Grand Bay-Westfield, Welsford, and Greenwich Area

COMMUNITY HEALTH NEEDS ASSESSMENT

WINTER 2020

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

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Acknowledgments:

We acknowledge that the land on which we gathered to facilitate Grand Bay-Westfield, Welsford and Greenwich Area's Community Health Needs Assessment (CHNA) is the traditional unceded and unsurrendered Wolastoqey and Mi'kmaq Peoples territory. We thank them for allowing us to gather and hold gratitude and appreciation to the Indigenous people who have been living and working on the land from time immemorial.

This report is produced by Horizon Health Network's Community Health Assessment Team for Grand Bay-Westfield, Welsford and Greenwich Area. The Community Health Assessment Team would like to extend gratitude to all the organizations, groups, and community members who took part in Riverview and Coverdale Area's CHNA.

List of Abbreviations

ASD-S: Anglophone School District-South
CAC: Community Advisory Committee
CHA Team: Community Health Assessment Team
CHNA: Community Health Needs Assessment
GBWWG: Grand Bay-Westfield, Welsford, and Greenwich Area
Horizon: Horizon Health Network
LGBTQ2+: Lesbian, Gay, Transgender, Bisexual, Queer or Questioning, Two-Spirited
LSD: Local Service District
NBHC: New Brunswick Health Council
NIHB: Non-Insured Health Benefits
RHA: Regional Health Authority
TOR: Terms of Reference
Vitalité: Vitalité Health Network

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1.0 Report Summary

Introduction to Community Health Needs Assessments

People in New Brunswick want to thrive and be healthy. Control over one's health and wellness is dependent, to a large extent, on the support provided by the people, places, and things that surround them. A Community Health Needs Assessment (CHNA) is a recognized approach to understanding health and wellness at a local, community level. Through community engagement, a CHNA can define an area's strengths and needs leading to the identification of local priorities that, when acted upon, can improve the health and wellness experienced by individuals and population groups.

Grand Bay-Westfield, Welsford, and Greenwich Area

In 2014, a CHNA for the Saint John area was completed and resulted in the recommendation of 13 priority areas in need of action to improve the health and wellness of the local population (see Table 2). Feedback related to this assessment identified that the scope was very large, and the resulting priorities did not fully reflect the health and wellness needs of areas located outside the City of Saint John. Upon the initiation of a second round of CHNAs a decision was made to offer Grand Bay-Westfield, Welsford, and Greenwich (GBWWG) area a separate assessment guided by the geographical boundaries defined by the New Brunswick Health Council (NBHC) (1) and in March 2019 the CHNA process began in collaboration with community representatives who live in the area and/or whose working roll supports local residents.

GBWWG is in southern New Brunswick and supports a population of approximately 9,000 people. It includes the Town of Grand Bay-Westfield and four Local Service Districts (LSD) within which the following communities are located: Bayswater, Brown's Flat, Carter's Point, Evandale, Lower Greenwich, Hampstead, Public Landing, Nerepis, and Welsford. The community boundaries created by the NBHC, used to define the GBWWG area, included the LSDs of Kars and Wickham. During our assessment process, local representatives from these communities advised our assessment team that they were less connected to the GBWWG area and suggested the health and wellness needs of their population would be better captured in the CHNA for the Sussex area. With this recommendation, Kars and Wickham LSDs were removed from GBWWG's CHNA boundary.

Current Snapshot of Grand Bay-Westfield, Welsford, and Greenwich Area's Health and Wellness

Based on data from NBHC's 2014 and 2017 Primary Health Survey for GBWWG area the self-reported incidence of most chronic health conditions has not changed except for an increase in the incidence of adults diagnosed with or treated for asthma. In addition, significantly more adults reported managing three or more chronic conditions and significantly fewer adults with one or more chronic condition reported feeling very confident in controlling and managing their health (1). Compared to provincial prevalence rates, fewer adults living in GBWWG indicated that they were diagnosed or treated for anxiety with 18 per cent reporting that they needed to see or talk to a professional about their mental or emotional health (2).

When considering the health of younger generations, more children and youth living in GBWWG report moderate to high levels of mental fitness[1] and fewer report experiencing symptoms of anxiety and depression when compared to provincial rates (8).

[1] Someone who has a moderate to high level of mental fitness has a positive sense of how they feel, think, and act.

1.0 Report Summary continued

Community Health Needs Assessment Process

Applying a population health perspective and an understanding of the Social Determinants of Health, Horizon's Community Health Assessment Team facilitated the current CHNA with a 14-step process to meaningfully engage community members. These steps provide a level of structure that ensures a consistency between individual assessments while, at the same time, offers flexibility to shift and adjust to unique local circumstances.

We acknowledge there are limitations within this process. Our time frame to introduce and facilitate a CHNA within a given area is between six months to one year. Some community organizations and important population groups would benefit from a longer time frame to learn about the CHNA process, how it could support their own efforts, and how action addressing identified priorities can support those living with health and wellness inequities. This limitation ultimately impacts who chooses to be involved in our CHNA process. We are learning, as a Community Health Assessment Team, ways we can share our process with communities well before beginning an assessment, so we give adequate time for community representatives to understand our process and trust the purpose of our work. A second limitation, also constricted by our time frame, is our inability to collect specific quantitative information at the local level during a CHNA such as creating and circulating a community-wide survey. Currently, we rely on statistical data already available to support our investigation, but we recognize other information, often gathered through quantitative means, may be missed.

Health and Wellness Knowledge Gaps and Areas of Concern

GBWWG's CHNA CAC reviewed available area-specific quantitative data compiled by the NBHC and identified knowledge gaps and areas of concern in need of further investigation. Seven consultations, three focus groups and four key-informant interviews, were facilitated. A total of 17 community members living and/or working in GBWWG participated. Each consultation had an intended focus, however because many identified concerns overlapped, the following is a list of the knowledge gaps/areas of concern that were purposefully discussed with community members throughout the consultation process.

- Aging Older Adults Living in Isolation
- Cultural Competency
- Health Promotion and Prevention Access
- Managing Chronic Health Conditions
- Transportation
- Local challenges facing households on low income
- LGBTQ2+ health and well-being
- Coping Skills and Mental Health
- Food Insecurity
- Navigating, Advocating, and Health Literacy
- Older adults whose care needs are changing
- Primary Care Access Equity
- Youth Engaged in Risky Health Behaviours

Grand Bay-Westfield, Welsford, and Greenwich Area's 2020 Health and Wellness Priorities

The following five *Health and Wellness Priorities* are the voiced needs ranked by GBWWG's CAC (Table 1). These priorities will be shared with those responsible for health service planning as well as other community stakeholders who are involved in the work of supporting the health and wellness of GBWWG residents.

Table 1: GBWWG's 2020 Health and Wellness Priorities and Recommendations

	Health and Wellness Priority	Community Recommended Action
1	Improve the mental health support system available to youth and their families, individuals managing substance use disorders, and individuals managing chronic health conditions.	Working with community representatives who have experience with the mental health care system, identify possible solutions to the barriers described above that limit the effectiveness of the mental health supports available to those living in the GBWWG area.
2	Address the lack of affordable and reliable transportation.	Look to other communities within NB and elsewhere who are working on transportation initiatives to identify local transportation solutions that will affordably, efficiently, and reliably help residents move within the area or into larger communities where services are often located.
3	Strengthen connections and collaborative capacity between provincial and local organizations supporting the same population groups.	Create opportunities to bring service providers from local and provincial services and organizations who support the same population groups together to learn about each others' services and to identify avenues to enhance connections in support of better care.
4	Advocate for and help those living in poverty to enable personal control over health and wellbeing.	Working with community, collaboratively identify local action that can be taken to help residents living with low-income become aware of and use opportunities made available to alleviate financial burdens.
5	Enhance local access to primary health care and supporting services.	Work with local health care service and support providers to address the health care needs of residents who are unable to regularly access services and supports in Saint John or Fredericton.

