and an improved process for referral to mental health & addictions	Further consult with mental health professionals working in the community and leadership form Horizon's mental health & addictions to determine what additional services are needed in the community and how to overcome system level challenges
3. The need for more access to Extra-Mural Program (EMP) services in the community	Further explore EMP access issues by consulting and communicating with EMP leadership and together review EMP utilization data for the community to determine if there are gaps in access and how best to fill them
4. The need for more affordable seniors housing in the community	Working with community leadership, representatives from Social Development and current senior's housing operators, assess current availability, wait lists and gaps and create a plan to address seniors housing needs in the community
5. Alcohol use in the community	Working with educators, mental health & addictions professionals and the community's Wellness Consultant, develop a strategy to address alcohol use in the community
6. Limited recreational programing/activities for youth in the community	Through partnerships with the Health Centers, village councils, and schools, develop a recreation council to review currently available recreational programming for youth and determine where additions can be made
7. Increase use of amphetamines among youth and young adults in the community	Working with mental health & addiction professionals, law enforcement and educators, develop a plan to address amphetamines use in the community

2.0 BACKGROUND

2.1 Primary Health Care Framework for New Brunswick

In 2012, the province of New Brunswick released the Primary Health Care Framework for New Brunswick with the vision of *better health and better care with engaged individuals and communities.*[1] The framework states that this vision will be achieved through an enhanced integration of existing services and infrastructure and the implementation of patient-centered primary health-care teams working collaboratively with regional health authorities to meet identified health needs of communities. The framework highlights "conducting community health needs assessments" as an important first step towards achieving these improvements and states that, "community health needs assessments have the potential to not only bring communities together around health care but to collectively identify community assets, strengths and gaps in the system[2]."

2.2 Horizon Health Network's Community Health Assessment Team

Although conducting CHNAs is a recommendation from the New Brunswick Department of Health, it is the responsibility of the two regional health authorities in the province, Horizon and Vitalité, to conduct the assessments in communities within their catchment areas. Prior to 2014, assessments conducted within Horizon communities were done with the services of external consultant companies. In 2014, Horizon decided to build internal capacity for conducting CHNAs in order to refine the process and make it more cost-effective. Horizon's CHA Team consists of one research lead and one project coordinator.

Responsibilities of the CHA Research Lead:

- formulate the research approach
- review available quantitative data sets
- collaborate with key community stakeholders
- qualitative data collection and analysis
- report writing

Responsibilities of the CHA Project Coordinator:

- coordinate with key community stakeholders
- establish and organize CACs
- coordinate data collection plans
- report writing and editing

2.3 Community Health Needs Assessment

CHNA is a dynamic, ongoing process that seeks to identify a defined community's strengths and needs to guide in the establishment of priorities that improve the health and wellness of the population[3].

The goals of a CHNA are:

- to gather and assess information about the health and wellness status of the community
- to gather and assess information about resources available in the community (community assets)
- to determine the strengths and challenges of the community's current primary health-care service delivery structure in order to adapt it to the needs of the community
- to establish health and wellness priority areas of action at the community level
- to enhance community engagement in health and wellness priorities and build important community partnerships to address priority areas

2.4 The Population Health Approach

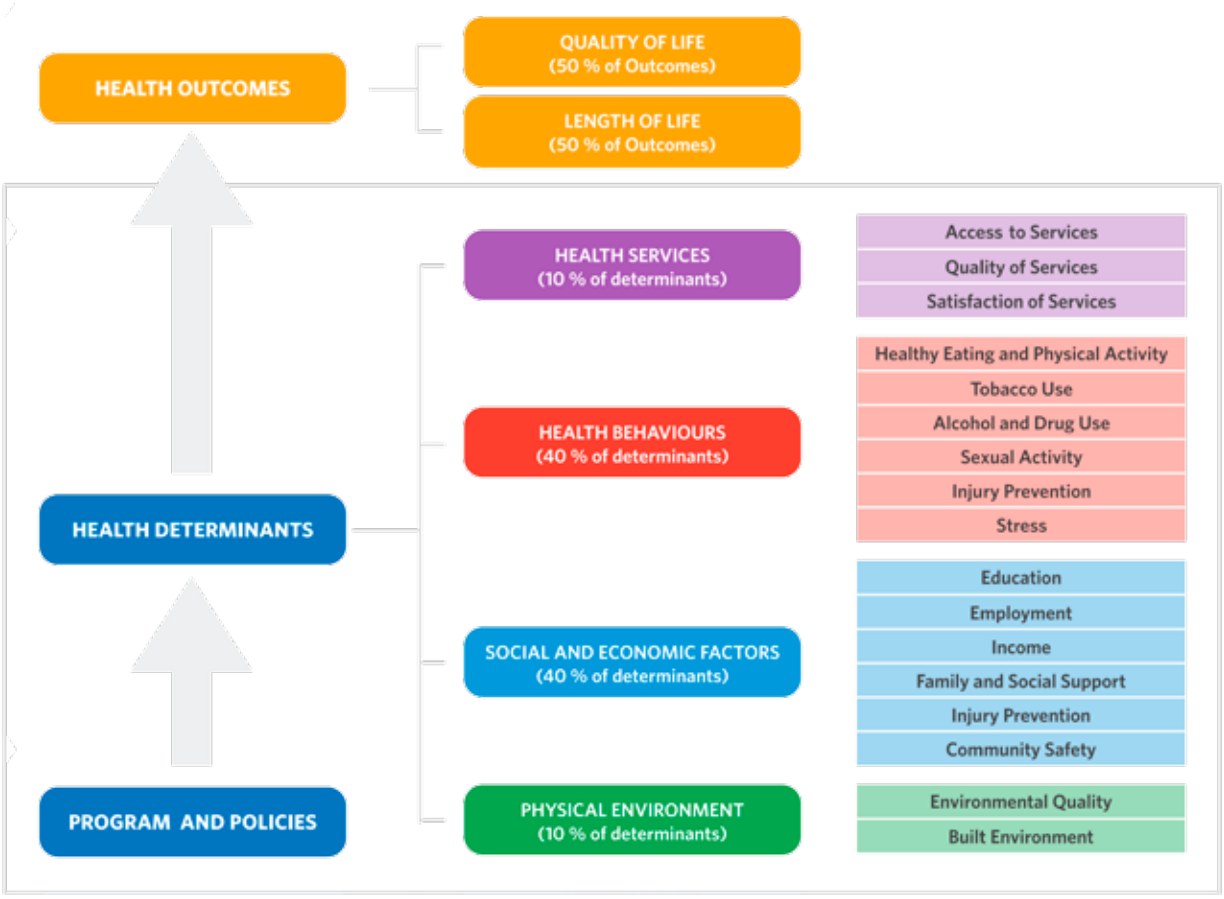
Health is a complex subject and assessing the health of a community goes far beyond looking at rates of disease and the availability of health-care services. Therefore, CHNAs conducted within Horizon communities are guided by the population health approach. This approach endeavors to improve the health of the entire population and to reduce health inequities (health disparities) among population groups by examining and acting upon the broad range of factors and conditions that have a strong influence on our health[4]. These factors and conditions are often referred to as the

