RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

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Community Health Needs Assessment: St. Stephen, St. Andrews and Surrounding Area

EXECUTIVE SUMMARY

St. Stephen, St. Andrews and Surrounding Area

PRODUCED BY: HFHG CONSULTING INC., GRAND FALLS/GRAND-SAULT, NEW BRUNSWICK

Introduction

As illuminated by the Primary Healthcare Framework for New Brunswick, our province has a strong orientation towards community based health infrastructure (GNB, 2012). The delivery of primary healthcare is performed by numerous individuals, organization and structures at the community level including: family physicians, health center staff, mental health and addiction services, the New Brunswick Extra-Mural Program, public health and emergency rooms.

Primary healthcare represents the first contact people have with the healthcare system. At this level, many key decisions regarding immediate, ongoing and future care for people are made.

The implications for successful, efficient performance of primary care services are critical. New Brunswick has declared itself to be at a "tipping point, where our economic future and subsequent healthcare system is threatened (GNB, 2012)."

In addition to the aging of a large segment of our population, the burden of chronic diseases is growing among persons of all age levels; in addition to reducing quality of life, chronic disease and its management represent a significant encumbrance on our acute care system.

Community Health Needs Assessment (CHNA)

A Community Health Needs Assessment (CHNA) is a dynamic, on-going process undertaken to identify the strengths and needs of the community and to enable community-wide establishment of health and wellness priorities that improve the health status of the population.

The CHNA process consists of five key activities:

1. **Community engagement**

2. **Data collection**: *Indicators and data sources*
   Gathering New Information

3. **Analysis**

4. **Develop Recommendations/priorities***: Criteria to assess importance*
   Share and Facilitate CHNA findings

5. **Report back to community**

Background

The CHNA for the St. Stephen, St. Andrews and Surrounding Area commenced in spring of 2013 with the assembly of CHNA Community Advisory Committee (CAC).

The CAC comprised of enthusiastic and energetic representatives of numerous localities throughout the area, the members of the CAC have committed to providing long term leadership and guidance for the CHNA process and outcomes.

Informed by the Community Health Needs Assessment Guidelines for New Brunswick, the community of St. Stephen, St. Andrews and area embarked on an ambitious and comprehensive initiative to fully engage the community in a process of self-exploration and consensus building, aimed at improving health of individuals, organizations and the community at large.

The CAC's conceptualization of health was defined as much more than the mere 'absence of disease;' whereby health is seen as "a capacity or resource rather than a state, a definition which corresponds more to the notion of being able to pursue one's goals, to acquire skills and education, and to grow (PHAC, 2013)."

"I thought we gathered to talk about healthcare, and I can't tell you how happy I am that this project is about our community"

The committee embarked on a process that sought to thoroughly identify and understand the community's assets, their interrelationships, local and global factors affecting health and wellness, and prioritize its needs informed by current issues, their development and likely future course.

Methodology

Participatory Action Research was used as the framework to help guide the CHNA process; this methodology provided an effective dynamic for embracing community empowerment, self-determination and the facilitation of agreed change.

A combination of quantitative and qualitative data were used to inform the CHNA; this 'mixed methods' approach was advantageous to providing meaningful information and insight.

CHNA Findings

The community is faced with continuous economic strain which places undue stress on families, children and seniors who are often living at the margins of poverty. The quantitative data found that the community is comparatively financially depressed; the focus groups with community members gave much meaning and experience to this determinant of health.

Transportation: There is a lack of affordable transportation, which can result in social isolation, decreased community connectivity and presents a significant barrier to accessing health, well being and social services.

Seniors: There is a need for the development of a less complex process for accessing and navigation of long term and at-home support services for seniors living in the community.

Mental Health and Wellness: The complexities of achieving good mental health, resiliency and coping skills to guide healthy behaviors among youth and children were identified as a key priority.

Food Security: The low cost, marketability and convenience of processed, low nutrition food was believed to impact residents across all socioeconomic strata. A high incidence of overweight and obese people at all ages throughout the community was believed to be a result of poor dietary habits and sedentary lifestyles.

A substantive proportion of children were seen as affected by household food insecurity; which can have a significant impact on child development and play a role in child's capacity to thrive, both in the now and well into the future.

Poor food consumption combined with sedentary habits and poor sleeping habits among youth were believed to be a '*cause of causes'* for many adverse health outcomes including mental health issues.

CHNA Recommendations

1. **Develop a collaborative model of care to deliver comprehensive, integrated primary health services for the community.**
2. **Address the lack of affordable transportation**
3. **Address the longstanding and emerging need for mental health and addictions services**
4. **Simplify the Long Term Care Assessment and placement process**
5. **Support the development of safe and affordable housing**
6. **Enhance services offered by the Charlotte County Hospital**
7. **Improve navigation for information sharing and knowledge of service access.**

Develop a collaborative model of care to deliver comprehensive, integrated primary health services for the community

Definitive actions appear necessary to sustainably and effectively meet the current and future care needs of the community. With chronic disease being highly prevalent among community members and occurring at younger ages, models which effectively and efficiently address the complexities of caring for this large proportion of clients are needed.

Such a model should be team based with strong linkages to other community organizations and resources. The service must be able to implement current and emerging best practices in chronic disease management employing the appropriate care providers, including more nurse practitioners, to full scope of practice. In addition to ongoing care, health promotion, disease prevention and client self-management education should be embedded programs (Bodemheimer et al, 2002, 2005; Rosser et al, 2011).

Transportation

Access to affordable, publicly available transportation including the ability to provide transportation services for seniors and people living with a disability was identified as a clear need.

Increasing access to transportation was also thought fundamental in support of reducing barriers to access for health, wellbeing and social services.

Address the Longstanding and Emerging Need for Mental Health and Addiction Services

- Enhancement of the local Methadone Maintenance Program was believed to be a necessity for the community.
- Increase the number of health care providers and services available locally to meet the mental health needs of the community.
- Develop a preventative approach to mental health and substance abuse programming.
- Explore the process to decrease the waiting list for mental health professional services; specially for adults.

Simply the Long Term Care and Placement Process

Increase timely access to residential care homes: nursing homes; assisted living, special care homes and homecare services.

Provide access to specialized care beds for people living with dementia and Alzheimer's Disease.

Support the Development of Safe and Affordable Housing

An emergency shelter for men who have experienced domestic violence and/or crisis was believed to be a fundamental need for the community.

Enhance the Services at the Charlotte County Hospital

- Develop a process to inform community and create awareness of available services; including specialist clinics
- Maintain 24 hour emergency room services
- Explore expanding day surgery services
- Enhance ambulatory care services, for example: IV day hospital, diabetes education clinic, oncology services and pulmonary rehabilitation clinic.

It is important to underline that the recommendations are highly interrelated and linked to existing community based assets.

There is a distinct effort on the part of this community to improve the health of their members and larger community; these recommendations are highly informed and supported by quantitative data obtained through the Community Health Needs Assessment process.

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