Next Steps

With the completion of this CHNA for GBWWG Horizon is committed to working in innovative ways with community members and stakeholders to address the priorities identified in this report. As a Regional Health Authority (RHA), we acknowledge that good work is already underway through existing partnerships and current collaborations. We recognize opportunities exist to join in this work to contribute to impactful solutions that will address health and wellness inequities experienced in this area[2]. We also acknowledge the need to be accountable to these priorities. Through our Department of Population Health, we have established mechanisms that will allow us to monitor action and initiatives, both within Horizon and through our collaborative partnerships, which are addressing the priorities identified in this report.

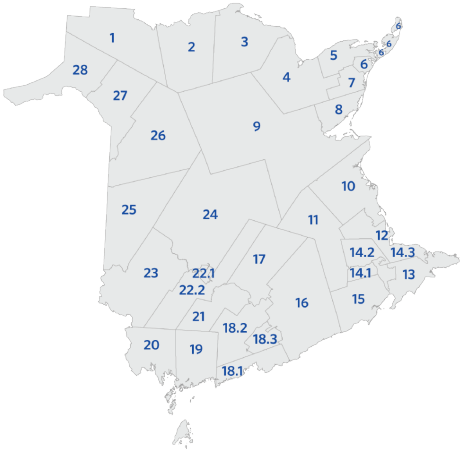
[2] More information on CHNAs can be found online: en.HorizonNB.ca/chna

2.0 Introduction

2.1 History of Community Health Needs Assessments in New Brunswick

To be healthy is to experience "a state of complete physical, mental, and social well-being; a fundamental right of everyone without distinction of race, culture, religion, political belief, economic or social condition"(4). In New Brunswick, two RHAs support the health of its citizens by sharing in the provision of health care services (5). An important piece to providing health care is learning about the assets that support healthy living and the factors and conditions that compromise the ability of citizens to enjoy life in a healthy and well manner. A CHNA, a practice conducted in many parts of the world, is a recommended approach to understanding health and wellness at a local level (6). In 2012, the New Brunswick Department of Health released the *Primary Health Care Framework* recommending the facilitation of CHNAs as a first step to understanding and enhancing the health and wellness of communities across the province (7). Since that time, Horizon has supported the completion of a CHNA for every community[3] within its region. Throughout this work it became evident that the practice of engaging citizens to share in the process of determining community health priorities was very valuable. It strengthened the local relationships between service providers and community members as well as the regional relationship between communities and Horizon as a health authority within the province. Also evident was the contribution CHNAs made towards fulfilling Horizon's mission of *Helping People be Healthy* (8). In 2017, the Government of New Brunswick committed to supporting both RHAs in the practice of facilitating CHNAs across the province on an on-going basis with the goal of completing one in each community every five years.

Figure 1: Map of NBHC Communities



2.2 What is meant by Community?

New Brunswick is divided into seven health care zones. Each zone, on its own, canopies several communities and represents many different groups of people. To allow for a focus on local health and wellness, the NBHC[4] has divided the province into 33 communities (Figure 1). Each NBHC community is a varied collection of cities, towns, municipalities, and LSDs that fall within the catchment area of health care centres, community health centres, and hospitals. Census subdivisions within the defined NBHC community boundaries were merged together to support the collection of statistical data. To confirm a fair representation, the 33 NBHC communities were further authenticated with various community members from all areas of the province. Each NBHC community was created with no less than 5,000 people to ensure any available statistical data was usable while at the same time maintaining the privacy of citizens who provided information to inform the data (9).

[3] 'Community' as defined by New Brunswick Health Council. See 2.2 'What is meant by Community?' for further clarification.
[4] NBHC is a legislated body working at arms-length from the government with a dual mandate to report publicly on the performance of the health system and to engage New Brunswickers in the improvement of health care service quality.

3.0 Grand Bay-Westfield, Welsford, and Greenwich Area

The geographical area included in this CHNA was named Grand Bay-Westfield, Westfield, Greenwich Area by the NBHC (9). During our CHNA facilitation, the name of this community was revised to better capture how the community members identify with the area. Those involved in the CHNA as members of the Community Advisory Committee (CAC) chose the name Grand Bay-Westfield, Welsford, and Greenwich Area (GBWWG) which includes the following municipalities and communities[5]:

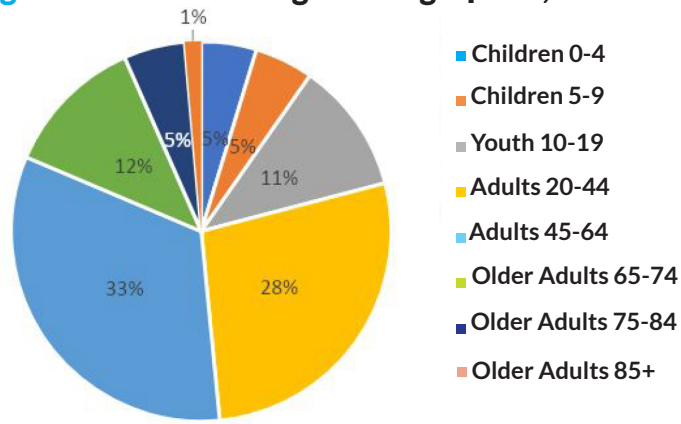
The Town of Grand Bay-Westfield; Westfield LSD including communities such as Bayswater and Carter's Point, Greenwich LSD including communities such as Brown's Flat and Evandale, Hampstead LSD including communities such as Hampstead, and Petersville LSD including communities such as Welsford and Nerepis[6].

Known to be a very supportive, vibrant, and community oriented area within New Brunswick, GBWWG is located in the southern part of the province close to the coastal city of Saint John. Many communities within the area are situated near the Saint John River with the exception of Welsford which is located 13 km inland heading towards Fredericton. 2016 Census data indicates that this area of the province supports a population of 8,942 people, a decrease of 3.7 per cent since 2011. Just over half of the residents live in the Town of Grand Bay-Westfield with the remaining 3,978 citizens residing in smaller, more remote communities.

Figure 2: Map of NBHC Communities, GBWWG Highlight

Adults between the ages of 45-64 years old represent the largest age group, similar to the province as a whole. Most older adults from this area, who are over the age of 65 years, live in private households and 21 per cent of these individuals live alone. The majority of residents speak English most often at home and, while there is no local First Nation community within or nearby GBWWG, it is home to 190 individuals who identified as First Nation or Metis in the 2016 Census.

Figure 3: GBWWG's Age Demographics, 2016 Census



[5] To acknowledge the local interpretation of the area boundaries, health and wellness considerations for Wirral, located in the Petersville LSD, and Hampstead community located in the Hampstead LSD were also included in the 2018 Oromocto and Surrounding Area CHNA, as per the recommendation of the CAC involved in that assessment. To access the final report for Oromocto and Surrounding Area's CHNA visit en.HorizonNB.ca/chna or click here.

[6] The NBHC community boundary created to support the collection of quantitative data for the area, included the LSDs of Kars and Wickham. During our CHNA process, representatives from those communities voiced a lack of association with the Grand Bay-Westfield CHNA area and asked to be included in the CHNA for the Sussex area.

3.0 Grand Bay-Westfield, Welsford, and Greenwich Area continued

Local programs and activities that support the promotion of healthy living are available throughout the GBWWG area made possible by the Town of Grand Bay-Westfield and three active recreation associations, but most of the provincially funded health services that support health and wellbeing operate from locations within the City of Saint John, a 20-30 minute drive away. Most children and youth over the age of five are enrolled in the Anglophone School District-South (ASD-S) and attend school in the Town of Grand Bay-Westfield up to and including Grade 8. For Grades 9 through 12, students travel into the City of Saint John as do any students enrolled in the Francophone school system.