determinants of health and are categorized by the Public Health Agency of Canada as:

1. Income and Social Status
2. Social Support Networks
3. Education and Literacy
4. Employment and Working Conditions
5. Social Environment
6. Physical Environment
7. Personal Health Practices and Coping Skills
8. Healthy Child Development
9. Biology and Genetic Endowment
10. Health Services
11. Gender
12. Culture[5]

CHNAs conducted within Horizon communities are also informed by the population health model of the New Brunswick Health Council (whose role we will discuss in section 2.5), which is adapted from the model used by the University of Wisconsin's Population Health Institute. This model narrows the list of determinants into four health determinant categories and assigns a value to each according to the degree of influence on health status: health services 10%, health behaviors 40%, social and economic factors 40% and physical environment 10%.

FIGURE 1: POPULATION HEALTH MODEL

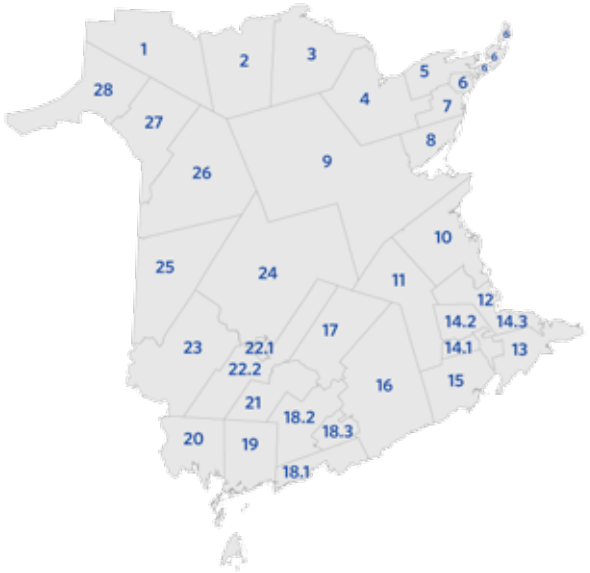


2.5 Defining Communities

For CHNAs, individual community boundaries are defined by the New Brunswick Health Council (NBHC). The NBHC works at arms length of the provincial government and has a dual mandate of engaging citizens and reporting on health system performance through areas of population health, quality of services, and sustainability.[6]

The NBHC has divided the province into 28 communities (with the three largest urban cores subdivided) to ensure a better perspective of regional and local differences. These community divisions can be seen on the map in figure 2 below. The actual catchment area of health-care centres, community health centres, and hospitals were used to determine the geographical areas to be included for each community. Census subdivisions were then merged together to match these catchment areas. The communities were further validated with various community members to ensure communities of interest were respected from all areas of New Brunswick. No communities were created with less than 5,000 people (as of Census 2011) to ensure data availability, stability, and anonymity for the various indicators. The NBHC uses these community boundaries as the basis for work and analysis done at the community level[7].

FIGURE 2: NBHC COMMUNITIES



2.6 The Central N.B. Area

One of the NBHC communities selected by Horizon for assessment in 2015 is community 24, identified by the NBHC as the *Douglas, Saint Marys, Doaktown* area. Based on feedback from key community stakeholders, for the sake of the CHNA, this community was renamed the **Central N.B. Area**. Figure 3 below shows the Central N.B. Area and lists the smaller communities that fall within it.

FIGURE 3: Central N.B. Area

Blissfield	Ludlow
Boiestown	McLeod Hill
Burtts Corner	New Bandon
Doaktown	Royal Road
Douglas	Saint Marys
Estey's Bridge	Stanley
Hamtown Corner	Tay Creek
Killarney Road	Upper Miramichi

The Central N.B. area is a mostly rural part of New Brunswick near the provinces geographic center. The community is made up of mainly small rural villages with the exception of the community of Douglas; a suburban community that has seen the development of 2 large residential subdivision in recent decades. The population of the Central N.B. Area is 15,803 (2011). The population has seen an increase of 3% between 2006-2011, but this increase is

due mainly to the development of the Douglas area as the more rural villages in this community have seen decreases in their populations. In the past, the more rural parts of Central N.B. were predominately reliant on the forestry industry which has seen a decline in recent decades. Given that a large part of the area follows the Miramichi River, the salmon fishing industry is a major aspect of the community's history and culture, as well as a source of employment. Age rates in the community show that Central N.B. has a younger population, however, this rate is also skewed by the inclusion of the Douglas area in the community where many younger families reside. In the more rural parts of the community, the population is mainly made up of seniors, and many of the younger families have left the community to seek employment elsewhere. The median household income in the community is $56,579 (2011) and 17% of people in the Central N.B. area live in low income. Consultations with community stakeholders reveal that income levels may also be skewed by the inclusion of Douglas; the median income is thought be much lower in the more rural areas. Data shows that the community has elevated rates of chronic diseases such as arthritis, asthma, diabetes, and emphysema/COPD.

TABLE 2: CHRONIC HEALTH CONDITIONS IN THE CENTRAL N.B. AREA[8]

Chronic Health Conditions[1]	2011 (%)	2014 (%)	2014[2] (#)	NB (%)
One or more chronic health conditions[3]	62.2 (56.8 – 67.6)	63.2 (57.6 – 68.8)	7,912	61.6 (60.8 – 62.4)
High blood pressure	25.9 (21.2 – 30.6)	26.5 (21.3 – 31.6)	3,313	27.0 (33.3 - 38.3)
Arthritis	18.5 (14.3 – 22.7)	21.1 (16.3 – 25.8)	2,635	17.4 (16.8 – 18.0)
Gastric Reflux (GERD)	23.7 (19.1 – 28.3)	15.1 (10.9 - 19.3)	1,892	16.4 (15.8 – 17.0)
Asthma	12.5 (8.9 – 16.0)	14.0 (10.0 – 18.1)	1,754	11.8 (11.3 – 12.4)
Chronic pain	15.3 (11.4 – 19.2)	13.7 (9.6 – 17.7)	1,709	14.0 (13.5 – 14.6)
Diabetes	10.5 (7.2 – 13.8)	12.9 (9.0 – 16.9)	1,618	10.7 (10.1 – 11.2)
Depression	13.3 (9.6 – 16.9)	10.6[E] (7.0 – 14.2)	1,332	14.9 (14.3 – 15.5)
Heart disease	10.4 (7.1 – 13.7)	8.1[E] (4.9- 11.2)	1,009	8.3 (7.9 – 8.8)
Cancer	7.6 [E] (4.8 – 10.5)	5.2[E] (2.6 – 7.8)	653	8.3 (7.8 – 8.7)
Emphysema or COPD	F	4.1[E] (1.8 – 6.4)	516	3.0 (2.7 - 3.3)
Stroke	F	F	274	2.5 (2.2 – 2.8)
Mood disorder other than depression	F	F	56	3.0 (2.7 – 3.2)

Primary health-care services in the Central N.B. Area are provided through the Central Miramichi Community Health Center, the Stanley Health Center, and the Boisetown Health Center. Based on data from the NBHC's Primary Health Care Survey of New Brunswick, 93.1% of respondents from this community have a personal family doctor. Also, Central NB Area primary health-care services are highly rated in a number of indicator areas. Table 3 below shows some of these indictors for the Central N.B. Area.

TABLE 3: PRIMARY HEALTH CARE SURVEY INDICATORS FOR THE CENTRAL N.B. AREA[9]

Primary Health Care Survey Indicator	2011	2014	NB
How often was a medical condition or prescription explained to you in a way that you could understand? (% always or usually)	91.3	92.3	91.0
How quickly appointment can be made with family doctor (% on same day or next day)	37.4	35.1	30.1
How quickly appointment can be made with family doctor (% within 5 days)	68.3	67.3	60.3
How often family doctor involves citizens in decisions about their health care (% always)	66.5	69.0	68.2
How often family doctor gives citizens enough time to discuss feelings, fears and concerns about their health (% always)	69.6	73.0	71.9
Satisfaction with services at a community health center (% 8, 9 or 10 on a scale of 0-10)	79.1	80.7	76.2

3.0 STEPS IN THE CHNA PROCESS

CHNAs are a community driven process where community members' opinions are valued and taken into account for planning purposes. Therefore, the CHNA process needs to be flexible in order to meet the needs of individual communities. Each community is unique and therefore the same approach to conducting CHNAs is not always possible. When communities feel that they have a role in driving the CHNA process, they are more likely to feel ownership for the results and have a higher level of engagement. That being said, Horizon's CHA Team uses a 12-step process that tends to work well for most communities while staying flexible to accommodate the unique needs of the communities they work with. These 12 steps are:

1. Develop a management committee for the selected community
2. Select CAC members with the assistance of the management committee
3. Establish CAC (the role of the CAC is discussed in section 4.0)
4. Review currently available data on selected community
5. Present highlights from data review to CAC members.
6. CAC members share insights about what is missing from currently available data and discuss how best to fill these information gaps
7. Development of a qualitative data collection plan
8. Qualitative data collection in the community
9. Data analysis
10. Share emerging themes from data analysis with CAC members and identify priorities
11. Finalize themes, recommendations, and final report
12. Share final report with CAC members and the larger community and begin work planning

Step One:
Develop a management committee for the selected community.

Because the CHA Team is not always closely connected to the communities undergoing assessment, it is important to first meet with key individuals who have a strong understanding of the community. These individuals are often key leaders within Horizon who either live or work within the selected community and have a working relationship with its residents. Management committee members are often able to share insights on preexisting issues in the community that may impact the CHNA.

Step Two:
Select Community Advisory Committee (CAC) members with the assistance of the management committee.