2016 census data suggest the GBWWG area is divided in terms of wealth with affluent households and communities existing alongside those living with greater financial constraints:

- The median household income ranges between $84,813 (Grand Bay-Westfield) and $42,624 (Hampstead LSD)[7]. Well above and well below the provincial median household income of $59,347/year.
- 63 per cent of residents are able and interested in working. Greenwich LSD and Hampstead LSD operate with unemployment rates well above the provincial rate of 11.2 per cent (16 per cent and 29 per cent respectively).
- The local poverty rate for adults ranges between 6 per cent (Grand Bay-Westfield) and 20 per cent (Hampstead LSD)[8]. The local poverty rate for older adults over the age of 65 ranges between 9 per cent (Grand-Bay Westfield) and 19 per cent (Hampstead LSD). Comparable provincial poverty rates for adults and older adults are 15 per cent and 20 per cent respectively.
- Private households are more often three- and four-bedroom dwellings with very few one-bedroom options. Seven per cent of households rent their dwelling. The majority live in the Town of Grand Bay-Westfield with 20 per cent of tenant households living in subsidized housing. Sixteen per cent of tenants and seven per cent of owners living in the area spend greater than 30 per cent of their income on shelter. The provincial rate is 14 per cent and 10 per cent respectively.

3.1 2014 Community Health Needs Assessment

In 2014, a CHNA for the Saint John area was completed. From this work, 13 prioritized health needs were identified (see Table 2).

Table 2: Saint John's 2014 Key Priorities

1. Access to Community-Based Health and Wellness Programs	8. Increased Focus on Prevention of Disease and Screening
2. Define Community School Concept	9. Enhance Public Transportation
3. Foster Community Partnerships	10. Leverage Telecare (211)
4. Engage community in policy and spending	11. Coordinate Food Security Planning
5. Address Poverty	12. Expand Rehabilitation Services
6. Safe and Accessible Recreation	13. Sexual Health Services
7. Address Mental Health	

Feedback from the 2014 CHNA for the Saint John Area suggested that the 13 priorities chosen were more specific to the City of Saint John and did not fully reflect the health and wellness concerns of the surrounding area. With the decision to move forward with a second cycle of CHNAs, it was clear that the surrounding areas would benefit from having their own separate assessment. This would also allow for more meaningful engagement with smaller communities resulting in a more focused set of priorities that better reflect their local needs and strengths. The assessment process and priorities detailed in this report reflect this change for GBWWG.

[7] Median Household Annual Income, Before Tax, 2016 Census
[8] Low-Income Measure, After Tax (LIM-AT), 2016 Census.

3.1 2014 Community Health Needs Assessment continued

Throughout the assessment process, several community-led initiatives supporting residents living in the GBWWG area were identified. One such initiative that is positively impacting the health and wellbeing of residents living in more remote communities is the River Road Hub located in the community of Brown's Flat. Under the operational leadership of the Greenwich Recreation Association and housed within the old elementary school in Brown's Flat, this community-run space first opened its doors in 2016. With a mission "to provide recreational opportunities and services for the community that enhance connectedness, well-being, and make the area a great place to live"[9], local residents are supported with a variety of regular and seasonal programs, activities, and services such as a weekly playgroup for young children, indoor and outdoor physical activity opportunities, monthly foot care and blood collection services, educational programming such as hunter safety and babysitting courses, socialization opportunities such as a Monday night Art Club, card parties, and community breakfasts, and an annual Winter Carnival. A new addition this past Fall was the repurposing of facility square footage to create a youth space called The Flat giving local youth a safe supportive place to hang out and connect. As an innovative example of upstream thinking, the River Road Hub is to be commended on its endeavors to remove barriers and enable residents in their own efforts to be healthy and well.

4.0 Guiding Principles for Community Health Needs Assessments

CHNA Guidelines for New Brunswick, collaboratively developed by both RHAs and the New Brunswick Department of Health, recommends the application of a *population health perspective* informed by the *social determinants of health* as a guiding structure to investigate health and wellness in communities (12).

4.1 Population Health Perspective

Many groups of people live alongside one another in any given community. These groups can include seniors who live alone, immigrants new to an area, or families living on low income. The health and wellness experienced by a group of people depends on a broad range of interconnected factors and conditions often referred to as the Social Determinants of Health (Table 3) (13,14). A population health perspective looks at different groups of people living in an area and assesses how different social determinants impact health outcomes. Certain social determinants have a stronger influence on our health than others and can contribute to health inequities between population groups that are unfair. With purposeful attention, these inequities can be addressed to positively impact health and wellness (15). Using the population health perspective during CHNAs, a community can develop an understanding of the differences in health and wellness between groups allowing action to be focused on minimizing the factors that limit the ability to live healthy and maximizing the factors that improve health and wellness (16).

[9] Retrieved from www.riveriadhub.com, 'About Us' ; February 2020

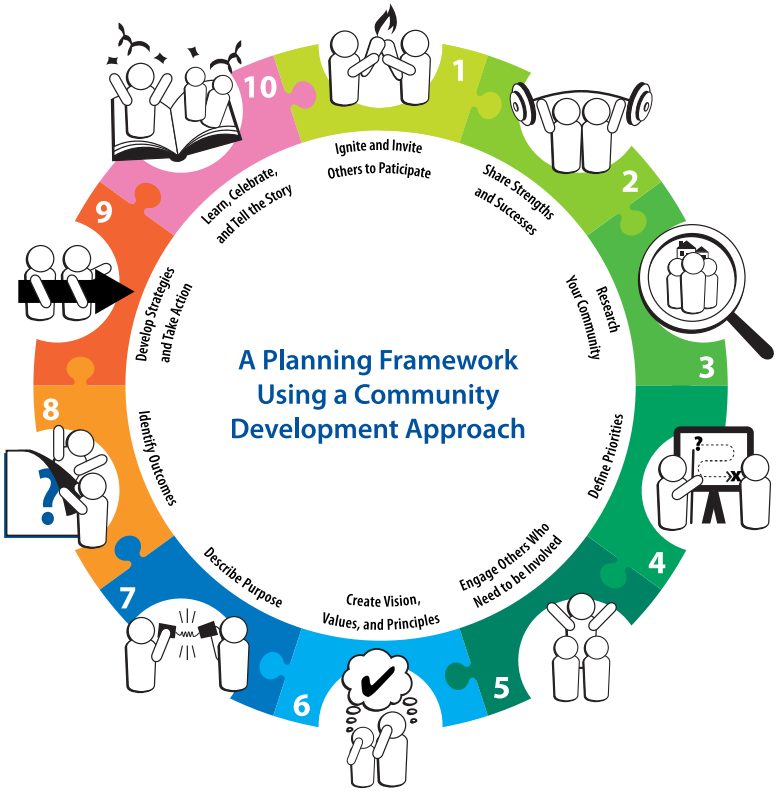
Table 3: Social Determinants of Health, Health Canada (15)

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

4.2 Community Development Approach

CHNAs are also guided by the *Community Development Approach* (17)[10]. This approach represents a belief that communities are the experts of their own needs and strengths. Engaging and consulting with communities about the lived experiences of their residents holds great value as it provides a deeper understanding of local strengths and concerns. The *Community Development Approach* used by Horizon involves 10 stages. The first four stages involve the process of inviting community representatives to come together around a focused issue to investigate and research the strengths and needs of their community. The result of this collective effort is to determine a list of priorities that need action and attention. A CHNA fulfills stages one through four within this approach with a coordinated investigation of community health needs. Upon the completion of a CHNA, work continues by sharing results from the assessment, engaging others to create a plan on how to address the identified priorities, taking collective action, and reflecting on this work to learn with the intention to improve and adjust efforts. The symbolism of displaying this approach in a circle is important as it shows the continuous commitment of community development that reflects upon and responds to evolving strengths, needs, and priorities and aligns with the intention to complete CHNAs every five years.

Figure 4: Herchmer's Planning Framework Using a Community Development Approach



[10] A Planning Framework Using a Community Development Approach by Brenda Herchmer is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License

5.0 Horizon's Community Health Needs Assessments

5.1 Our Community Health Assessment Team

Horizon's Community Health Assessment Team (CHA Team), housed within the Department of Population Health, has expanded since 2017 to not only support the completion of CHNAs but to also be involved in and support the work of responding to identified priorities. In addition to the Research Lead and Project Coordinator whose work includes the planning and facilitation of CHNAs, there is also a Regional Facilitator who serves as a connecter across the region to ensure opportunities to learn from and collaborate with each other on related health and wellness priorities are promoted and to monitor, measure, and track collective action responding to the priorities. We also benefit from a network of Community Developers who are rooted in communities and work alongside community members and stakeholders. Using the Community Development Approach and the priorities identified from CHNAs, Community Developers collaborate to create healthier, stronger, more connected communities with an overall intention to improve the health and well-being of all community members with an emphasis on those who need it the most.

5.2 Our Process

Horizon's CHA Team follows 14 steps to meaningfully engage with communities during a CHNA (Table 4). These steps offer a backbone to the process and provide a level of structure that reassures each community of consistency between individual assessments while offering flexibility to shift and adjust to distinct local circumstances. In summary, the process unfolds over approximately six to nine months whereby community representatives are engaged through CHNA meetings and/or consultations where they contribute to identifying local *Health and Wellness Priorities* in need of action and attention.

Table 4: Horizon's 14 Step CHNA Process

Step 1: Establish a Planning Team	A Planning Team is formed with key community members who have a strong understanding of the area to be assessed. These individuals are often leaders within the community serving in a health care or community service capacity who have an established relationship with its residents.
Step 2: Identify Community Advisory Committee (CAC) members	Guided by the Social Determinants of Health, possible CAC members are identified by the Planning team. The CHA Team's Project Coordinator and Planning Committee members share in inviting potential CAC members to participate in the CHNA.
Step 3: Establish CAC	During the first CHNA meeting, the CHA Team shares the goals and objectives of the CHNA. A Terms of Reference (TOR) is introduced to clarify CAC roles and responsibilities. CAC members are given opportunity to provide feedback on the TOR and a final revised version is accepted by the committee.
Step 4: Identify local health and wellness assets	Throughout the health needs assessment process, assets and resources mentioned during CAC discussions and community consultations are recorded. Informed by the Social Determinants of Health, this activity supports the creation of an asset list. The asset list is a 'living document' and is used and updated as planned action unfolds to address the CHNA Priorities.

5.0 Horizon's Community Health Needs Assessments continued

Step 5: Review available quantitative data	CHNAs are based on the geographic community breakdowns defined by the NBHC. Data compilations, which come from multiple surveys and administrative databases are made available by the NBHC. The CHA Research Lead explores this data looking for any indicators that reflect areas that need further investigation and/or clarification by the CAC.
Step 6: Present highlights from data review to CAC	The CHA Team shares highlights from the quantitative data with the CAC.
Step 7: Share insights and discuss knowledge gaps emerging from quantitative data review	CAC members discuss issues raised through the quantitative data review and give feedback about knowledge gaps that exist and need further clarification.
Step 8: Develop a qualitative data collection plan	From knowledge gap discussions with the CAC, the CHA Team develops a preliminary qualitative data collection plan outlining who may be consulted, how they may be consulted, and the timeline for consultation. CAC feedback and input about the qualitative data collection plan is solicited.
Step 9: Collect qualitative data in the community	The CHA Team collects qualitative data through community consultations with identified community groups and representatives. This data complements the quantitative data compilations provided by the NBHC.
Step 10: Facilitate consultation participant input to inform CAC priority ranking	To contribute to community voice, participants are offered the opportunity to prioritize a broad list of health and wellness issues generated from the quantitative data discussions held by the CAC. This helps to inform the CAC during Step 12.
Step 11: Analyze qualitative data	Qualitative data, collected during consultations, is analyzed. Findings are compared alongside the reviewed quantitative data (Step 5) and contribute to the creation of a list of specific, local health and wellness issues.
Step 12: Share health and wellness issues and facilitate ranking to establish health and wellness priorities	The list of specific, local health and wellness issues is shared and discussed with CAC members. Through a formalized ranking process, each CAC member is given the opportunity to rank the top health and wellness issues they believe need action and attention.
Step 13: Finalize health and wellness priorities and recommendations	As a committee, the CAC reviews and confirms the final ranked order of issues. Depending on the community, the top four to eight issues are chosen by the CAC as Key Health and Wellness Priorities. A final report is created detailing the CHNA process and the community's priorities along with community voiced recommendations for action. This report is shared with Horizon's Board of Directors for endorsement.
Step 14: Share final report and begin planning for action	The final report is shared with the CAC during the final CHNA meeting. Discussion regarding next steps also takes place. The CHNA results are also shared with the larger community through various avenues.

5.0 Horizon's Community Health Needs Assessments continued

5.3 Limitations

We acknowledge there are limitations within our CHNA process. Our time-frame to introduce and facilitate a CHNA within a given area is between six months to one year. Some community organizations and important population groups would benefit from a longer time frame to learn about the CHNA process, how it could support their own efforts, and how action addressing identified priorities can support those living with health and wellness inequities. This limitation ultimately impacts who chooses to be involved in our CHNA process. We are learning, as a CHA Team, ways that we can share our work with communities well before beginning an assessment so we give adequate time and space for community representatives to understand our process and trust the purpose of our work. A second limitation, also constricted by our time frame, is our inability to collect specific quantitative information at the local level during a CHNA such as creating and circulating a community-wide survey. Currently, we rely on statistical data already available to support our investigation, but we recognize other information, often gathered through quantitative means, may be missed.

6.0 GBWWG's 2020 Community Advisory Committee

An initial step in Horizon's CHNA process is the formation of a Community Advisory Committee (CAC). CACs play a significant role in a CHNA as they are the link between the community and Horizon's CHA Team. Attention is placed on creating a balance of individuals who work to support the health and wellness of community members alongside individual residents who represent various population groups living in the community. A variety of perspectives are represented throughout the CHNA process. Prior to any CHNA work, a TOR is established with each CAC to clarify roles, responsibilities, and guiding engagement principles. The commitment a CAC member offers is their contribution to investigating the health and wellness of their community through attending and participating in five face-to-face meetings spread out over six to nine months.