With the use of the CAC membership selection guide (found in the technical document), the research team and management committee brainstorm the best possible membership for the CAC. First a large list of all possible members is compiled and then narrowed down to a list that is comprehensive of the community and a manageable size (the role of the CAC is discussed in section 4.0).

Step Three:
Establish CAC.

Coordinated by Horizon's CHA Project Coordinator, the first CAC meeting is established. Both the project coordinator and the management committee play a role in inviting CAC members to participate. At the first meeting, the research team shares the goals and objectives of the CHNA with the CAC and discusses the particular role of the CAC (CAC terms of reference can be found in the technical document).

Step Four:
Review currently available data on selected community.

Because CHNAs conducted within Horizon are based on the geographic community breakdowns defined by the NBHC, the research team used many of their data compilations,

which come from multiply surveys and administrative databases. The team reviews this data looking for any indicators that stand out in the selected community.

Step Five:
Present highlights from data review to CAC members.

Highlights from the data review are shared with CAC members and they are asked to reflect on these indicators. Often this leads to good discussion as members share their experience of particular indicators. This usually takes place during the second meeting of the CAC and at the end of this meeting; members are asked to reflect on what is missing from the data reviewed for discussion at the next meeting.

Step Six:
CAC members share insights about what is missing from currently available data and discuss how best to fill these information gaps.

This often takes place during the third meeting of the CAC. Members share what they feel is missing from what has already been reviewed and sometimes members will have other, locally derived data to share with the research team. This leads to a discussion about who should be consulted in the community.

Step Seven:
Development of a qualitative data collection plan.

Using the suggestions shared by CAC members, the CHA Team develops a qualitative data collection plan outlining what methods will be used, who the sample will be and timelines for collection.

Step Eight:
Qualitative data collection in the community.

During this step, the CHA Team is in the community collecting qualitative data as outlined in the data collection plan from step seven.

Step Nine:
Data analysis.

All qualitative data collected is audio recorded and then transcribed by a professional transcriptionist. These data transcriptions are used in the data analysis process. This analysis is then cross referenced with the currently available quantitative data reviewed in step four.

Step Ten:
Share emerging themes from data analysis with CAC members and identify priorities.

Discussion summaries are developed for each of the themes that emerged from the analysis that are shared with CAC members, both in document form and also verbally shared through a presentation by the CHA Team. CAC members are then asked to prioritize these themes, which are taken into account when the CHA Team finalizes the themes and recommendations. This usually takes place at the fourth meeting of the CAC.

Step Eleven:
Finalize themes, recommendations, and final report.

Utilizing the CAC members' prioritization results, the CHA Team finalizes the themes to be reported and develops recommendations for each theme. These are built into the final CHNA report.

Step Twelve:
Share final report with CAC members and the larger community and begin work planning.

A final fifth meeting is held with the CAC to share the final report and begin work planning based on the recommendations. During this step, the CHNA results are also shared with the larger community. This process differs from community to community. Sometimes it is done through media releases, community forums or by presentations made by CAC members to councils or other interested groups.

4.0 CENTRAL N.B. AREA COMMUNITY ADVISORY COMMITTEE

One of the first steps in the process when completing the CHNA is the establishment of a CAC. CACs play a significant role in the process as they are an important link between the community and Horizon's CHA Team. The mandate of the Central NB Area CAC is:

To enhance community engagement throughout the Central NB Area CHNA process and provide advice and guidance on health and wellness priorities in the community.

The specific functions of the Central N.B. Area CAC are to:

- attend approximately five two-hour meetings
- do a high level review of currently available data on the Central N.B. Area provided by the CHA Team
- provide input on which members of the community should be consulted as part of the CHNA
- review themes that emerge through the CHNA consultation process
- contribute to the prioritization of health and wellness themes

As explained in step 2 of the CHNA 12-step process above, members for CACs are chosen in collaboration with key community leaders on the CHNA Management Committee. This is done with the use of the CAC membership selection guide which can be found in the technical document. To help ensure alignment with the population health approach and that a comprehensive representation of the community is selected, this guide uses the 12 determinants of health categories listed in section 2.4.

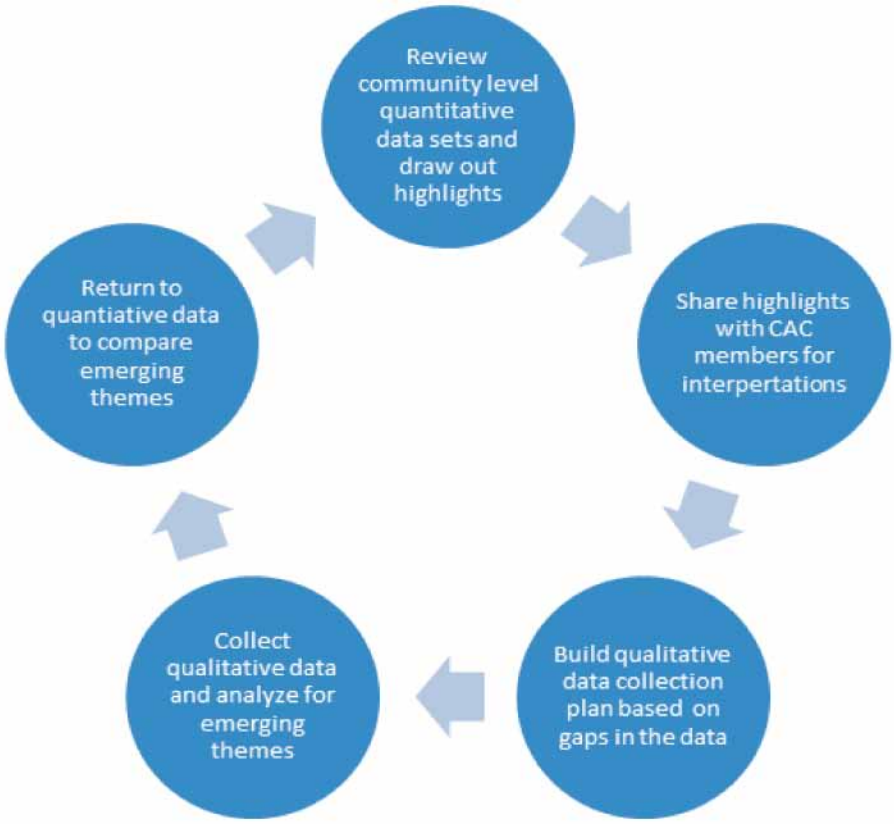
Membership for the Central N.B. Area CAC consisted of representation from:

- Management, CMCHC
- Social Worker, CMCHC
- Registered Nurse, Boiestown Health Center
- Registered Nurse, Stanley Health Center
- Nurse Practitioner, CMCHC
- Mayor of Doaktown
- Teacher, Central N.B. Academy
- Upper Miramichi Rural Council
- Boiestown Nursing Home
- Stanley Village Council
- Stanley Food Bank
- Clerk, Stanley Health Center
- RCMP Community Program Officer
- Wellness Consultant, Social Development
- Upper Nashwaak Community Outreach Inc.
- Dietitian, Stanley, Boiestown, Doaktown
- Anglican Parish of Stanley
- Live Well Bien Vivre Health Coach

5.0 RESEARCH APPROACH

As outlined in section 3.0, one of the first steps in the CHNA process is a review of currently available quantitative data on the community by the CHA Team. Significant highlights are drawn out and shared with CAC members. The CAC members are asked to apply their own interpretation to these highlighted indicators and to indicate when further exploration is required to determine why a particular indicator stands out. These issues are further explored through the qualitative component of the CHNA. Once qualitative data is collected and analyzed for emerging themes, the CHA Team reviews the quantitative data once more to compare.

FIGURE 4: RESEARCH APPROACH



5.1 Quantitative Data Review

As outlined in section 3.0, one of the first steps in the CHNA process is for the CHA Team to review currently available quantitative data on the community. The bulk of the data reviewed comes from data compiled by the NBHC. As mentioned earlier, the NBHC has divided the province of New Brunswick into unique communities with their own data sets. The CHA Team uses two of these data sets extensively:

- **My Community at a Glance.** These are community profiles that give a comprehensive view about the people who live, learn, work, and take part in community life in that particular area. The information included in these profiles comes from a variety of provincial and federal sources, from either surveys or administrative databases.[10] In keeping with our guiding approach of population health, indicators within these profiles are divided based on the model shown in figure 1 above.
- **The Primary Health Care Survey.** First conducted in 2011, and then again 2014. Each time, over 13,500 citizens responded to the survey by telephone, in all areas of the province. Its aim is to understand and report on New Brunswickers' experiences with primary health services, more specifically at the community level.[11]

5.2 Qualitative Methodology: Interpretive Description

The qualitative component of CHNAs conducted by Horizon's CHA Team is guided by the Interpretive Description (ID) methodology. Borrowing strongly from aspects of grounded theory, naturalistic inquiry, ethnography and phenomenology, ID focuses on the smaller scale qualitative study with the purpose of capturing themes and patterns from subjective perceptions.[12] The products of ID studies have application potential in the sense that professionals, such as clinicians or decision makers could understand them, allowing them to provide a backdrop for assessment, planning and interventional strategies. Because it is a qualitative methodology and because it relies heavily on interpretation, ID does not create facts, but instead creates "constructed truths." Thorne and her colleagues argue that the degree to which these truths are viable for their intended purpose of offering an extended or alternative understanding depends on the researcher's ability to transform raw data into a structure that makes aspects of the phenomenon meaningful in some new and useful way.[13]

5.3 Qualitative Data Collection

Step 7 of the CHNA process outlined in section 3.0 is the development of the qualitative data collection plan. This is done based on input received from CAC members. For the Central N.B. area CHNA, five key stakeholder groups were identified for consultation through the method of focus group interviews:

- Stanley Women's Breakfast Club
- Seniors Issues
- Mental Health & Addictions Professionals
- Young Adults
- Primary Health-Care

5.3.1 Focus Group Interviews

A focus group interview is an interview with a small group of people on a specific topic. Groups are typically six to 10 people with similar backgrounds who participate in the interview for one to two hours.[14] Focus groups are useful because you can obtain a variety of perspectives and increase confidence in whatever patterns emerge. It is first and foremost an interview, the twist is that, unlike a series of one-on-one interviews, in a focus group participants get to hear each other's responses and make additional comments beyond their own original responses as they hear what other people have to say. However, participants need not agree with each other or reach any kind of consensus. The objective is to get high-quality data in a social context where people can consider their own views in the context of the views of others.

There are several advantages to using focus group interviews:

- Data collection is cost-effective. In one hour you can gather information from several people instead of one.
- Interactions among participants enhances data quality
- The extent to which there is a relatively consistent, shared view or great diversity of views can be quickly assessed
- Focus groups tend to be enjoyable to participants, drawing on human tendencies as social animals.

It is also important to note that there are some limitations to conducting focus group interviews, such as restraint on the available response time for individuals, and full confidentiality cannot be assured if/when controversial or highly personal issues come up.

The CHA Research Lead acted as the moderator for the Central N.B. Area focus groups with the main responsibility of guiding the discussion. The CHA Project Coordinator was also present to collect consent forms, take notes, manage the audio recording, and deal with any other issues that emerged so that the moderator could stay focused and keep the discussion uninterrupted and flowing.