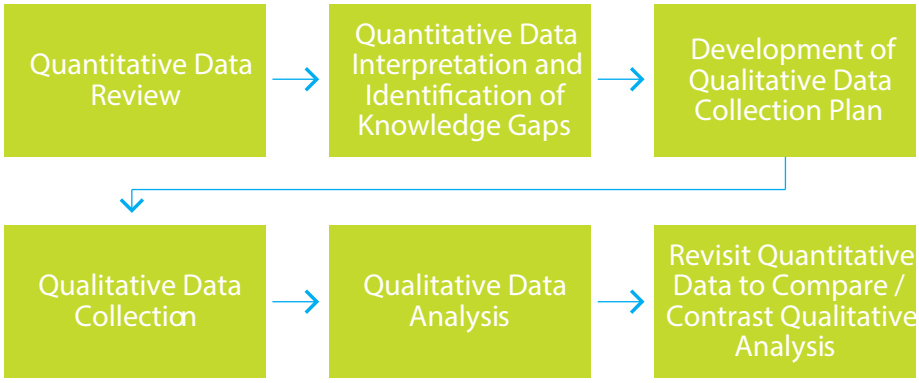
A broad range of community representatives who live in, work in, or support residents from the GBWWG were invited to take part in the CHNA. Horizon's CHA Team was fortunate to be supported by the following representation throughout the course of GBWWG's CHNA:

- Ambulance NB, South Region
- École Westfield School, Leadership
- Community Mental Health and Addiction Services, Integrated Service Delivery, (East) Horizon
- Community Residents
- Greenwich Recreation Association
- Greenwich Volunteer Fire Department
- The Medicine Shoppe
- NB Extra-Mural Program, Fundy Area
- Regional Service Commission, Fundy Region
- Primary Health Care, Horizon
- Public Health, Horizon
- United Church, Local Ministry
- Town of Grand-Bay Westfield
- Wellness Branch, Department of Social Development
- Westfield Recreation Association

7.0 Assessing Health and Wellness

Below is a figure depicting the research process taken to ensure local information, reviewed and collected by the CHA Team, is combined and analyzed in a way that supports a deeper understanding of the factors and conditions that impact community health and wellness. Further detail of this process is described in the proceeding paragraphs[11] .

Figure 5: CHNA Research Approach used by Horizon's CHA Team



7.1 Quantitative Data Review and Interpretation

Guided by the Social Determinants of Health, the process of deepening an understanding of what impacts health and wellness within GBWWG began with a review of available quantitative data. The NBHC has compiled community quantitative data sets, one for each of its 33 communities within the province and have made them publicly available through the publication of *My Community at a Glance* reports (9). Communities can use this information to understand their area and how it relates to provincial results as well as identify local trends in the indicators that represent the level of health and wellness experienced by their residents. The information detailed in these data sets comes from federal, provincial, and in-house NBHC data sources as well as relevant indicators found through the review of several federal and provincial organization reports. A full description of where individual community profile indicators are sourced can be found in the *NBHC My Community at a Glance 2017 Technical Document* (18).

For the purpose of GBWWG's CHNA, the CHA Team extensively reviewed *My Community at a Glance 2017 & 2014* reports, *2017 Primary Health Survey* results[12], and *2016 Census data* (2,3,10). Using highlights from these quantitative data sources CAC members collectively identified areas of significant concern relating to health and wellness in need of more understanding and provided feedback on a summary of identified knowledge gaps.

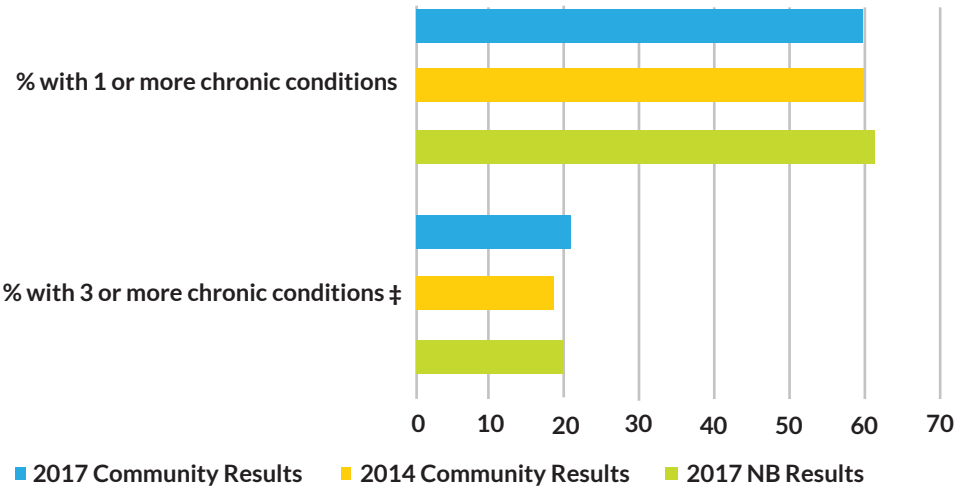
7.2 Current Snapshot of GBWWG's Health and Wellness

Statistical data, from NBHC's Primary Health Survey, detailing self-reported health outcomes of people living in GBWWG in 2014 and 2017 shows that the percentage of adults 18 years and older who self-report that they manage three or more chronic health conditions has significantly increased (Figure 6). This overall change in health is supported by the significant increase in residents reporting that they take six or more medications to manage their chronic health conditions.

[11] To request more technical information about Horizon's CHNA process please contact CHNA@HorizonNB.ca

[12] Data from the *Primary Health Survey* are included in *My Community at a Glance* reports; however, 2017 results were made available after the *My Community at a Glance 2017* reports were published.

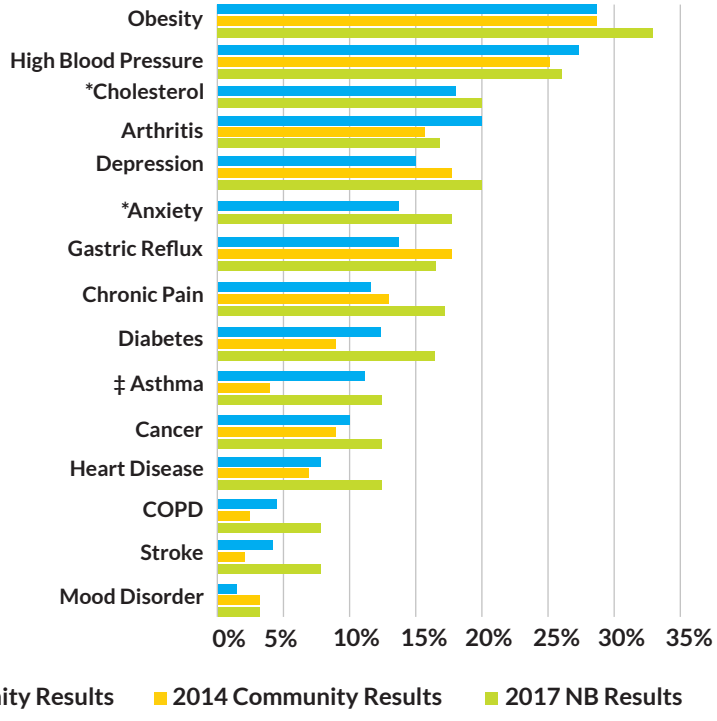
Figure 6: Prevalence of Chronic Health Conditions in GBWWG (2)



‡ significantly higher or lower in 2017 when compared to 2014

The self-reported incidence of specific chronic conditions in the GBWWG area did not change for most illnesses between 2014 and 2017 and, when compared to the province, the prevalence of most illnesses was lower for adults living in GBWWG with the exception of high blood pressure and arthritis (Figure 7). Overall, adults living in this area of New Brunswick are healthier than their provincial counterparts, but more manage multiple chronic health conditions.

Figure 7: Prevalence of Specific Chronic Health Conditions in GBWWG (2)

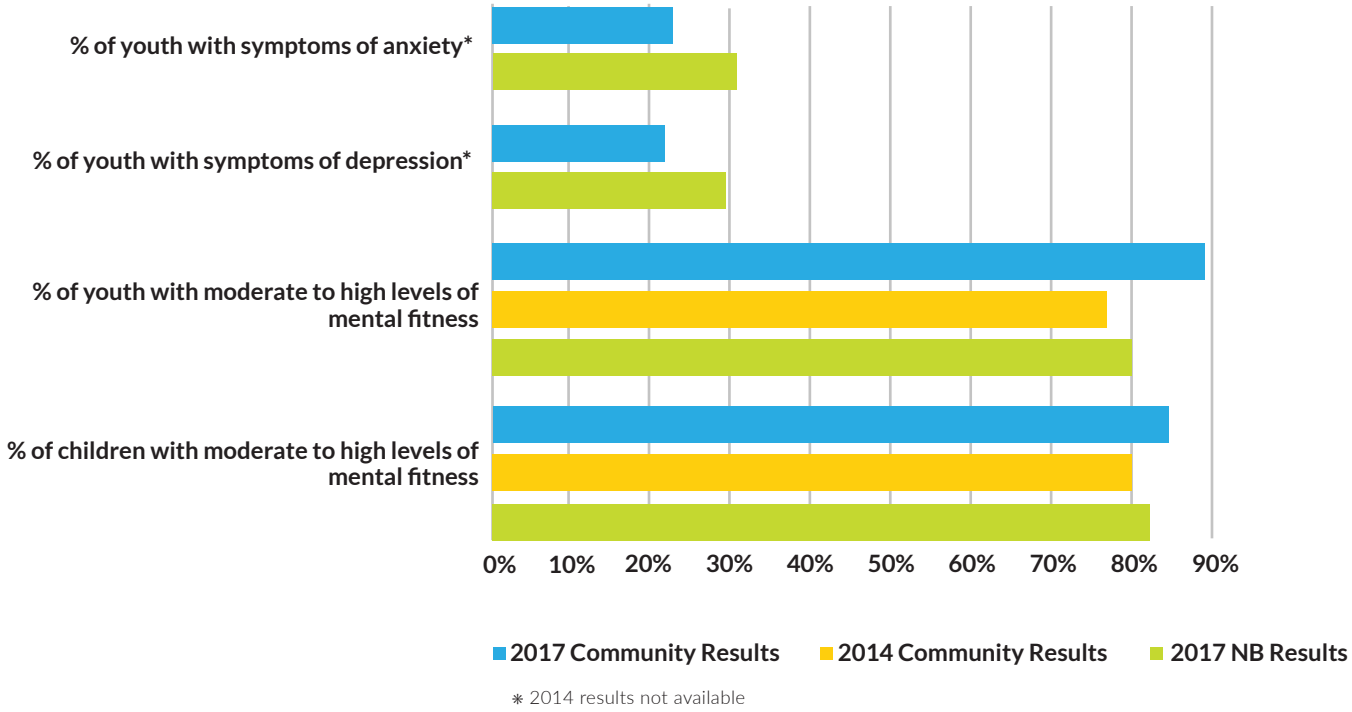


‡ Significantly higher or lower in 2017 when compared to 2014
* 2014 results not available

7.0 Assessing Health and Wellness continued

When considering the health of younger generations, the prevalence of children and youth from the GBWWG area who reported a moderate to high level of mental fitness was higher than provincial rates[13] when last assessed during the 2015-2016 school year (3). In addition, *My Community at a Glance 2017* reveals that GBWWG has fewer youth who reported experiencing symptoms of anxiety and depression in the 2015-16 school year when compared to provincial data (Figure 8).

Figure 8: Mental Health Indicators for Children and Youth Living in GBWWG (3)



* 2014 results not available

At this point, it is important to reflect on the social determinants of health and the influence each determinant has on health and wellness. To promote health and prevent disease, attention needs to include but also extend beyond health care services, inequities between populations groups need to be identified and addressed, and adequate supports need to be made available to those who need them the most (13,14).

[13] Someone who has a moderate to high level of mental fitness has a positive sense of how they feel, think, and act.

7.0 Assessing Health and Wellness continued

7.3 Qualitative Data Collection and Analysis

Qualitative research, often used to answer why, how, and what questions, complements quantitative data. When used in combination, unique and complex elements influencing a given community are understood more clearly and can support a more meaningful use of information to inform change (19). Equipped with a summary of knowledge gaps identified collectively by the CAC, the CHA Team applied purposive sampling principles (20) to connect with community members living and working in GBWWG who could contribute to a deeper understanding about the health and wellness challenges experienced in the area. Community members were invited to participate in consultations[14]. Participation was voluntary, and the process of Informed Consent was reviewed with each participant. Each consultation was audio-recorded and transcribed. Identifying information, such as the names of people and places, was removed at the time of transcription. Using a research methodology known as Interpretive Description (21), transcripts were analyzed by our CHA Research Lead. As a secondary step in the analysis process, all CHA Team members independently reviewed qualitative analysis results and, through group discussions, debated the interpretation of findings to safeguard against researcher bias (22). Qualitative findings from this analysis process resulted in the creation of a list of specific health and wellness issues for GBWWG.

Health and Wellness Knowledge Gaps and Areas of Concern

GBWWG's CHNA CAC reviewed available area-specific quantitative data compiled by the NBHC and identified knowledge gaps and areas of concern in need of further investigation. Seven consultations, three focus groups and four key-informant interviews, were facilitated. A total of 17 community members living and/or working in GBWWG participated. Each consultation had an intended focus, however because many identified concerns overlapped, the following is a list of the knowledge gaps/areas of concern that were purposefully discussed with community members throughout the consultation process.

Older Adults Living in Isolation
Coping Skills and Mental Health
Cultural Competency
Food Insecurity
Health Promotion and Prevention Access
Navigating, Advocating, and Health Literacy
Managing Chronic Health Conditions
Primary Care Access Equity
Transportation
Youth Engaged in Risky Health Behaviours
Local challenges facing households on low-to-moderate income

[14] Consultations included KEY INFORMANT INTERVIEWS (an interview with one or two people with similar backgrounds focused on a specific topic) and FOCUS GROUPS (face-to-face interviews with three to 10 people with similar backgrounds focused on a specific topic).

8.0 GBWWG's 2020 Health and Wellness Priorities

The following five *Health and Wellness Priorities* for GBWWG were identified through a priority ranking process. This process includes input from consultation participants to help inform the ranking decisions of individual CAC members to support a stronger and more diverse community voice.

1. **Improve the mental health support system available to youth and their families, individuals managing substance use disorders, and individuals managing chronic health conditions.**
2. **Address the lack of affordable and reliable transportation.**
3. **Strengthen connections and collaborative capacity between provincial and local organizations supporting the same population groups.**
4. **Advocate for and help those living in poverty to enable personal control over health and wellbeing.**
5. **Enhance local access to primary health care and supporting services.**

In the following pages, profiles of each priority have been provided. Included in each priority profile is a *Community Recommended Action* and a *Suggested Approach* to inform action intended to give Horizon, stakeholders, and other interested partners/individuals a place from which to begin or, in many cases, to join in and continue the good work already underway. Related social determinants of health and quotes from consultations are also included as well as relevant quantitative data indicators detailing how GBWWG compares to the rest of the province and how it compares to 2014. Finally, where possible, existing community assets aligning with a given priority are highlighted.

▲▼ Positive changes or differences in data

= No changes or differences in data

▲▼ Negative changes or differences in data

Priority 1

Improve the mental health support system available to youth and their families, individuals managing substance use disorders, and individuals managing chronic health conditions.

Social Determinant(s) of Health: Health Services

"If I was going to pick one thing that I think would be important it would be that mental health piece and the access to it for all ages or lack thereof...You know I'm educated, I'm connected, I'm stubborn and I had one hell of a time."

Concern around the mental health support system available to GBWWG residents was raised by our Community Advisory Committee. Throughout several consultations it was articulated that, for those living in the area who need mental health support, the current mental health support system is not effective at meeting need or expectations.

- Local barriers described by consultation participants with direct experience with the mental health care system described challenges that include issues with accessing services in Saint John, inconsistent follow-up care with long wait-times which is of great concern when medications need to be re-assessed, limited capacity of mental health staff leading to burn-out and staff turn-over, an education system challenged with managing the mental and emotional issues that children and youth are experiencing, and limited application of trauma-informed care.