Focus group settings varied throughout the Central N.B. Area CHNA. Attempts were always made to hold focus groups in a setting that was familiar, comfortable and accessible for participants. Upon arrival, participants were asked to wear a name tag (first name only) to help with the conversation flow. The CHA Team developed a script that was shared at the beginning of each session, which can be found in figure 5 below. Individual focus group interview guides can be found in the technical document.

FIGURE 5: FOCUS GROUP INTRODUCTION GUIDE

INTRODUCTION:

- CHA Team introduce themselves
- General discussion of CHNA goals
- General discussion of the community boundaries
- General discussion of the role of CAC and how it relates to FGs
  - reviewed currently available data
  - this review lead to further consultations (FGs)
- What is expected of FG Participants:
  - engage in guided discussion
  - no agenda
  - do not need to come to any censuses - may not agree, that is ok.
  - no work to be done, not a problem solving or decision making group.
  - just sharing insights.
  - please feel free to respond to one another
  - as the facilitator, my role is just to guide the discussion. Just a few questions so there are lots of room for discussion.
- Confirm that everyone has signed the consent/confidentiality form and remind everyone to remember that what is shared during the session is to remain confidential.
- ANY QUESTIONS BEFORE WE BEGIN?
- Explain that, as stated in the consent form, we will be recording the session
  - confirm that everyone is comfortable with being recorded.
- Turn on recorders
- Group Introductions

5.4 Content Analysis Framework

Content analysis done by Horizon's CHA Team is based on the Key Issues analytical framework approach.[15] The first step in this approach is to have all audio recordings that are produced as part of the qualitative data collection plan transcribed into text by a professional transcriptionist. Each transcript is then read in its entirety by the CHA Team while using a code book and an open coding process. During this process all possible 'issues based' content is coded and is divided into general categories that emerge through the review. At this stage it is about making a volume list of anything that could possibly be viewed as an issue and less about the frequency, significance and applicability of the issue. This process helps to eliminate text that is more 'conversation filler', and leads to the creation of a data reduction document where text is sorted into board category areas.

At this stage of the framework, a second review is done of the data reduction document to pinpoint more specific issues in the text, once again with the use of a code book and more detailed coding. During this round of coding, the CHA Team considers frequency, significance, and applicability of the key issues (for the Central N.B. Area at this stage the list was 12 key issues). With the list complete, the CHA Team develops a summary of the discussion for each key issue. With the list of key issues and summaries developed the CHA Team returns to the quantitative data sets to see how certain indicators compare to what was shared through qualitative data collection. Sometimes the quantitative indicators support what is being said and sometimes they do not; either way the indicators related to the key issues are highlighted and incorporated into the key issue summaries.

This list of key issues and summaries is brought forward to the CAC as stated in Step 10 of the CHNA process outlined in section 3.0. The key issue summaries are shared with CAC members, and the CHA Team also meets with CAC members face-to-face to describe the key issues and review the summaries. After this review, CAC members are asked to participate in a prioritization exercise with the key issues based on their own opinion and experience of the community. The priorities that emerge from the exercise are used to finalize the list. This is a very significant step in the process because it helps to eliminate bias from the CHA Team by drawing on the input from CAC members who represent a comprehensive representation of the community.

6.0 RESULTS

Data analysis resulted in the identification of seven priority issues:

1. Transportation Issues in the community that impact health
2. The need for more mental health services in the community and an improved process for referral to mental health & addictions
3. The need for more access to Extra-Mural Program services in the community
4. The need for more affordable seniors housing in the community
5. Alcohol use in the community
6. Limited recreational programing/activities for youth in the community
7. Increase use of amphetamines among youth and young adults in the community

Table 2 outlines the eight priority issues and provides recommendations for each. Following the table, a profile for each of the priority issues is presented. These profiles include a summary of the qualitative consultation discussion, available community level quantitative indicators related to the priority issue, quotes from consultation participants and recommendations.

Given that CHNAs conducted within Horizon communities are guided by the population health approach as discussed in section 2.4 above, each priority issue is also connected with the determinant of health area(s) that is strongly influenced by or impacts the priority issue being discussed. You will recall from section 2.4 that the determinants of health are the broad range of factors and conditions that have a strong influence on our health and are categorized by the Public Health Agency of Canada as:

1. Income and Social Status
2. Social Support Networks
3. Education and Literacy
4. Employment and Working Conditions
5. Social Environment
6. Physical Environment
7. Personal Health Practices and Coping Skills
8. Healthy Child Development
9. Biology and Genetic Endowment
10. Health Services
11. Gender
12. Culture[5]

Table 4: Central N.B. Area CHNA Identified Priority Areas and Recommendations

Priority → → → → → → →	Recommendation
Transportation issues in the community that impact health	Examine the health challenges faced in the community due to limited transportation, review how other communities are addressing this challenge and work with key community stakeholders to develop a strategy to improve transportation
The need for more mental health services in the community and an improved process for referral to mental health & addictions	Further consult with mental health professionals working in the community and leadership form Horizon's mental health & addictions to determine what additional services are needed in the community and how to overcome system level challenges
The need for more access to Extra-Mural Program (EMP) services in the community	Further explore EMP access issues by consulting and communicating with EMP leadership and together review EMP utilization data for the community to determine if there are gaps in access and how best to fill them
The need for more affordable seniors housing in the community	Working with community leadership, representatives from Social Development and current senior's housing operators, assess current availability, wait lists and gaps and create a plan to address seniors housing needs in the community
Alcohol use in the community	Working with educators, mental health & addictions professionals and the community's Wellness Consultant, develop a strategy to address alcohol use in the community
Limited recreational programing/ activities for youth in the community	Through partnerships with the Health Centers, village councils, and schools, develop a recreation council to review currently available recreational programming for youth and determine where additions can be made
Increase use of amphetamines among youth and young adults in the community	Working with mental health & addiction professionals, law enforcement and educators, develop a plan to address amphetamines use in the community