- Although an issue impacting the broader Fundy Region, it was also described that emergency services in Saint John are sometimes used by individuals to access mental health and addiction support. Consultation participants shared that this service is limited in its ability to refer them to timely mental health and addiction support.

- In addition, it was voiced during several consultations that local families with youth who are in crisis feel unsupported and lost. Although they are aware that supports are in Saint John, these are not as easily accessed. Many families are unsure of the help they need or find it hard to ask for support. An identified gap in the local support system is a lack of opportunities for families in the GBWWG area to learn about the various avenues available to them to support them through the process of living with a child who is struggling with a mental health condition.

Who is affected? All community residents but most importantly youth and their families, individuals managing substance use disorders, and individuals managing chronic health conditions.

Related Quantitative Data (2,3,10)

Compared to the provincial data for New Brunswick: (GBWWG vs. NB)

▼ Compared to provincial data, fewer youth living in GBWWG reported experiencing symptoms of anxiety over a 12-month period during the 2015-2016 school year. (23% vs. 33%).

▼ Compared to provincial data, fewer youth living in GBWWG reported experiencing symptoms of depression over a 12-month period during the 2015-2016 school year. (22% vs. 33%).

= Compared to provincial data, roughly the same per cent of adults living in GBWWG reported that they felt they needed to see or talk to a health professional about their mental or emotional health. (18% vs. 19%).

Compared to GBWWG in 2014: (2014 vs. 2017)

= Compared to 2014, roughly the same per cent of adults living in GBWWG in 2017 reported that they had been diagnosed or were being treated for depression.

Priority 1

Improve the mental health support system available to youth and their families, individuals managing substance use disorders, and individuals managing chronic health conditions.

Social Determinant(s) of Health: Health Services

Strengths, Resources, and Assets that align with this priority:

- Child and Youth Team, Integrated Service Delivery
- Addictions and Mental Health Services
- River Valley Recreation Association
- Westfield Recreation Association
- The River Road Hub run by the Greenwich Recreation Association

Community Recommended Action: Working with community representatives who have experience with the mental health care system, identify possible solutions to the barriers described above that limit the effectiveness of the mental health supports available to those living in GBWWG area.

Suggested Approach:

- Create or enhance avenues for youth to access mental wellness check-in opportunities and ensure youth are consulted to better define how these avenues can be made accessible.

- Create local opportunities for parents to learn about the supports available to help them support a child in crisis. Use such an opportunity to identify what local supports parents would need/use if available.

- With clients from Addictions and Mental Health Services, re-examine, from a user's perspective, the current process used to access and receive mental health support.

- In collaboration with the emergency departments in Saint John, re-define the communication pathway used to connect those who access mental health and addiction support through emergency services to appropriate services.

Priority 2

Address the lack of affordable and reliable transportation.

Social Determinant(s) of Health: Income and Social Status, Social Environment and Community Cohesion, Physical Environment

"Well right now, other than asking a friend to help, we don't have alternative transportation options in this community. I think losing that is one of the main reasons for people to have to leave their homes."

Community Advisory Committee members raised concerns over the lack of transportation in the area and the impact this has on health and wellbeing. Several consultation participants shared such concerns and described a lack of affordable and reliable transportation available to residents to help them move within the local area and to access services, programs, and daily supports located in the City of Saint John.

- This issue is related to income as some households do not have a personal vehicle or rely on one vehicle that is often needed for commuting to work leaving other family members isolated at home. Families with young children and foster families were described as households to be experiencing such circumstances.

- This issue is also related to the area's aging demographic. Consultation participants voiced that many older adults either don't drive or are uncomfortable driving during inclement weather or into the city for services. Some are even challenged getting to services within the area.

- Local youth who live in more remote locations and whose family members work outside of the home are also affected by the lack of local transportation options. Without a local transportation service youth are unable to take part in programming, services, or activities limiting their ability to identify and connect with this area of the province. More remote communities are trying to address this issue by having opportunities, programs, and spaces that can be accessed by walking/biking.

Who is affected? Community residents who lack access to or the ability to afford a private vehicle.

Related Quantitative Data (2,3,10)

Compared to the provincial data for New Brunswick: (GBWWG vs. NB)

= Compared to provincial data, the same per cent of residents living in GBWWG in 2017 indicated that they had transportation problems in getting health care when needed. (5% vs. 5%).

Compared to GBWWG in 2014: (2014 vs 2017)

NA

Strengths, Resources, and Assets that align with this priority:

- From Surfaces to Services: An inclusive and sustainable transportation strategy for the province of New Brunswick, 2017-2037

Community Recommended Action: Look to other communities within NB and elsewhere who are working on transportation initiatives to identify local transportation solutions that will affordably, efficiently, and reliably help residents move within the area or into larger communities where services are often located.

Suggested Approach:

- Develop a plan to collect transportation data to better define the extent of the transportation issues in the area.

- Work towards creating a vision of a local transportation plan to provide solutions that will affordably, efficiently, and reliably help residents move within the area or into Saint John.

- Consider how to enhance and communicate delivery-service options within the area.

Priority 3

Strengthen connections and collaborative capacity between provincial and local organizations supporting the same population groups.

Social Determinant(s) of Health: Social Environment and Community Cohesion, Health Services

"There is no continuity and no matter how hard we try to maintain a connection between services we lose that connection, and I think that's a big part why a lot of people do not even want to access the system because they are getting nowhere."

During many consultations, commentary was shared regarding the level of connection and the state of collaboration between the provincial service system and non-profit or community-based organizations supporting the same population groups living in GBWWG; such as between Horizon and community groups supporting older adults.

- Connecting between services was described to be hampered by the siloed operation of service providers, the lack of awareness and understanding service providers have about other services supporting the same population, the need to assure privacy/confidentiality of information, and a lack of network liaisons who could connect and align services, funding options, and programs.

- Better connections between services supporting the same population groups was felt to be a key ingredient needed to strengthen the local capacity to collaborate on community initiatives to improve population health and wellness. In addition, the sustainability of initiatives with short-term funding, often planned and organized by non-profit or community-based services, is reduced when partnerships are missing with larger, more established service organizations.

- Several local groups and organizations are already working to provide more year-round opportunities to youth and more social engagement/check-in opportunities to older adults whose care needs are changing. Opportunity exists to bring such efforts together to collaborate on certain aspects of work to spread the work-load, make opportunities available to all residents across GBWWG area, and to ensure gaps in funding, programs, communication, and resource availability can be identified and collectively addressed.

- Population groups living in GBWWG who would benefit from strongly connected care networks include children and youth, youth with mental health issues, and older adults who need more care and support including those who live alone.

Who is affected? All community residents.

Related Quantitative Data (2,3,10)

Compared to the provincial data for New Brunswick: (GBWWG vs. NB)

= Compared to provincial data, roughly the same per cent of GBWWG residents find it hard to navigate the health care system. (7% vs. 8%).

Compared to GBWWG in 2014: (2014 vs 2017)

▼ Compared to 2014 data, significantly fewer adults with one or more chronic condition living in GBWWG in 2017 felt very confident that they could control or manage their health. (44% vs. 54%).

Priority 3

Strengthen connections and collaborative capacity between provincial and local organizations supporting the same population groups.

Social Determinant(s) of Health: Social Environment and Community Cohesion, Health Services

Strengths, Resources, and Assets that align with this priority:

- River Valley Recreation Association
- Westfield Recreation Association
- The River Road Hub run by the Greenwich Recreation Association
- Town of Grand Bay-Westfield

Community Recommended Action: Create opportunities to bring service providers from local and provincial services and organizations who support the same population groups together to learn about each other's services and to identify avenues to enhance connections in support of better care.

Suggested Approach:

- Identify effective modes of communication to access different populations groups and work together to build awareness of and connection to health and wellness opportunities.
- Consider the role of a community developer.
- Identify local service access points that could be collaboratively used to support specific populations.

Priority 4

Advocate for and help those living in poverty to enable personal control over health and wellbeing.

Social Determinant(s) of Health: Income and Social Status

"If [those with inadequate income] have to decide OK, am I going to pay my light bills at the end of the week or take this extra arthritis pill that is not covered? Well, it's the middle of winter, I've got to put the heating on."

"Well I think food insecurity is getting worse. I don't know how you fix that because our generation is retiring with not a whole lot of money to retire with. Do you know what I mean? "

Consultation participants shared concern over the challenges facing individuals and families from GBWWG who live on low incomes and the impact this has on overall health and wellbeing. Beyond a lack of affordable and reliable transportation, two major barriers impacting an individual's control over health and wellbeing were shared by many consultation participants and echoed by Community Advisory Committee members:

- It was voiced that individuals living with chronic conditions who live on limited incomes are often unable to afford the most effective medications challenging primary care providers to find alternative, more affordable options. One consultation participant estimated that well over half of the residents they support do not have adequate insurance coverage.

- Challenges with food insecurity were also voiced by several consultation participants. A variety of households were described to be struggling with regular access to healthy food including families with young children, single parents with two to three children, and older adults. Food options in more remote areas are available however they are more expensive. In addition, this area, like many areas of NB, have few who would outwardly ask for support in accessing and affording healthy food. Positive work is underway: Welsford is trying to start a summer market to help bring local farmers to the area to sell food. Produce Clubs or Gleeming programs exist, but residents still need to know what to do with the food and not everyone has cooking skills to make use of what is available.

Who is affected? Individuals and families living on low-to-moderate income.

Related Quantitative Data (2,3,10)

Compared to the provincial data for New Brunswick: (GBWWG vs. NB)

▼ Compared to provincial data, fewer adults living in GBWWG report that the cost of medications is too high to get the health care they need. (30% vs. 33%).

▼ Compared to provincial data, fewer households in GBWWG report experiencing moderate to severe food inseurity. (4% vs. 9%).

Compared to GBWWG in 2014: (2014 vs. 2017)

▼ Compared to 2014 data, significantly fewer adults with at least one chronic condition living in GBWWG in 2017 felt very confident that they could control or manage their health. (52% vs. 40%).

▲ Compared to 2014 data, significantly more adults with at least one chronic condition living in GBWWG in 2017 took 6+ medications regularly. (9% vs. 16%).

Strengths, Resources, and Assets that align with this priority:

- The River Road Hub, Brown's Flat
- River Valley Food Bank, 3224 Westfield Rd.

Community Recommended Action: Working with community, collaboratively identify local action that can be taken to help residents living with low-income become aware of and use opportunities made available to alleviate financial burdens.

Suggested Approach:

- Collectively investigate how households access affordable healthy food year-round to identify gaps in support.
- Advocate for a more equitable pharma-care program.

Priority 5

Enhance local access to primary health care and supporting services.

Social Determinant(s) of Health: Personal Health Practices and Coping Skills and Health Services

"Other groups of people that have critical conditions like arthritis and heart disease, stroke and so on... there's really no additional resources for those groups of people to be properly educated about their illnesses in the community."

Currently, most residents living in GBWWG access primary health care through their family doctor. Two family physicians operate out of Grand Bay-Westfield, others are located in the greater Saint John and Fredericton areas. There is also a local walk-in clinic at the Guardian Pharmacy in Grand Bay-Westfield and many consultation participants shared the benefit of having a walk-in clinic although the inconsistency of hours and primary care provider availability has limited its use. Other health promotion and prevention services are available in the community. The Medicine Shoppe supports the community with education about medications, health promotion support, and facilitates flu vaccination clinics in the area. The River Road Hub hosts a nurse who comes in once a month to draw blood. To support this, the Hub offers space for free and the community members pay ~$15 for the service. This is affordable considering the money they would spend on gas and parking should they travel elsewhere for similar support.

- Consultation participants and CAC members describe the GBWWG area to be transitioning whereby new families with younger children are moving into the area while older adults with financial security are moving out of the area into more appropriate housing options that are closer to needed services. Households either travel regularly or infrequently into the larger cities of Saint John or Fredericton where most health care services and supports are available. Those who infrequently visit larger municipalities, who do not have access to a private vehicle, are left to rely on the kindness of a neighbour or relative to get them to necessary appointments, including medical appointments. For those who have complicated health care needs, this is a major barrier to health and wellbeing.

- A gap described during consultation was a sustainable approach to connect with those living in isolation to support their health and wellness needs without removing their independence. It is important to acknowledge that several consultation participants shared that the Extra Mural supports offered in this area are highly valued allowing people to manage at home with complicated health care challenges. Support is also gaining for new approaches that are unfolding such as the concepts of Advance Care Paramedics and Community Paramedics to help support the care of residents who have complex health care needs.

- A second issue raised by consultation participants was the amount of time family physicians have available to address health concerns and the limited local education opportunities to help individuals manage their health. Most health education and supportive therapeutic services are located elsewhere. Opinions were voiced during consultation that the GBWWG area has many assets, including available space, to support more local health-related opportunities for residents in need.

- Concern was also raised around how the sexual health needs of teens are supported in the area including the local availability of resources accessible to this population group.

- Finally, Indigenous people who live outside of a First Nation community, who are eligible for the Non-Insured Health Benefits (NIHB) program, are often limited by the lack of local health service providers within the Fundy Region who hold registrations with the NIHB program allowing them to submit claims. It was noted that many in leadership and service provider roles often think that this area of New Brunswick does not have an Indigenous population however, there is a community of Indigenous people who are eligible for the NIHB program but do not know where to locally access service providers.

Enhance local access to primary health care and supporting services.

Who is affected? All community residents, especially those managing chronic health conditions.

Related Quantitative Data (2,3,10)

Compared to the provincial data for New Brunswick: (GBWWG vs. NB)

▼ Compared to 2014 data, significantly fewer residents living in GBWWG in 2017 reported that they could get a doctor's appointment within 5 days.

Compared to GBWWG in 2014: (2014 vs 2017)

▲ Compared to provincial data, more residents living in GBWWG in 2017 reported that they had a primary care provider involved in their care. (49% vs. 40%).

▲ Compared to 2014 data, significantly more residents living in GBWWG in 2017 reported that they most often go to an after-hours clinic or walk-in clinic when sick or in need of care. (2% vs. 11%).

▼ Compared to 2014 data, significantly fewer residents living in GBWWG in 2017 reported that their family doctor always gives them enough time to discuss their feelings, fears, and concerns about their health. (77% vs. 70%).

Strengths, Resources, and Assets that align with this priority:

- Extra-Mural Program
- Ambulance NB
- Local General Practitioners
- Primary Care, Horizon
- Local Pharmacies
- Local After-hours/walk in clinic

Community Recommended Action: Work with local health care service and support providers to innovatively address the health care needs of residents who are unable to regularly access services and supports in Saint John or Fredericton.

Suggested Approach:

- Innovatively work with current local resources to bring supports to those in need. Consultation participants envision opportunities to use existing spaces that could be made available to supporting services to come into the community as well as creating more mobile care options to reach those who are isolated.
- Find solutions to address the lack of transportation so that residents can more easily access Saint John services and supports.
- Support the concepts of Advance Care Paramedics and Community Paramedics.
- Continue to support local efforts aimed at enhancing sexual health knowledge among youth.
- Create opportunities for individuals to review health care management plans with health care professionals to better understand how to manage their own care needs.
- Actively facilitate a stronger network of local health care providers that are registered with NIHB.

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