6.1 Transportation issues in the community that impact health

Transportation issues were discussed by many participants as being a barrier to good health. Many discussed that because much of the community is rural and covers a large area, getting somewhere is a challenge. Participants shared how this challenge was particularly concerning for seniors in the community, who often live in the farther rural pockets of the community. It was discussed that lack of transportation means many members in more rural communities may not have good access to fresh whole foods. Participants also shared how lack of transportation impacts access to health services, and how this leads to missed appointments which cost the system money and may leave the health of the patient at risk. It was also discussed that transportation becomes a barrier for many students to be involved in after school activities because of long commutes home. Exclusion from these activities can impact both the mental and physical development of children and youth.

- Had transportation problems in getting health care when needed **6%**
- Health services not available in your area when needed **20%**
- Median commuting duration **21 minutes**

DETERMINANTS OF HEALTH: Social Environment, Personal Health Practices & Coping Skills, Healthy Child Development and Health Services

"Transportation for one. Getting to appointments, especially the elderly usually they rely on someone else to bring them or they have to hire somebody."

"There's always transportation, always that comes up with every single issue. Getting to appointments, getting to Fredericton, getting even to the clinic."

"…getting your kids drives because most people don't live close to where it's going to happen, if you're going to play games against other schools or other people, other communities there's more driving involved so it's hard."

RECOMMENDATION

Examine the health challenges faced in the community due to limited transportation, review how other communities are addressing this challenge and work with key community stakeholders to develop a strategy to improve transportation

6.2 The need for more mental health services in the community and an improved process for referral to mental health & addictions

Participants discussed the challenges faced when trying to access mental health services in the community. They explained that the services they do have are great, but that they do not have enough resources to meet the growing need in the community. Participants discussed the barriers in the system such as the initial uptake assessment which requires travel to Fredericton that many residents are not able to do. They also discussed that the wait-times for these initial assessments can be discouraging for patients, and shared stories about patients who did not access services because of these barriers. Participants also expressed concern that sometimes, because of the long wait to see someone, patients end up being prescribed medication as an only alternative while they wait.

- Evaluation of care received for mental or emotional health (% very or somewhat helpful) **86%**
- Health services not available in your area when needed **20%**
- Self-rated mental or emotional health (% very good or excellent) **67%**
- Depression **13%**

DETERMINANTS OF HEALTH: Health Services and Personal Health Practices & Coping Skills

"It's the availability of accessible services to begin with, I'm thinking mental health especially. We just don't have in our community available professionals to help meet that demand. We have to always refer our patients outside our community."

"So put them on meds right because it's going to take 6 to 8 weeks before they see anyone, we got to do something for them so I'm starting to see a lot of kids going on it."

"Wait list. There's too long of a time, I have parents talk to me about not being able to get their sons or daughters to mental health and then even working with the mental health wait list, the wait list is just 6-8 weeks before they would be able to see anybody…But that's for an initial screening assessment…And then they go back on the wait list to see somebody."

"That whole process is a nightmare - the centralized intake."

RECOMMENDATION

Further consult with mental health professionals working in the community and leadership form Horizon's mental health & addictions to determine what additional services are needed in the community and how to overcome system level challenges

6.3 The need for more access to extra-mural program (EMP) services in the community

Participants discussed the high quality of care received through EMP in the community and some participants shared positive experiences they have had using this service. However, participants felt that there was not enough availability of the service in the community. They discussed a time when an EMP office was located in the community and they perceived that these services were easier to access that way. They felt that now, since referrals and request must go through Fredericton, that the service is harder to access. Participants also felt that by not having the office in the community, fewer people can be seen because of travel time from Fredericton for the EMP employee.

- Health services not available in your area when needed **20%**

DETERMINANTS OF HEALTH: Physical Environment, Social Support Networks & Health Services

"… we got really, really good care…managed to negotiate the system for us. My experience with Extra Mural is that it's a fabulous program and there should be all kinds of resources going into it."

"In Boiestown they were available a lot more then. It's a distance that they have to travel so they can only see so many in a day if they're full, they can't see certain people."

"Another thing that I have noticed is Extra Mural is not in the country like it used to be. Extra Mural doesn't come out like they used to. There was a time when we had a nurse who was for each area. They were satellite I think from Boiestown but they did the Stanley area. We got really good care. Now it's almost impossible to get Extra Mural because they're out of Fredericton and they're too busy. They can't cover this big an area."

RECOMMENDATION

Further explore EMP access issues by consulting and communicating with EMP leadership and together review EMP utilization data for the community to determine if there are gaps in access and how best to fill them

6.4 The need for more affordable seniors housing in the community

Participants discussed that many seniors are leaving the small communities of Central N.B. to move to more urban areas. They explained that this is not because seniors want to leave the community, in fact, many of them would prefer to stay, but they are not able to maintain their homes, physically and financially as they age. Participants also discussed how many younger people from the community are leaving to seek employment elsewhere, limiting the amount of social support for seniors in the community. Participants also expressed concern that for many seniors, a large part of their income is going toward home maintenance costs, causing seniors to cut costs in other areas that impact health status such as food costs; sacrificing fresh whole foods and relying on cheaper more affordable processed options. Participants described a need for different levels of seniors housing options, as some seniors are quite independent and just need a more affordable and manageable home, while other seniors may require more assistance with day-to-day tasks.

- Seniors 'seeing your stress as quite a bit or extreme' **11%**
- Seniors living in low income **23%**
- Seniors living in private households **97%**
- Seniors living alone **21%**

DETERMINANTS OF HEALTH: Income & Social Status, Physical Environment and Social Support Networks

"The number of people who somehow have to leave the area when they can't stay in their own homes anymore; so there's been a big exodus into apartments in Fredericton. Many of those seniors would stay here if they had another option."

"Just the cost to keep the house going, paying your taxes, paying your heat."

"Why do you think they're leaving now as opposed to before? Their sons and daughters are in Alberta… they have no support, no family support."

"Assisted living being things like when people get older they can't keep up their lawns, they can't keep up their snow shoveling. They want to stay in the community but they just want a little smaller place, an easier place to look after."

RECOMMENDATION

Working with community leadership, representatives from Social Development and current senior's housing operators, assess current availability, wait lists and gaps and create a plan to address seniors housing needs in the community

6.5 Alcohol use in the community

Participants discussed how alcohol use is a significant problem in the community and described several reasons as to why. For youth, participants felt that boredom and lack of recreational activities had a lot to do with the problem. Participants also shared that alcohol consumption is deeply rooted in the culture of the community, a social norm, and generational in nature, especially on the weekends. Participants also noted that, due to new employment trends in the community, where some members would work away for a set period of time and have a set period of time off (with extra money in their pocket), alcohol consumption increased during the time off.

- Alcohol use (Grades 9 – 12) **50%**
- Alcohol use (age 18 to 64) **19%**
- Alcohol use (age 65 and over) **8%**

DETERMINANTS OF HEALTH:
Personal Health Practices & Coping Skills, Healthy Child Development, Employment & Working Conditions and Culture

"I think the sense we get at the clinic is that alcohol is the number one abused substance and that's legal, right, so it's not, people talk about marijuana and speed and opiates but there's way more alcohol use than any of those combined… Yeah and it's such a part of the culture I think around here is to drink."

"…whole chunk of money in their wallet and then their drinking increases or their drug use increases while they're home because they're almost on vacation mode like every two weeks or every…they come home and just drink the whole time they're home or use recreational drugs the whole time because they have ten grand cash in their pocket or something."

RECOMMENDATION
Working with educators, mental health & addictions professionals and the community's Wellness Consultant, develop a strategy to address alcohol use in the community

6.6 A need for more recreational activities for youth in the community

Participants discussed the need for more recreational activities in the community for youth. Some participants felt that this may reduce the risky behaviors youth are engaging in, such as alcohol consumption and drug use. Additional activities may also help address the growing rate of mental health problems being faced by youth in the community. Participants discussed that the options for recreation available in the community are underutilized. Some participants felt that this was because transportation was a major barrier to participation for some youth in organized activities, given long commute times between home and school. Participants also discussed that it is now more difficult to get volunteers to take the lead for recreation programs, compared to how it used to be. Participants also discussed that the collapse of the roof over the hockey arena in Doaktown was a tremendous loss for recreation in the community.

- Youth, physically active at least 90 minutes daily **46%**
- Median commuting duration **21 minutes**

DETERMINANTS OF HEALTH: Income & Social Status, Social Environment, Physical Environment and Healthy Child Development.

"…I know kids who would play on teams but they don't have that resource of somebody driving, picking them up and stuff like that. That would definitely be a factor but yeah in terms of youth…I think it's probably one of the causes for you know, that choice of using some sort of substance."

"But transportation came back into play with our group called Commob, that's what they named themselves, short for Community Mobilization and they were really active and awesome…but I would say in the last year and a half it just kind of fizzled. When they can they are engaged, we've seen the success."

"Because I find like for me personally like because we're in such a small area and there's not a lot to do, that's what kids are drawn to, it's like you know let's have a party and let's go and we'll you know, get drunk and we'll, you know… try some stuff because we don't really have like a movie theatre is like an hour away or whatever so I mean there's not really a lot to do unless you have a car and you can go somewhere to do something else. Well we used to have a hockey rink but that collapsed and it never got fixed."

RECOMMENDATION

Through partnerships with the Health Centers, village councils, and schools, develop a recreation council to review currently available recreational programming for youth and determine where additions can be made

6.7 An increase in the use of amphetamines in the community among youth and young adults.

Participants discussed that the problem of drug addiction has improved in the community over the past 6 years, and shared how they felt the methadone program offered in the community has helped to address this problem. However, participants expressed concern about the growing use of amphetamines (speed) in the community among youth and young adults. Some members felt that this drug was becoming more popular because it is relatively inexpensive. Educators explained the negative changes they see in students who are using speed, such as dramatic weight loss and mood changes. Participants also expressed concern around the potential for it to lead to addiction, but also concerning was the risky behaviours that comes with the use of this drug.

DETERMINANTS OF HEALTH: Income & Social Status, Personal Health Practices & Coping Skills and Social Environment

"Mostly speed is the new one that we're seeing a lot of, speed, ice, molly, all of that which of course methadone doesn't help."

"There is an increase in the use of speed as well…because it's inexpensive…and what we're hearing from the young people is that speed has become at a party now on the weekend, it's just second nature for there to be speed floating around so everyone is using alcohol and speed together at parties."

"Even if the drug use doesn't lead to addiction, the risky behaviour that comes along with it - that in of itself is enough to make it a priority, like people do dangerous things."

RECOMMENDATION

Working with mental health & addiction professionals, law enforcement and educators; develop a plan to address amphetamines use in the community

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